

The Pasts, Presents and Futures of AIDS, Norway (1983–1996)

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Summary. This article explores the Norwegian AIDS epidemic from a temporal perspective. It argues that interrogating the epidemic's tempos and rhythms provides useful tools in writing the history of an epidemic by drawing on a wide array of material from its first decade. By using various theories of temporality and chronology, this article maps out three phases of the Norwegian AIDS epidemic. In the first phase (1983–85), the emergence of the first cases of AIDS threw the positive perception of medicine's past into question and fundamentally challenged the notion of incessant medical progress. In the second phase (1985–87), as grim epidemiological prognoses were created and the general population was increasingly targeted, panic grew across Norwegian society. In the third phase (1987–96), as it was slowly realised that the initial prognoses would not materialise, the epidemic faded from the public imagination. With the unremembering of AIDS, HIV was turned into a chronic disease. The article argues that analysing past temporalities, like past pasts and past futures, provides insights into the presents of the past.

Keywords: HIV/AIDS; epidemics; temporality; past futures; public health

'In six years, 50,000 will have AIDS in Norway.'¹ To a country with a population of just over 4.1 million, the numbers published by a major national liberal newspaper in August 1985 seemed extreme.² A year later, a conservative national newspaper reported on its front page: 'AIDS figures in 1992: 200,000 Norwegians infected?'.³ If these predictions had been correct, AIDS would have been the biggest medical threat to the Norwegian population in the second half of the twentieth century.⁴ The threat challenged the self-congratulatory post-war image of omnipotent Western medicine, built on the idea of progress and hope. New pharmaceuticals and medical technologies had transformed medicine over just a few decades. Antipsychotics had given psychiatrists new tools for

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¹Arvid Bryne, '50.000 med AIDS i Norge om seks år', *Dagbladet*, 10 August 1985, 12.

²Per 1 January 1985, the Norwegian population counted 4,145,845. *Statistisk årbok 2013*, 132. årgang (Oslo: Statistisk sentralbyrå, 2013), 68.

³AIDS-tall i 1992: 200 000 nordmenn smittet?', *Aftenposten*, 31 July 1986.

⁴Nowadays, it is common to refer to 'HIV/AIDS'. The virus causing AIDS was first isolated in 1983, and until

the abbreviation 'HIV' was suggested in 1986, it was labelled differently, among others lymphadenopathy-associated virus (LAV) and human T-lymphotropic virus 3 (HTLV-III). The clinical presentation in the early years of the epidemic was immune failure with secondary infections and/or cancers. In this article, I will mainly refer to AIDS when not talking specifically about the virus.

treating mental illness.⁵ Anti-hypertensives, cholesterol-lowering drugs and anti-diabetics not only fundamentally changed people's understandings of chronic disease and the concept of risk factors, but also expanded the domain of medicine to ever-bigger parts of people's lives.⁶ Technical and technological interventions—like dialysis, heart surgery, transplantation medicine and highly specialised intensive care medicine—enabled doctors to treat ever more complex medical conditions and prolong life. The rising life expectancy and declining infant mortality witnessed in the twentieth century have led some scholars to define the decades before and after the Second World War as 'the golden age of medicine'.⁷ By the start of the 1980s, the medical future looked bright, especially for infectious medicine. Antibiotics had revolutionised the treatment of infectious diseases and made surgery safe. In 1979, the World Health Organisation declared smallpox eradicated with the release of the Global Commission for the Certification of Smallpox Eradication report. In the medical community, there was a general belief that the era of the infectious diseases was history. Controlling infectious diseases appeared to be 'a routine process of discovering its cause and cure'.⁸ Chronic and non-communicable diseases, it was thought, would dominate medicine in the decades to come. It was against this backdrop that the first reports of young men dying from rare diseases appeared, including in Norway.

Much of the considerable body of scholarship on the history of HIV/AIDS has focused on the USA.⁹ Less has been written about the European context and almost nothing from a Norwegian perspective.¹⁰ In this article, I argue that from the start of the epidemic until the development of efficient treatment (highly active antiretroviral therapy, HAART), time and chronology were constructed and invoked in various ways—past, present and future.¹¹ The temporalities of AIDS have mainly been explored from a perspective of

⁵For how pharmaceuticals changed twentieth-century medicine, see Jeremy A. Greene, Flurin Condrau and Elizabeth Siegel Watkins, eds, *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century* (Chicago: The University of Chicago Press, 2016); for how psychopharmacology changed modern psychiatry, see David Healy, *The Creation of Psychopharmacology* (Cambridge, MA: Harvard University Press, 2002).

⁶Jeremy A. Greene, *Prescribing by Numbers: Drugs and the Definition of Disease* (Baltimore: Johns Hopkins University Press, 2007).

⁷For an analysis and critique of the term, see Allan M. Brandt and Martha Gardner, 'The Golden Age of Medicine?', in Roger Cooter and John Pickstone, eds, *Companion to Medicine in the Twentieth Century* (London and New York: Routledge, 2000), 21–39.

⁸Daniel M. Fox, 'AIDS and the American Health Polity: The History and Prospects of a Crisis of Authority', in Elizabeth Fee and Daniel M. Fox, eds, *AIDS: The Burdens of History* (Berkeley: University of California Press, 1988), 316–43.

⁹See, for instance, Ronald Bayer and Gerald M. Oppenheimer, *AIDS Doctors: Voices from the Epidemic* (New York: Oxford University Press, 2000); Steven Epstein, *Impure Science: AIDS, Activism, and*

the Politics of Knowledge (Los Angeles: University of California Press, 1996); Fee and Fox, *The Burdens of History*.

¹⁰The UK is a notable exception, see Virginia Berridge, *AIDS in the UK: The Making of Policy, 1981–1994* (Oxford University Press, 1996); Jeffrey Weeks, 'AIDS and the regulation of sexuality', in Virginia Berridge and Philip Strong, eds, *AIDS and Contemporary History* (Cambridge: Cambridge University Press, 2002). For Norway, see Olav André Manum, *Kjærlighet, kunnskap og kondom. Den hivpolitiske kampen i Norge* (Oslo: Pax forlag, 2010) for an account of late 1980s AIDS activism; the transcription of an oral history seminar, Stein A. Evensen et al., 'Da hiv kom til Norge', *Michael Quarterly*, 2010, 7, 12–157; Bjørn G. Iversen, 'Homosomatikk – Seksuelt overførbare infeksjoner og den norske hivhistorien i et homseperspektiv', in Marianne C. Brantsæter et al., eds, *Norsk homoforskning* (Oslo: Universitetsforlaget, 2001).

¹¹In this article, I draw heavily on Richard Koselleck's theorisation of natural and historical time and the roles acceleration and progress have played in modern understandings of historical time. See Reinhart Koselleck, *Futures Past: On the Semantics of Historical Time* (New York: Columbia University Press, 2004).

queer theory.¹² This article analyses the connections between time and the epidemic from a medical–historical perspective. It traces the different times awakened and contested during the epidemic’s early years by analysing a range of primary sources, like archival material, newspaper articles, action plans, information campaigns, educational leaflets, circulars and meeting reports, as well as published materials, including books for lay people, academic articles, published interviews, a transcribed oral history seminar and secondary literature.

By using various theories of temporality and chronology, this article maps out three phases of the Norwegian AIDS epidemic. In the first phase, which began with the first cases of AIDS in 1983, various temporalities collapsed into one another: In AIDS, the old and the new co-existed on several levels—old microorganisms and new technologies, natural time and historical time. This contemporaneity of the non-contemporaneous played out differently in different discourses.¹³ In the press, medicine’s past glory was thrown into question, and AIDS invoked feelings of deep insecurity and uncertainty about the period ahead. In the Norwegian medical community, however, the initial responses were rather slow and cold-headed.

In the epidemic’s second phase, from 1985 to 1987, when public panic was at its height, time was accelerated. Even if scholars of time have argued that acceleration is a distinguishing mark of modernity,¹⁴ in AIDS, the acceleration threatened a notion of modernity and progress itself. The historian Reinhart Koselleck has argued that the modern perception of time as historical and forward-directed (*‘geschichtliche Zeit’*) can be traced back to a break with an understanding of time as rooted in a nature defined by the seasons and the movement of the sun. A lack of comparable historical templates rendered future possible: ‘The lesser the experience, the greater the expectation’, Koselleck observed, ‘this is a formula for the temporal structure of the modern, to the degree that it is rendered a concept by “progress”’.¹⁵ With AIDS, however, the ever-growing cleft between experience and expectation, the pre-condition for an idea of a better future, threatened the very idea of progress.

AIDS constructed and disrupted futures: insecurity, grief, premature deaths and a dying society. Yet, as Nik Brown and Mike Michael have argued, ‘The future is not simply a neutral space into which objective expectations can be projected’. It is also an ‘analytical object’.¹⁶ A central ambition in the growing literature on the historiography of

¹²See Carolyn Dinshaw et al., ‘Theorizing Queer Temporalities: A Roundtable Discussion’, *GLQ: A Journal of Lesbian and Gay Studies*, 2007, 13, 177–95; Elizabeth Freeman, *Time Binds: Queer Temporalities, Queer Histories* (Durham, NC: Duke University Press, 2010); Judith Halberstam, *In a Queer Time and Place: Transgender Bodies, Subcultural Lives* (New York: New York University Press, 2005); Christopher Castiglia and Christopher Reed, *If Memory Serves: Gay Men, AIDS, and the Promise of the Queer Past* (Minneapolis: University of Minnesota Press, 2012). See also Kevin Warth, ‘If I Could Turn Back Time: AIDS, Photography, and Queer Temporality’. Webpage, available at: <http://www.kevinwarth.com/writing/#/if-i-could-turn-back-time/> [last accessed 8 November 2019].

¹³For the definition of the contemporaneity of the non-contemporaneous (*‘die Gleichzeitigkeit des Ungleichzeitigen’*), see Koselleck, *Futures Past*, 89–92, 95. Koselleck did not refer to Ernst Bloch, even if he wrote extensively about the concept of *‘Ungleichzeitigkeit’* (often translated as non-simultaneity or non-contemporaneity) in his work.

¹⁴See Hartmund Rosa, *Social Acceleration: A New Theory of Modernity* (New York: Columbia University Press, 2013).

¹⁵Koselleck, *Futures Past*, 274.

¹⁶Nik Brown and Mike Michael, ‘A Sociology of Expectations: Retrospecting Prospects and

expectations is to shift the perspective from 'looking into the future to looking at the future'.¹⁷ The AIDS epidemic's different phases, tempos and rhythms enabled various kinds of lives and expectations for the future. This article argues that analysing past futures can provide insight into the presents of the past. Futures too have a history and paying attention to them can help us understand how futures are not merely static representations of expectations but also objects that are performed and mobilised to act in the present. Expectations for the future are, among other things, used to form alliances and agendas, build networks and attract funding. In medical-historical writing, the study of future and past futures has often been forgotten, but looking at shifts in expectation over time—in other words, past futures—can provide insight into the scientific and cultural contexts in which they were formulated.¹⁸ In AIDS, expectations for the future, like prognoses, were mobilised not only for funding but also to advocate for harsh measures, like coercive mass testing and isolation of the sick. In the debate about how society and medicine should confront AIDS, history—the past pasts—was invoked too for action in the present.

Ultimately, in the third phase, from 1987 to 96, as it was realised that the dramatic prognoses would not materialise, the epidemic began silently fading away before turning into a chronic illness. The press played an important role in this process of 'unremembering', which enabled a new set of stories to emerge as others were made unseen.¹⁹ Against this backdrop, the health authorities struggled to hammer out strategies to fight the looming epidemic of ignorance and prejudices. They were concerned that the preventive strategies that had been meticulously built up could easily collapse if the population forgot about the risk of HIV.

The article ends by returning to its beginning. It asks what a non-linear history of AIDS might look like, one that takes seriously the entanglement of time in producing 'origins' and the temporal transformation of events in writing history.²⁰

The Beginning: Times Collapsing into One Another, 1983–1985

In January 1983, a young man was admitted to the National Hospital in Oslo with candidal oesophagitis, weight loss and recurrent bouts of diarrhoea and quickly developed Kaposi's sarcoma, *Pneumocystis carinii* pneumonia and cytomegalovirus retinitis, which eventually made him blind.²¹ Even if this probably represented the first person diagnosed with AIDS in Norway, the public had already been well informed about the looming North American tragedy. In many ways, the years between the first reported cases in 1981 and the first Norwegian cases were spent waiting for a future catastrophe. Stig Frøland, an infectious disease specialist at the National Hospital, recalled in an oral history seminar that from mid-1981, when they received the first reports from the USA about a potential new immune deficiency epidemic, 'I was just walking around waiting for the first cases to show up here in Norway. In Europe, the epidemic manifested itself quickly,

Prospecting Retrospects', *Technology Analysis and Strategic Management*, 2003, 15, 3–18, 4.

¹⁷*Ibid.* (emphasis in original). See also: Mads Borup et al., 'The Sociology of Expectations in Science and Technology', *Technology Analysis & Strategic Management*, 2006, 18, 285–98.

¹⁸Scott H. Podolsky and Anne Helene Kveim Lie, 'Futures and Their Uses: Antibiotics and Therapeutic

Revolutions' in Greene, Condrau and Watkins, eds, *Therapeutic Revolutions*, 18–43.

¹⁹On 'unremembering' AIDS, see Castiglia and Reed, *If Memory Serves*, 1–37.

²⁰Hans-Jörg Rheinberger, *Experiment. Differenz. Schrift: zur Geschichte epistemischer Dinge* (Marburg/Lahn: Basilisk-Verlag, 1992), 47–65.

²¹Frøland in Evensen et al., 'Da hiv', 30–31.

and it was frightening, of course'.²² Even though nobody in Norway had yet been diagnosed, the press had inserted the epidemic into Norwegians' imagination. In the summer of 1981, the U.S. Centers for Disease Control's Morbidity and Mortality Weekly Report alerted the medical world about an outbreak of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia in young homosexual men, a story that was picked up by the *New York Times* and, 1 week later, by the Norwegian newspaper *Dagbladet*.²³ Later the same year, *Dagbladet* published another article titled 'Deadly disease hit homosexuals', which referred to an article in *New England Journal of Medicine* about unusual cases of opportunistic infections and Kaposi's sarcoma in homosexual men.²⁴ An article from late 1982 in VG, a popular tabloid, stated that a new disease affecting homosexuals had been discovered.²⁵ In the article, a doctor described the disease as 'mystical'. For the medical community, the anticipation was not without excitement. 'I was fascinated too', Dr Frøland remembered: 'Over many years, I had had an interest in immune deficiencies, both from a clinical and a scientific perspective, and now there was an immune deficiency epidemic that targeted the patients' T cells.'²⁶

In the Norwegian medical community, the sentiments were, initially at least, relatively optimistic. Many professionals thought the 'AIDS riddle' would be solved within a short time and, assuming the disease was caused by a virus, that it was just a question of time before it would be identified. Medicine had a long history of tackling epidemic challenges: 'The medical knowledge about the human panorama of diseases seems not to be static', the *Journal of the Norwegian Medical Association* argued in 1983.²⁷ 'We are used to a continuous flow of findings and observations from different parts of medical research. Sometimes one is confronted with sensational and alarming news like the outbreak of Legionnaires' disease or the swine flu'.²⁸

Because the AIDS epidemiology was thought to be confined to certain 'risk groups', many doctors assumed that it would probably not pose a major problem for the Nordic countries.²⁹ The medical community had already responded quickly and methodically, and the journal underlined that it was 'impressive' how many observations had been collected in the short time since the first reports of the disease. Doctors had responded efficiently, mobilising the medical machinery of statistical and clinical observation, registration and reporting: 'There is probably no reason to implement extensive

²²*Ibid.*, 30–31. '[G]ikk jeg bare og ventet på de første tilfellene her i Norge. Epidemien viste seg raskt i Europa og den var naturligvis skremmende'.

²³Lawrence K. Altman, 'Rare Cancer Seen in 41 Homosexuals', *New York Times*, 3 July 1981; Arvid Bryne, 'Krefttype rammer homoseksuelle', *Dagbladet*, 10 July 1981, 21.

²⁴'Dødelig sykdom rammer homofile', *Dagbladet*, 16 December 1981, 20.

²⁵Karin Haugen, 'Ny sykdom oppdaget: homofile rammes', VG, 17 December 1982, 10.

²⁶Frøland in Evensen *et al.*, 'Da hiv', 31. 'Men jeg må erkjenne at jeg også var fascinert. For immunsvikt var et tema som hadde opptatt meg både klinisk og vitenskapelig i mange år, og nå hadde vi altså en immunsviktepideemi som rammet pasientenes T-celler'.

²⁷Miklos Degré, 'Ervervet immundefekt – AIDS', *Tidsskrift for Den norske Lægeforening*, 1983, 103, 887–88, 887. 'Medisinsk viten om det humane sykdomspanorama er visst ingen statisk kunnskap'.

²⁸*Ibid.* 'Vi er vant til en jevn strøm av resultater og observasjoner fra forskjellige grener av medisinsk forskning. Av og til blir man konfrontert med sensasjonelle og alarmerende nyheter som for eksempel utbrudd av legionærsykdommen eller svineinfluensa'.

²⁹Numerous historians have pointed to the politics of constructing 'risk groups'. For an early analysis in the history of AIDS, see Gerald O. Oppenheimer, 'In the Eye of the Storm: The Epidemiological Construction of AIDS', in Fee and Fox, eds, *The Burdens of History*, 267–300.

immunological diagnostics of patients with relatively common infectious diseases or lymphadenopathy. A thorough medical history, including sexual behaviour, is probably the most important part of the exam'.³⁰ Doctors also saw little reason to alarm the population, as the risk AIDS posed to the 'general population' was so small. As a result, one infectious disease specialist warned, in an interview with a major Norwegian newspaper, that the attention given to the epidemic was 'a bit exaggerated'.³¹ Doctors conveyed the impression to the public that threat was under control.

Initially, the disease was thought to have several stages. The pre-stage was characterised by weight loss, lymphadenopathy, bursts of fever and diarrhoea. The medical community believed the disease did not always progress from its early stages to its fulminant form, and that AIDS was survivable.³² In the early years of the epidemic, when the US Centers for Disease Control conducted a cluster study and drew maps over possible spread sources and transmission routes, it was thought that the incubation period, that is the period from exposure to an infectious agent and development of an AIDS-associated manifestation, was comparable to patients who had undergone kidney transplantation and were put on immune-suppression medication, e.g. from seven to fourteen months. It would take several years before it became clear that the asymptomatic phase could last for years.³³ There were therefore several reasons why AIDS did not pose a threat to medicine's self-image of continuous progress during the early period of the epidemic, including in Norway. There, doctors were instead encouraged to treat this new situation as any other medical problem and continue their regular practice of taking patients' histories and examining them clinically. An editorial in the *Journal of the Norwegian Medical Association*, for instance, argued that the medical community had 'no reason to suspect an epidemic'.³⁴

The arrival of AIDS both in Norway and internationally, however, represented a collision between two different narratives of modern medicine and modernity. These narratives were communicated by the press and reflected in the ways medical professionals talked about the epidemic. On the one hand, in the press at that time, medicine was largely seen as an unstoppable force of progress: 'Medicine cures, operates plastic hearts and exceeds ever more limits', *Dagbladet*, a major left-wing/liberal newspaper reported in 1983.³⁵ On the other hand, society had just witnessed major societal changes with the women's rights movement and sexual liberation, which many opposed. Furthermore, the same developments that had contributed to the progress of modern societies and made

³⁰Degré, 'Ervervet immundefekt', 888. 'Det er neppe grunn til å sette i gang store immunologiske utredninger av pasienter med relativt vanlige infeksjonssykdommer lymfadenopati. En grundig anamnese som inkluderer seksuelle forhold, er sannsynligvis den viktigste del av undersøkelsen'.

³¹Interview with Dr Johan Bruun, 'Liten generell smittefare i befolkningen', *Aftenposten*, 12 September 1983, 4. '... oppmerksomheten som nå rettes mot sykdommen [er] noe overdreven'.

³²Gro Møllerstad, 'AIDS kan overleves', *Dagbladet*, 13 June 1983, 16.

³³Richard A. McKay, "'Patient Zero": The Absence of a Patient's View of the Early North American AIDS Epidemic', *Bulletin of the History of Medicine*, 2014,

88, 161–94. Sources disagree when it was realised that the incubation period usually last for years. For instance, in a report from the first European conference on AIDS from 1983, it was reported that incubation time was probably between 2 months and 5 years, see Jan Doubloug, 'AIDS in Europe – status quo 1983', *Tidsskrift for Den norske Lægeforening*, 1983, 103, 2343–44.

³⁴Degré, 'Ervervet immundefekt', 888. 'Det er ingen ting som taler for at vi kan vente noen epidemi her i landet'.

³⁵Arvid Bryne, 'Nye sykdommer avløser gamle', *Dagbladet*, 14 May 1983, II, 9. 'Legevitenenskapen kurerer, opererer inn plast-hjerner og sprenger stadig nye grenser'.

medicine efficient now threatened society itself. Technology and modern lifestyles, including 'promiscuous behaviour' and the sharing of needles among people who injected drugs, were at the centre of the menace. Blood banks also became unsafe, since people with haemophilia had gotten infected through blood transfusions.³⁶ Technology had provided new breeding grounds for old microbes that had long stayed dormant in their natural habitat:³⁷ 'New infections that we barely know the name of are popping up like mushrooms and spread epidemically', *Dagbladet* reported.³⁸ New modern mass transportation systems made it possible for bacteria and viruses to travel 'from China to Setesdal [a rural district in southern Norway] in a few hours'.³⁹ Just years after medicine had eradicated smallpox, society was witnessing 'the paradox that medicine's sterile strongholds, the new giant hospitals, are not sterile, but hotbeds for gruesome diseases and illnesses, provoked by millions of old bacteria, staphylococci and streptococci, which have now become immune to antibodies'.⁴⁰

The emergence of the epidemic in Norway occurred at the same time as a frantic search to find the causes of AIDS. Some suspected the causes to be connected to modernity itself. In the early days of the epidemic, one aetiological theory discussed among scientists internationally was that poppers, a liquid in the chemical class of amyl nitrites used to enhance sexual experiences, could be involved in the pathogenesis.⁴¹ According to another theory, AIDS was the end result of an accumulation of immune system defects due to reactivation of Epstein–Barr virus and autoantibody response, homosexual men's continued exposure to other men's semen ('allogenic semen') and repeated sexually transmitted infections (including cytomegalovirus). The theory posited that these processes ultimately led to a collapse of the immune system.⁴² It argued that no single infectious agent was responsible for immune deficiency, and that a series of necessary cofactors instead had to be present, including sexual habits, travel practices and lifestyle choices.⁴³ In the gay communities in North American metropolises, these ideas were also well known and widespread.⁴⁴ The first review article about AIDS in a Norwegian medical

³⁶Arvid Bryne, 'AIDS tar livet av homofile og barn', *Dagbladet*, 16 May 1983, 35.

³⁷The HIV-1 pandemic emerged in Kinshasa in the 1920s and spread through central Africa pre-1960 by the means of active transportation networks. The jump from the Caribbean to the USA happened around 1970. Nuno R. Faria *et al.*, 'The early spread and epidemic ignition of HIV-1 in human populations', *Science*, 2014, 346, 6205; M. Worobey *et al.*, '1970s and "Patient 0" HIV-1 genomes illuminate early HIV/AIDS history in North America', *Nature*, 2016, 539, 7627. For a very early 'origin story' of AIDS, the importance of societal factors in the emergence of epidemics and the concept of 'pathocenosis', see Mirko D. Grmek, *History of AIDS: Emergence and Origin of a Modern Pandemic*, Russell C. Maulitz and Jacalyn Duffin (trans) (Princeton: Princeton University Press, 1990).

³⁸Bryne, 'Nye sykdommer', 9. 'Nye infeksjoner som vi knapt kjenner navnet på spretter opp som sopp og har fått epidemisk utbredelse'.

³⁹*Ibid.* '... fra Kina til Setesdalen på timer'.

⁴⁰*Ibid.* 'Vi opplever i dag det paradoksale at medisinen sterile høyborger, de nye gigantsykehusene, ikke er sterile, men utklekkingsanstalter for grusomme sykdommer og lidelser framkalt av millioner av gamle bakterier, stafylokokker og streptokokker, som nå er blitt immune mot antistoffer'.

⁴¹Oppenheimer, 'Eye of the Storm', 273.

⁴²Joseph Sonnabend, Steven S. Witkin and David T. Purtilo, 'Acquired Immunodeficiency Syndrome, Opportunistic Infections, and Malignancies in Male Homosexuals: A Hypothesis of Etiologic Factors in Pathogenesis', *JAMA*, 1983, 249, 2370–74.

⁴³Paula A. Treichler, 'AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification', in Douglas Crimp, ed., *AIDS, Cultural Analysis, Cultural Activism* (Cambridge, MA: MIT Press, 1988), 31–70.

⁴⁴Richard A. McKay, *Patient Zero and the Making of the AIDS Epidemic* (Chicago: University of Chicago Press, 2017), 289–353.

journal in 1983 did not exclude the possibility of it being caused by a new virus but also found the 'several hit' theory credible.⁴⁵ In his report from a scientific symposium in New York City in April 1983 to Norwegian health authorities, Dr Frøland underscored that the new disease was probably being caused by several different viruses.⁴⁶ Modern lifestyle was part of the reasoning around aetiology in the press, in the medical debate and in the political discussion.

AIDS put ideas of continuous medical and technological progress and the advancement of society to the test. 'New diseases replace old' was the heading in one newspaper article in May 1983 that was part of a bigger journalistic series on 'new diseases'.⁴⁷ Bacteria and viruses had shaped history more than any king or scientific discovery, the newspaper argued. The Black Plague, it pointed out, had wiped out up to one-third of the European and Russian population, and more people perished from infectious diseases than bullets in many wars. The appearance of AIDS made new and old ideas about diseases, microbes and infectious agents co-exist simultaneously. 'New' diseases like AIDS, Legionnaires' disease and tampon sepsis clashed with ideas of 'old' bacteria and pathogens, creating a *contemporaneity of the non-contemporaneous*. Edvard Munch's famous painting 'The Sick Child' was used to illustrate the newspaper series. Originally painted in 1885–86, Munch would return to this motif in several paintings and works in different media over a 40-year period, like a ghost haunting his memory. 'The Sick Child', a collection of paintings and lithographs depicting Munch's 15-year-old, bedridden sister dying from tuberculosis, epitomises this assemblage of new and old. AIDS evoked a memory of a forgotten past, of long-gone plagues and suffering, of the Black Death and the Spanish flu—of the collective trauma of untreatable tuberculosis. It was with a certain resignation that Dr Frøland wrote an article looking back at the first 2 years of AIDS in Norway in the *Journal of the Norwegian Medical Association* published in early 1985. The prognosis was grim, he stated, no therapy for AIDS nor HTLV-III/LAV infection was available, and the new antibody tests, which would soon be commercially available, posed a conundrum of medical and ethical questions. What we had witnessed was 'the end of the beginning', he wrote, 'not the beginning of the end'.⁴⁸

An Epidemic Accelerated: Tempo, Panic and Political (in)Action, 1985–1987

The official Norwegian guidelines for the care of patients suspected of having AIDS published in January 1985 underscored that contractibility was low. Healthcare personnel were recommended to take the same precarious measures as with patients with hepatitis B, and it was the only cause of concern in situations when blood, secretions and excretions from patients were inoculated in or transferred to wounds or mucous membranes.⁴⁹ Protective gear was to be used when there was a risk of getting contaminated

⁴⁵Øystein Anders Strand, 'Ervervet immunsivikt (AIDS)', *Tidsskrift for Den norske Lægeforening*, 1983, 103, 895–97.

⁴⁶Stig Frøland to the Directorate of Health, 'Rapport fra symposiet "Epidemic Kaposi's sarcoma and opportunistic infections in homosexual men: expression of an Acquired Immunoregulatory Disorder", 17. til 19. mars 1983 ved New York University', 19 April 1983, S-1287 Sosialdepartementet, Helsedirektoratet,

Hygienekontoret, H5, D, box 151, the National Archives of Norway, Oslo (hereafter NAN).

⁴⁷Bryne, 'Nye sykdommer', 9.

⁴⁸Stig Frøland, 'AIDS i 1984', *Tidsskrift for Den norske lægeforening*, 1985, 105, 1–2. 'Slutten på begynnelsen, ikke begynnelsen på slutten'.

⁴⁹Helsedirektoratet, 'Retningslinjer for pleie av pasienter med AIDS, mistenkt AIDS og lymfadenopatisyndrom', AIDS-skriv nr. 2, 8 January 1985 in *AIDS—samling av rundskriv om AIDS og HTLV-III/LAV*

by the patient's body fluids. Patients with a cough or those with suspected contagious lung diseases were to wear face masks.

When the first large-scale official response strategies, the Control Programme for AIDS and the comprehensive Action Plan, were initiated in the mid-1980s, authorities argued that most vulnerable groups could be reached and involved by building trust with them and encouraging them to take voluntary precautions.⁵⁰ From the very beginning, Norwegian health authorities followed a policy of avoiding the stigmatisation of those groups seen to be most at risk and of the sick and of empowering affected communities, in many ways resembling official approaches in Denmark.⁵¹ The guidelines for healthcare workers made it explicitly clear that preventive measures should not hinder 'human contact' or good care.⁵² Care for the affected, the sick and those who tested positive (tests were available as of 1985) were leitmotifs in the Norwegian guidelines and whitepapers produced during this early period. It was seen as an important part of the healthcare system's response to AIDS that medical professionals be able to help people deal with fear, acute stress reactions, personal crises and grief. The whole public system for the rehabilitation of drug users, including psychiatric youth teams, was mobilised. These outpatient treatment and outreach teams, which had been developed during the 1970s and existed all over the country by the mid-1980s, were given a dedicated role in preventive work and the education of social workers.⁵³ Many drug users had applied for rehabilitation treatment in public institutions because of the spread of the virus and the fear in the community. Institutions were explicitly told to ensure people were handled appropriately, and public health officials even encouraged institutions to offer intensive inpatient care for the treatment of acute grief or stress reactions.⁵⁴ Official approaches to prevention were rooted in a voluntary philosophy and non-coercive approach. Measures were directed towards safer drug injection practices and safer sex practices. The authorities recognised that, although changing sexual habits and attitudes towards sexuality could be 'very difficult – at least in the short term', advice needed to be customised to different groups.⁵⁵ Men who had sex with men, drug users, youths and adults with an active non-monogamous sex life, authorities argued, all had different needs when it came to information and action.⁵⁶ Nevertheless, the question of how to stop the epidemic among injecting drug users (IDUs) was controversial. The police argued against needle and syringe distribution, and criminalisation of illicit drug use was an important part of

(Oslo: Helsedirektoratet, 1986). Already in April 1983, the similarities with hepatitis B were underlined by the authorities in a circular to all Norwegian hospitals. See, the Directorate of health to Norwegian hospitals, circular, AIDS, Rundskriv nr. 1-1030/83, Pa-1216 Det Norske Forbundet av 1948, Db, Box 7, Helsedirektoratet, NAN.

⁵⁰Helsedirektoratet, 'Helsedirektørens kontrollprogram for AIDS-sykdommen', 2 July 1985, Helserrådet, box 52, aids, Oslo City Archives, Oslo (hereafter OCA); Helsedirektoratet, 'Helsedirektørens tiltaksplan for bekjempelse av HIV-infeksjonen', AIDS-skriv nr. 17, 15 October 1986, 19–21; Kari Tveito, 'Et fargerikt fyrtårn', *Tidsskrift for Den Norske Lægeforening*, 2006, 126, 3150–51.

⁵¹Erik Albæk, 'Denmark: the political "Pink Triangle"', in David L. Kirp and Ronald Bayer, eds, *AIDS in the Industrialized Democracies: Passions, Politics, and Policies* (New Brunswick: Rutgers University Press, 1992), 281–316.

⁵²Helsedirektoratet, AIDS-skriv nr. 2, 1985.

⁵³Helsedirektoratet, 'De psykiatriske ungdomsteam – tiltak for å møte spredning av HTLV-III smitte blant stoffmisbrukere', AIDS-skriv nr. 12, 29 April 1986, in *AIDS – samling av rundskriv om AIDS og HTLV-III/LAV* (Oslo: Helsedirektoratet, 1986).

⁵⁴*Ibid.*

⁵⁵Helsedirektoratet, AIDS-skriv nr. 17, 1986, 21.

⁵⁶*Ibid.*

Norwegian drug policy. The Directorate of Health underlined that 'the most efficient way of stopping spread of HIV among intravenous drug abusers is to stop the intravenous drug abuse'.⁵⁷ Still, it was seen as important to secure clean syringes as part of a harm-reducing strategy: the Directorate encouraged local health authorities to secure access to user equipment around the country, and syringes were not only sold over-counter in pharmacies through the whole epidemic but were also available through vending machines.⁵⁸ Once again, Norwegian policy was closer to its Danish than Swedish counterpart. In Sweden, a country with a long history of compulsory treatment for drug users, access to syringes during the epidemic was very restricted, and the general approach towards IDUs moved in a compulsory direction.⁵⁹

In Norway, as in the USA, the narrative of AIDS in public and medical contexts in the early phase was largely communicated with the use of metaphors invoking time and the military: 'AIDS alarms', 'revolutions' and 'AIDS – a time bomb'.⁶⁰ Susan Sontag argued that military metaphors had become increasingly common in descriptions of diseases, as they 'invaded' not only individual bodies but societies,⁶¹ and AIDS enacted notions of 'otherness', like enemies in modern wars.⁶² This was also true of the Norwegian context. Two decades before AIDS came to Norway, the Director of Health, Karl Evang, referred to the health administration as a 'general staff', which needed to be up to date on medical 'weapon technology' if it was to lead 'the continuous battle against all the deleterious agents that seek to undermine human health and work power'.⁶³ Ironically, the same metaphors Evang had used to justify increasing power to the health administration were used in the early stages of the AIDS epidemic to describe the disease that challenged his system.⁶⁴

⁵⁷*Ibid.*, 14. '[D]en mest effektive måten å stoppe spredningen av HIV blant intravenøse misbrukere, er å stoppe selve sprøytemisbruket ...'.

⁵⁸*Ibid.* From 1988 in the Oslo-area syringes were distributed by a dedicated buss, 'Sprøytebussen'. Terje Lie, Hild Stuland Larsen and Jostein Rise, 'Aktører, organisering og informasjon' in *Hiv/aids-forebyggende arbeid i Norge. En evaluering* (Oslo: Norges forskningsråd: 1995), 59–60.

⁵⁹Signild Vallgård, 'Problematisations and Path Dependency: HIV/AIDS Policies in Denmark and Sweden', *Medical History*, 2007, 51, 99–112; Benny Henriksson and Hasse Ytterberg, 'Sweden: the power of the moral(istic) left, in Kirp and Bayer, eds, *AIDS in the Industrialized Democracies*, 317–38.

⁶⁰Karin Bøhm-Pedersen, 'Sex-revolusjon etter AIDS-alarm', *Dagbladet*, 18 August 1983, 9. Karin Bøhm-Pedersen, 'AIDS – tidsinnstilt bombe', *Dagbladet*, 15 March 1984, 10.

⁶¹Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus & Giroux 1978), 65–68.

⁶²Susan Sontag, *AIDS and Its Metaphors* (New York: Farrar, Straus & Giroux 1989), 9–11.

⁶³Karl Evang, 'Den medisinske fagkyndiges plass i helseadministrasjonen', *Läkartidningen*, 1965, 36, 2826, cited in Rune Slagstad, *De nasjonale strategier* (Oslo: Pax forlag, 1998), 313.

⁶⁴As Director of Health from 1938 to 1972, Karl Evang played a significant role in the development of the Norwegian welfare state, which gradually developed through the twentieth century but became more pronounced in the decades after the Second World War. The state secured its authority and legitimacy through a gradual 'expertification' of public institutions, most prominently with the creation of a strong and public healthcare system. 'The Evang system', the politico-administrative public health bureaucracy created from the pre-war period to the 1970s by the Director of Health, Karl Evang, was a social-democratic 'knowledge regime' rooted in the belief in and mobilisation of science in several public sectors. Medical paternalism was an integral part of this social-democratic healthcare system. In the Evang era, the Directorate gained significant authority and independence and became a central instrument in building and supporting the social-democratic welfare state. When AIDS came to Norway in the early 1980s, however, the empire had started to crumble. In the mid-1970s, and under the new director, Torbjørn Mork (1928–92), the directorate was moved out of the Ministry of Social Affairs. Public health bureaucracy, however, remained an expertocracy, and physicians enjoyed a respected position in society. See Trond Nordby, *Karl Evang – en biografi*

In 1985, however, 3 years after the first AIDS cases appeared, the way the epidemic was temporally constructed changed radically in the press and in the medical and political discourse. A sense of urgency was created on different levels—in newspaper articles, white papers and information campaigns. Tempo played a fundamental role in the panic that resulted. In many ways, the mid-1980s can be described as an *accelerated* phase of the epidemic: uncertainty, fear and dire prognoses played out on several levels in public debates. This became visible, for instance, in the metaphors used to describe the epidemic. The USA and Europe now witnessed an ‘explosion’ in the number of people infected, Norwegian newspapers reported. If the epidemic were to develop in the same ‘explosive way’ in the Nordic countries as it had in the USA or other European countries, there would be 200 cases of AIDS in 3 years, and their treatment would cost 100 million Norwegian kroner annually, Georg Petersen, an activist, physician and AIDS expert warned in an interview in the newspaper.⁶⁵ ‘100 000 Norwegians at risk of AIDS infection’ was the title of another article.⁶⁶ The time bomb metaphor, which had been used to describe the early period of the epidemic, was suddenly inadequate. The bomb had exploded, the crisis was here.⁶⁷ Society had now entered the steepest part of the epidemiological curve, an expert warned.⁶⁸ ‘Norway and the rest of the world face a big threat to public health and a big problem for the public health services which give reason for serious concern’, the Director of Health wrote in October of 1986.⁶⁹ In the worst-case scenario, with the highest replication rate and in which every preventive measure had failed, 280,000 would be infected by the end of 1990, with 180,000 of the infections taking place in 1990.⁷⁰ Even in the best-case scenario, 60,000 would be infected.⁷¹ For a small country, these were extreme numbers. ‘There is a major risk of massive spread of the virus – primarily in high-risk groups and secondary to sex partners outside of these groups’, doctors at the Norwegian Institute of Public Health wrote, in an article titled ‘AIDS: The threat and challenge of our time’.⁷² In the article, a diagram over the cumulative prevalence of AIDS showed the curve skyrocketing the following 4 years, even though the assumed doubling time at that point was 12 months, 4 months longer than what had previously been observed (Figure 1). ‘AIDS might become the most common cause of death in the mid-90s’, the authors stated.⁷³ The radical prognoses and grim expectations for the future radically changed the temporality of the epidemic. The shift of attention in Norway (and internationally) towards the general population in the mid-1980s led to the construction and targeting of new ‘risk groups’, among them sex workers, who were depicted as ‘vessels of contagion’ and ‘contagion embodied’ in the press.⁷⁴

(Oslo: Aschehoug, 1989); Slagstad, *De nasjonale strategier*, 308–17.

⁶⁵Per Arne Langen, ‘200 norske AIDS-tilfeller i 1988?’, *Aftenposten*, 15 January 1985, 7.

⁶⁶Per Arne Langen, ‘AIDS-smittefare for 100 000 nordmenn’, *Aftenposten*, 15 January 1985, 7.

⁶⁷Karin Bøhm-Pedersen, ‘AIDS-eksplosjon både i USA og Europa’, *Dagbladet*, 12 September 1985, 7.

⁶⁸*Ibid.*

⁶⁹Helsedirektoratet, AIDS-skriv nr. 17, 1986, 1. ‘Norge står sammen med resten av verden foran en meget stor trussel mot folkehelsen og et stort helsetjeneste-problem som gir grunn til betydelig bekymring’.

⁷⁰*Ibid.*, 8–10.

⁷¹*Ibid.*

⁷²Per G. Djupesland, Øivind Nilsen, and Arve Lystad, ‘AIDS – Vår tids trussel og utfordring’, *Tidsskrift for Den norske lægeforening*, 1986, 106, 1963–66. ‘Faren for massiv spredning av viruset er med andre ord stor – primært innen høyrisikogrupper og sekundært til seksualpartnere utenfor disse’.

⁷³*Ibid.* ‘Innfris en slik prognose, kan AIDS bli den hyppigste dødsårsak i Norge mot midten av 1990-tallet’.

⁷⁴Ketil Slagstad and Anne Kveim Lie, ‘Selling Sex in the Age of HIV/AIDS: Activism, Politics, and Medicine in

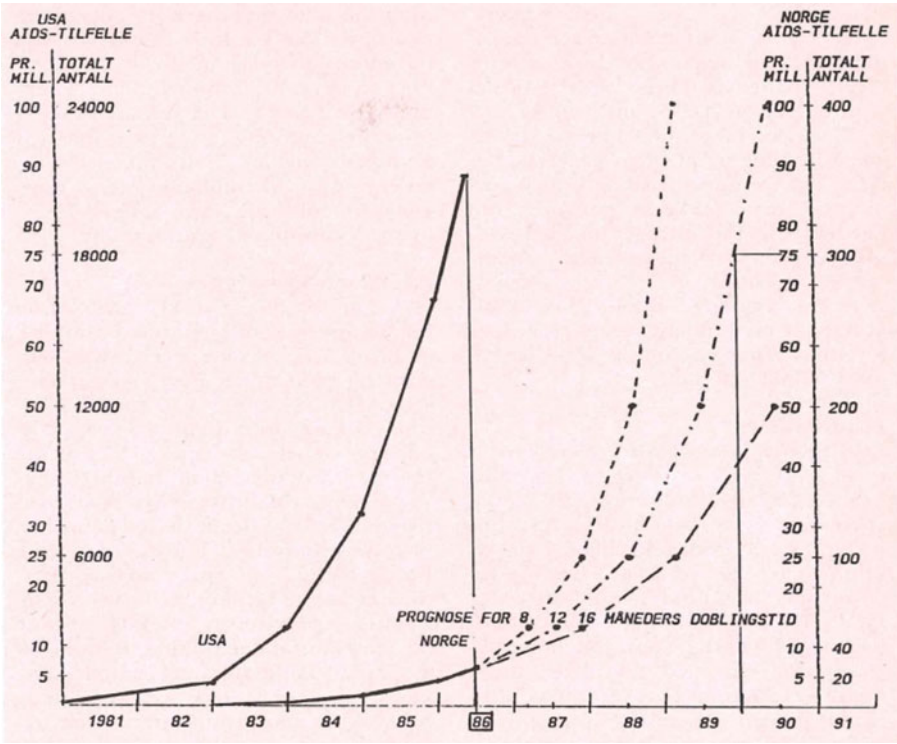


Fig. 1 Curve demonstrating AIDS prevalence in the USA and Norway and estimated cumulative prevalence the following 4 years in Norway with a doubling time of 8, 12 and 16 months, respectively. Illustration taken from Per G. Djupesland, Øivind Nilsen and Arve Lystad, 'AIDS – Vår tids trussel og utfordring', *Tidsskrift for Den norske lægeforening*, 1986, 106, 1963–66, with permission from *Tidsskrift for Den norske lægeforening*.

The press played an important role in the panic accompanying this development. Several newspapers published sensational front-page stories about AIDS. In August 1985, after the news broke that two inmates in an Oslo prison were carriers of the HTLV-III virus, all inmates were transported by bus to the emergency room to get blood tests. 'We are pretty hysterical', a prisoner told the journalist, 'the atmosphere is nervous'.⁷⁵ The coverage included frightening pictures of prison guards wearing protective gear, like rubber gloves, plastic aprons and disposable face masks, so it looked like the guard was on the verge of attacking the photographer (Figure 2). News spread that AIDS might be contracted by mosquitoes.⁷⁶ The Director of Health, Torbjørn Mork, who was responsible of coordinating the Norwegian AIDS policy, warned the population against getting ear piercings because of transmission risks.⁷⁷ Furthermore, a newspaper article about a

Norway, 1983–1990', in Janet Weston and Hannah J. Elizabeth, eds, *Alternative histories of HIV/AIDS in Western Europe, 1980–2019*, (Manchester: Manchester University Press), forthcoming.

⁷⁵Signy Fardal, 'Hysteriske fanger frykter AIDS', *Dagbladet*, 3 August 1985, 6.

⁷⁶Arvid Bryne, 'Mygg sprer AIDS?' *Dagbladet*, 3 August 1985, 7.

prison using gas to calm down a violent inmate with AIDS depicted the prison guard in full protective gear with gloves, gas mask, helmet and shield (Figure 3). 'The prison guards are scared of contracting AIDS through bites', the front page of the newspaper stated.⁷⁸ The picture not only epitomised society's fear of an epidemic, but it also invoked the long history of using force to contain 'the plagued' or 'the other'.

It was not only the dramatic prognoses published in the mid-1980s that created the changed rhythm of the epidemic. Commercial antibody tests were made available in the spring of 1985 and implemented for clinical testing later the same year. In 1985, the US Department of Defence implemented a screening programme for HIV among military personnel, and other screening programmes were discussed.⁷⁹ In Norway, some experts and doctors backed extreme measures to protect the population from a looming threat, like coercive mass testing. Directors of the blood banks advocated for testing all donors from early 1985. One director had returned from the USA, where she had seen with her own eyes how people had been infected through blood transfusions.⁸⁰ Some doctors publicly argued that so-called 'high-risk groups' should be tested for the HTLV-III virus against their will, and that people with AIDS be isolated in mental hospitals.⁸¹ A professor of biology, who would later become the president of the Norwegian Academy of Science and Letters, suggested testing the entire population and for all HIV-positive people to be tattooed in the groin with a small blue heart to warn their sex partners.⁸² Stigma, originally Greek for a mark made by a pointed instrument, was given renewed and concrete meaning.⁸³ The tests made it possible to target groups in much more precise and discriminatory manners.

The Director of Health was nevertheless reluctant to test donors, at least to begin with. The tests were too unspecific, the officials thought, and mass testing would lead to large number of false positives, increasing panic and causing too much unnecessary worry. Implementing testing practice in the blood banks before a testing programme was made available in other places could also lead people to go to the blood banks to get tested. That would be a potential catastrophe for the banks. Finally, the health officials argued, in line with the official policy of care, routine testing should not be implemented before a programme to take care of and follow-up with the people who tested positive had been established.⁸⁴ Public health officials strongly opposed mass screening, since only certain

⁷⁷Kristin Høiland, 'Hull i ørene kan gi AIDS', VG, 22 August 1985, 9.

⁷⁸Bård Wormdal, 'Gass mot AIDS-smittet fange', *Dagbladet*, 9 August 1986, front page. 'Fangevokterne er redde for å bli AIDS-smittet ved bitt'.

⁷⁹Brandt, 'AIDS: From Social History to Social Policy', in Fee and Fox, eds, *The Burdens of History*, 147–71.

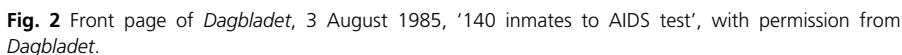
⁸⁰Gerd Selset Aandahl in Evensen et al., 'Da hiv', 41–42.

⁸¹Gro Møllerstad, '–Skal vi isoleres på en øde øy?', debate between Torbjørn Mork and Dr Per Nyhus, *Dagbladet*, 4 March 1986, 12; Hans Robertsen, 'Tvangssjekk og isolering mot aids', interview with Dr Hans B. Svindland, *Dagbladet*, 7 July 1986, 16; Turid Grønlund, '–Sjokkert', interview with Dr Magne K. Fagerhol, *Klassekampen*, 30 July 1986, 8.

⁸²Hans Chr. Stenseth, 'AIDS-merking og tvang', *Dagbladet*, 3 February 1987, 2. The professor's arguments mirrored the comments made by conservative columnist and editor William F. Buckley Jr, 'Crucial Steps in Combating the Aids Epidemic; Identify All the Carriers', *New York Times*, 18 March 1986.

⁸³I am indebted to Anne Kveim Lie for this observation; for a thorough analysis of stigma trajectory in HIV/AIDS illness, see Angelo A. Alonzo and Nancy R. Reynolds, 'Stigma, HIV and AIDS: An Exploration and Elaboration of a Stigma Trajectory', *Social Science & Medicine*, 1995, 41, 303–15.

⁸⁴Helsedirektoratet, 'AIDS og testing av blod på HTLV-III-antistoff', AIDS-skriv nr. 3, 27 July 1985, in *AIDS – samling av rundskriv om AIDS og HTLV-III/LAV* (Oslo: Helsedirektoratet, 1986); Frøland in Evensen et al., 'Da hiv', 90–92.



groups had been shown to be at risk: men who had sex with men, people who injected drugs, sex workers and people with sex partners from certain parts of the world. Probably most importantly, officials were concerned that the use of force could scare away people in 'high-risk groups', the ones who would benefit the most from getting tested. Nevertheless, the tests made it possible to get an overview of the epidemiological

Dagbladet

NYHETER

Lørdag 9. august 1986 16

GASS MOT AIDS-SMITTET FANGE

En AIDS-smittet som soner langtidstraff for voldsforbrytelser har siden onsdag sittet innelåst døgn rundt på ei fullstendig ribbet celle på Oslo kretsfengsel. Eneste møbel er en gummimadrass. Den kraftige ungdommen kan være svært aggressiv, og truer med å bite betjenter. De ansatte gasser cella hans for å roe ham ned. I løpet av fjorten dager blir han satt på frihet.

Av BARD WORMDAL

Flere ganger har vokterne brukt verneutstyr for å få seg inn på cella til 24-åringen. Både hjelm, og gassmaske og skjold harer med til utrustningen. Han har også blitt lagt i håndjern på cella for å holde seg rolig.

Mange medfanger synes det er uoverdig å bruke gass for å lure og gå inn til mannen. Fengselsdirektør Odd Solheim mener ledelsen må ta faren for AIDS-smitte ved kutt alvorlig.

— Vi er nødt til å ta de nødvendige sikkerhetsforanstaltninger, sier Odd Solheim.

Provosert

Langtidfangen har i sommer til stundighet provosert medfanger og betjenter. For noen dager siden kom han med rasistiske tilrop til en neger. Det blei tas et voldelig slagmål. Den AIDS-smittede dro til medfanger over ryggen med en biljardkule og truet med å ta livet av ham før betjentene kom til. Det var den direkte årsaken til at 24-åringen ble satt på gasscelle.

Den største koren har i sommer gentatte ganger hamret på cellene og skruket. Hylse har gått gjennom flere etasjer. Braket har irritert svært mange av fangene ved avdelingen. De har lagt protestaksjoner for å få ro.

Fengselsledelsen er overbevist om at volds- mannen er psykotisk, men det foreligger ingen legeerklæring på det.

Ingen psykiater

— Vi har ingen psykiater ved fengselet. Det tar derfor en del tid før å få en psykiatrisk undersøkelse. For vi har en legeerklæring, kan vi ikke søke om plass på sykehus, understreker fengselsdirektør Odd Solheim. Alle AIDS-smittede må sitte på vanlig celle.



LIVET BAK MURENE

— Mange anstalter preges av en tørkesjokk som legger tungt på trykk i tid. Dette mener både inn- og utsatte i norske fengsler. Dagbladet vil gjennom en del artikler sette søkelyset på forholdene i fengsling.

Sinnstemningen for langtidfangen varierer sterkt. I et øyeblikk kan han true og slå både inn- og utsatte. Fungende inspektør Halvvard Hagvedt frykter 24-åringen vil begå nye lovbrudd når han settes fri på prøve.

«Gir laen»

— Han gir laen i alt. Det er helt uforutsigelig at han slipper ut. Han kan godt gå inn i den nærmeste butikken og dra med seg en kasse øl rett forbi kassa. Spør noen om betaling, kan det smelle uten varsel.

Da kan vi få ham her igjen, men vi kan dessverre ikke hjelpe ham på noen måte, opplyser Halvvard Hagvedt.

Slippes fri

Oslo kretsfengsel kan ikke nekte å slippe fri den færlige 24-åringen etter at han har sonet to-tredjedeler av straffen.

Det opplyser sjef i Fengselsstyret, Rolf B. Wegner. Det eneste fengselet kan gjøre, er å prøve å overbevise den halslos murett om at han ikke må begå nye lovbrudd, men Wegner innrømmer det i praksis faller på stengrum.



Fengselsbetjentene gasser cella til den 24-årige AIDS-smittede for å roe ham ned. Ustyr med gassmaske, gummihansker, hjelm og skjold tar de seg inn til fangen. (Foto: Jens Sørø)

Fig. 3 Newspaper article titled 'Gas against AIDS infected prisoner' in *Dagbladet*, 9 August 1986, with permission from *Dagbladet*.

situation in the population through mass testing. By September 1988, around 10 per cent of the population had been tested. The exponential increase in testing frequency, however, had not led to a similar increase in the number of positive tests. The findings were encouraging because it meant that the decision to direct measures towards the so-called 'risk groups' had been a wise one.⁸⁵

Hartmund Rosa has argued that modern societies are characterised by a separation of history and life, time and space, and that these changes were the result of technological developments.⁸⁶ In his view, tempo not only characterises modern society, but it has also changed societal processes.⁸⁷ Looking at AIDS as a societal phenomenon, the importance of speed and tempo becomes clear: If one was laying out the rhythm of the AIDS epidemic, the mid-1980s were the moment the epidemic turned into a modern event. In the epidemic's early years, AIDS challenged medicine's self-congratulatory image by resurrecting a past that was thought to have been over. In the epidemic's second phase, its newness, tempo and urgency increased the gap between historical experience and future expectation. Koselleck argued that acceleration—through sociopolitical, technoindustrial and scientific progress—played a significant role in creating completely new time rhythms and time spans and 'stabilized progress as a temporally progressive difference between experience and expectation'.⁸⁸ Even if, to an increasing degree, expectations could not be inferred from experience, science and technology nonetheless promised a better future. During the AIDS epidemic of the mid-1980s, however, acceleration threatened the very concept of progress itself. The ever-growing cleft between experience and expectation, the very premise for progress and historical time, now seemed to implode, not only because of the recurrence of forgotten pasts but also the uncontrollable, unforeseeable futures. The extraordinariness of the situation rendered a variety of futures possible and foreclosed others.

Intermezzo: The Past Futures of AIDS

The futures of people living with the virus or diagnosed with AIDS were indeed unpredictable, scary and filled with insecurity. Some shared their stories with the public. These are, on one hand, testimonies of mostly young people facing existential crises. But they are also reflections of a society struggling to come to terms with the death of its young members. The stories provide insights into how ways of dying and versions of death were created. These past futures were often *futures interrupted*. In 1986, news started to reach the public that everybody who was infected with the HTLV-III virus probably eventually would develop AIDS. A newspaper article stated that 3,000 Norwegians were 'sentenced to death'.⁸⁹ It was increasingly understood that AIDS for many people was a fight against the clock they would eventually have to lose. One 52-year-old described it as a fight against 'the dwindling of the brain'.⁹⁰ 'The HIV virus is about to devour my left

⁸⁵Helsedirektoratet, 'AIDS: Handlingsprogram for skolerings- og opplysningsarbeid om HIV/AIDS', AIDS-skriv nr. 28, 1 September 1988, 10. Anne-Lise Middelthun private archive (hereafter ALMA).

⁸⁶Rosa, *Social Acceleration*, 20–32; Peter Conrad has argued that 'Modernity is about the acceleration of time', see Peter Conrad, *Modern Times and Modern Places. How Life and Art Were Transformed in a*

Century of Revolution, Innovation and Radical Change (New York: Alfred A. Knopf 1999), 9, cited in Rosa, *Social Acceleration*, 14.

⁸⁷Rosa, *Social Acceleration*, 55–56.

⁸⁸Koselleck, *Futures Past*, 269.

⁸⁹Magne Storedal, '3000 nordmenn dødsdømt', VG, 27 June 1986, 10.

hemisphere,' he said. 'It is one thing to die from AIDS, but I think it is worse to gradually turn sluggish. . . . I am isolated, most people shun me like the plague. I have stopped offering coffee to people when they come visit. They usually decline anyways.'⁹¹

As Susan Sontag has argued, AIDS reinstated a premodern experience of illness by producing a myriad of incurable symptom illnesses. AIDS imposed social death before actual death.⁹² Time mattered, especially for those affected. Would the scientific community be able to produce new drugs fast enough for them to get access? When testing became available in 1985, new temporalities were created, among them grim prospects and new futures of unknown lengths and with unknown possibilities. Medical technology and diagnostic testing practices had led to a new kind of 'ill', what Sontag defined as *the future ill*. Tests identified people who were not yet sick but who knew they eventually would be. Testing changed the present too: '[P]eople are understood as ill before they are ill', Sontag wrote.⁹³ With the knowledge that there was an inevitable path from infection to death, death was inscribed into peoples' lives often years before death would occur. This observation resonates with the experience of AIDS doctors in the U.S. too: one doctor recalled thinking 'I'm looking at a healthy dead person. It's just a matter of time'.⁹⁴ AIDS embodied death in the present.

For some, the prospect of an inevitable future death dominated the present. For many, the fear of infecting their partner or beloved, or a fear of rejection, was a bigger threat than a retraction into solitude. The stigma of being positive and the fear of passing the virus on led many to live in solitude or in celibacy. For Henki Hauge Karlsen, a 30-year-old gay man with AIDS, meeting other men was 'like having a volcano in my stomach'.⁹⁵ He did not dare to let it loose: 'The pressure increases and increases but I cannot let it explode'.⁹⁶ Even long after it became known that HIV was not actually very contagious and what measures one could take to protect oneself or one's lovers, this was a brutal reality for many people. 'I miss the time before I became HIV positive', Karlsen recalled, 'I miss having a sex life'.⁹⁷ Karlsen, who worked as a server in a restaurant in a small city outside of Oslo, lost his job when he was diagnosed with HIV. After taking the case to court with media in tow, he came to personify an epidemic in a country with no public figures on the frontline. As a small country with few un-closeted public gay figures, being open and HIV positive was unheard of. As a result, the epidemic had a profound impact on the visibility of sexual minorities, in Norway as in other countries.⁹⁸ A nurse, activist and former leader of the main Norwegian LGBTQI organisation who played a central role in

⁹⁰Arve Juritzen, 'Hjernen ødelegges', VG, 2 April 1987, front page.

⁹¹*Ibid.*, 12. 'HIV-viruset er i ferd med å spise opp den venstre delen av hjernen min. . . . En ting er å dø av AIDS, men jeg synes det er verre først å bli sløv. . . . Jeg er isolert, folk flest skyr meg som pesten. Jeg har sluttet å by frem kaffe når jeg får besøk. De fleste takker likevel nei'.

⁹²Sontag, *AIDS*, 33–37.

⁹³*Ibid.*, 34.

⁹⁴Bayer and Oppenheimer, *AIDS Doctors*, 173–74.

⁹⁵Arve Juritzen, *Henki – å leve med AIDS-viruset* (Oslo: J.W. Cappelens Forlag A/S, 1987), 142. "[D]et er som å ha en vulkan i magen'.

⁹⁶*Ibid.* 'Trykket stiger og stiger, men jeg kan ikke tillate en eksplosjon'.

⁹⁷*Ibid.*, 141. '[J]eg savner tiden før jeg ble HIV-positiv. . . . Jeg savner også å kunne ha et sexliv'. The last chapter in Juritzen's biography of Henki Hauge Karlsen was reprinted in a national newspaper, and the whole front page was dedicated to his story with the heading 'When I die...' [Når jeg dør. . .], *Dagbladet*, 22 August 1987.

⁹⁸Dagmar Herzog, *Sexuality in Europe: A Twentieth-Century History* (Cambridge: Cambridge University Press, 2011), 181–83.

Norwegian AIDS work has argued that the epidemic gave sexual minorities a public face and thus ultimately led to increased visibility and openness.⁹⁹ This increased visibility, however, came at a price, namely increased stigmatisation.¹⁰⁰ Karlsen's story illustrates a complex picture of, on one hand, lives filled with anxiety and despair, preparing for death. On the other hand, they also included small hopes, like the survival of a secondary infection or news about promising drugs.

Some people, haunted by the prospect of death, preferred to end their lives, and patients with AIDS asked their doctors and nurses for help. 'Help me to die', a 23-year-old man with haemophilia told a newspaper.¹⁰¹ 'Every day is a nightmare of pain, depression and loneliness', he said. 'The last months, fevers and diarrhea have drained my energy. Some days I don't even manage to get out of bed to use the bathroom. I hate my frail body, which doesn't obey anymore. I can't stand the thought that I will be tormented to death'.¹⁰² Since no cure was available, some healthcare workers found a particular motivation in sustaining hope in their patients and caring for them: 'We try to help them gather the forces they still have, so that they can get as much as possible from the time they have left', an infectious disease nurse said. 'And when they don't have any power left, our job is to help relieve their pain'.¹⁰³ This sense of looming death made some people demand more openness about the disease and in the process, mobilised communities and the public: 'We die alone in the hospitals. Nobody visits us', a woman in her thirties who was infected through intravenous drug use said.¹⁰⁴ Having isolated herself in her apartment for over a year, she argued, it was time for people to act: 'Now we have to help each other'.¹⁰⁵

Healthcare professionals working in infectious medicine were used to caring for young patients, among them injecting drug users. But infectious disease medicine was not a field in which healthcare workers were used to see young patients dying. That had largely been the reserve of oncologists. This changed with AIDS.¹⁰⁶ The stories of healthcare workers grappling with the fact that they were losing their patients reflect a more general notion of a society struggling with the fact that a young generation was dying: 'More than anything it has been hard to accept that young people will die without you being able to do anything about it. Even nurses are not used to that', a nurse told Norwegian press.¹⁰⁷ 'We are used to patients being discharged when the medicines

⁹⁹Kjell Erik Øie in Evensen et al., 'Da hiv', 106–07.

¹⁰⁰For the conflicted effects of HIV/AIDS on gay liberation, see, for instance, Dennis Altman, 'Legitimation Through Disaster: AIDS and the Gay Movement', in Fee and Fox, eds, *The Burdens of History*, 301–15.

¹⁰¹Jorun Stølan, 'Hjelp meg å dø', VG, 17 March 1988, 11.

¹⁰²*Ibid.* 'Hver dag er et mareritt av smerter, depresjoner og ensomhet. De siste månedene har febertokter og diaré tappet meg for krefter. Enkelte dager greier jeg knapt å kravle meg ut av sengen for å gå på do. Jeg hater den skrøpelige kroppen, som ikke vil lystre meg lenger. Jeg greier ikke tanken på at jeg skal seigpines inn i døden'.

¹⁰³Jorun Stølan, 'AIDS-syke ber om dødshjelp', VG, 17 March 1988, 11. '[V]i prøver å hjelpe dem til å hente

fram den kraften de ennå har, slik at de kan få mest mulig ut av den tiden de har igjen å leve. Og når de ikke har mer krefter igjen, blir vår oppgave å døyve smertene'.

¹⁰⁴Anne-Mette Hjelte, 'Angst, ensomhet, død', *Bergens tidene*, 7 August 1991, II, 13. 'Vi dør alene på sykehusene. Ingen besøker oss'.

¹⁰⁵*Ibid.* 'Nå må vi hjelpe hverandre'.

¹⁰⁶For the US situation, see Bayer and Oppenheimer, *AIDS Doctors*, 69–79.

¹⁰⁷Jorunn Stølan, 'Dagbok fra en AIDS-pleier', VG, 12 September 1987, 9–11. 'Det aller vanskeligste har vært å akseptere at unge mennesker må dø uten at du kan gjøre noe med det. Selv ikke sykepleiere er vant til det'.

have cured them'.¹⁰⁸ With AIDS, *juvenile death* was brought back to a society in which death had often been hidden away or had even become taboo: 'To talk about death in our society is worse than talking about sexuality in the Victorian age', the nurse said.¹⁰⁹ For care providers, however, working with AIDS could be meaningful and profoundly change their lives. In a newspaper interview, a nurse said that if you dared to open up yourself, 'your perspectives on life [would] change, and, personally, many of my own attitudes have been challenged'.¹¹⁰

The future expectations of people living with HIV or AIDS also reflected the social climate. In their attempts to make their anxieties about and fears of death intelligible, they (and their caregivers) would have gotten little comfort from reading newspapers, information material or popularised medical literature.¹¹¹ When a gay activist non-profit organisation published an information pamphlet on AIDS in 1985 written by a gay doctor and activist, it did not broach topics like how to face an insecure future, how to talk about these insecurities with friends and family or how to die or prepare for death.¹¹² A folder published by the Oslo Health Council in 1987 with information and advice for people living with HIV included a short chapter titled 'Confronting an uncertain future'. People were advised to think through economic and legal issues, like writing a will or signing an economical contract with their life partner. The folder also informed readers about an organisation working to prevent the 'unnecessary prolonging of the death process'.¹¹³ Even if death was brought up in a few stories in newspapers, *existential death* was mostly absent from newspaper articles, whitepapers, books intended for a mass audience and pamphlets written for the affected communities. AIDS death became an abstract endpoint that society had to prepare for economically and structurally, but not a topic to be treated in a direct personal or existential manner. Yet at the end of the decade, gay activists had started to address the existential sides of death more directly, for instance, in the seminar 'Our encounter with death' where people were encouraged to share experiences and thoughts about death.¹¹⁴

This future, in which Norwegian society was dying, was not confined to medical wards or personal experiences but also reflected in prognostics. Economists were asked to make prognoses for future costs, and epidemiologists tried to estimate the future demographics of the epidemic. The first grim prognoses created in the mid-1980s were based on figures from the USA and a duplication rate between 8 and 12 months. In the action

¹⁰⁸*Ibid.* 'Vi er vant til at pasientene blir skrevet ut når medisinen har gjort dem friske'.

¹⁰⁹*Ibid.* 'Å snakke om døden i vårt samfunn i dag er verre enn det var å snakke om seksualitet i viktortiden'.

¹¹⁰Erik Stephansen, 'AIDS-pasienter gir meg styrke', *Dagbladet*, 31 January 1987, 14–15. 'Du får et annet perspektiv på livet, og jeg personlig har måttet ruske opp i mange av mine egne holdninger'.

¹¹¹For a rare exception on existential aspects of treating and caring for the terminal ill AIDS patient written for health professionals and lay people early in the epidemic, see Jerome Schofferman, 'Medicine and Psychology of Treating the Terminally Ill', in Leon McKusick, ed., *What to Do about AIDS:*

Physicians and Mental Health Professionals Discuss the Issues (Berkeley: University of California Press, 1986), 51–60: 'Care of the Person with AIDS Requires That Attention Be Paid to Biological, Psychological, Social, and Spiritual Aspects of the Patient', 60.

¹¹²Georg Petersen, *Fakta om AIDS* (Oslo: Helseutvalget, 1985).

¹¹³*Hva nå? Råd og veiledning til HIV-positive* (Oslo: Oslo Helsesråd, 1987), 42.

¹¹⁴Helseutvalget, invitation to seminar 27–28. October 1989, 'Vårt møte med døden', A-0078 Helseutvalget, Da, L0008–0003 Dødsseminar, Skeivt arkiv, Bergen.

plan from 1986, the dire prognoses were reproduced based on information about the transmissibility of hepatitis. Without efficient countermeasures, officials argued, the risk of the epidemic 'being massively spread' was big.¹¹⁵ The prognoses led the authorities to plan for home services and dedicated nursing homes where patients could stay indefinitely, potentially permanently.¹¹⁶ According to the plan, 75 per cent of all patients with AIDS would stay in their own homes and probably require resource-intensive services. However, the dire situation put scientists' predictive skills to the test. Was it even possible to develop models to estimate the future number of sick or of beds needed in the hospitals or estimate costs 5 or even 10 years into the future?

In his writing about experimental systems in science, Hans-Jörg Rheinberger has emphasised that the present as the future of the past is still not a product of the past: 'the past is rather the product of a future – its present as a surrogate'.¹¹⁷ Science, as a 'machine for making the future',¹¹⁸ does not produce futures in linear, coherent, or 'progress'-directed ways. This insight about experimental systems is also helpful when examining the prognostics in the AIDS epidemic: Instead of simply asking why it was possible to construct misleading prognoses or why they failed to materialise, we should also ask what the prognoses—the past futures—do? Which questions did they respond to? What possibilities did they foreclose? What actions did they enable?

There were now imagined futures to be expected and to be avoided. A fundamental question for health authorities and the affected communities themselves was how the epidemic could most efficiently be contained. It was therefore pertinent to imagine the future in order to prevent it. The lack of data and the changing parameters made the models unreliable, given that information campaigns would also affect sexual behaviour. The authorities needed to plan for these questions, and they invited experts to provide answers. 'The needs of healthcare services for people with HIV in the years to come. Should and can we say anything about this?' was the title of a speech given by a leading professor of medicine to officials in a meeting in September 1987.¹¹⁹ To provide answers to the politicians, several dilemmas had to be solved, for instance, which statistical model to use. Some argued that curve-fitting models could be used to extrapolate trends from current data in the short term.¹²⁰ For long-term prognoses dynamic models using biological parameters like transmission rate and epidemiological parameters like sexual behaviour, prevalence of HIV in different groups and distribution of clean syringes, on the other hand, would be suitable.¹²¹ Could other historical epidemics help predict the current situation? Or did HIV represent something altogether new? Experts were divided. Some argued that epidemiological data from hepatitis B could be used to predict the AIDS epidemic, at least in the short term. Others argued that unknown variables, like the virus' unknown infectiousness and transmissibility period, would impact the model profoundly.¹²² Historical examples, like the handing of tuberculosis, were also used to justify

¹¹⁵Helsedirektoratet, AIDS-skriv nr. 17, 1986, 10.

¹¹⁶*Ibid.*, 48.

¹¹⁷Rheinberger, *Experiment*, 53. '[D]ie Vergangenheit ist vielmehr das Resultat einer Zukunft – ihre Gegenwart als Surrogat'.

¹¹⁸François Jacob, *La statue intérieure* (Paris: Seuil, 1987) quoted in Rheinberger, *Experiment*, 53.

¹¹⁹Helsedirektørens rådgivende utvalg i forebyggende infeksjonsmedisin, minutes, 22 September 1987, S-5241 Statens institutt for folkehelse, Immunologisk avdeling, D, Da, box 2, Helsedirektørens rådgivende utvalg i forebyggende infeksjonsmedisin, NAN.

¹²⁰*Ibid.*

¹²¹*Ibid.*

the argument that an official policy based on information and cooperation was both more efficient and more humane than using coercive measures.¹²³ But history was also used to make the opposite argument that awareness work was not enough. 'We must not repeat the mistakes of the past', a doctor and member of the Director of Health's advisory board on AIDS wrote in an article in the *Journal of the Norwegian Medical Association*.¹²⁴ Radesyge and syphilis had shown that puritanism and shaming had not worked. Even the Wassermann reaction and penicillin had not completely eradicated syphilis, he argued. HIV antibody testing should be implemented for targeted screening and in clinical practice, he wrote, but most importantly, people had to change their sexual habits.¹²⁵ Another doctor, advocating for harsh measures, like detention of HIV-positive people, referred to the fight against syphilis in the 1970s: 'Back then we used the same measures that I suggest we use now. And we fought the disease within two years'.¹²⁶ As Anne Kveim Lie has argued, the invocation of history in medical arguments is not a neutral process. The use of history, she argues, is not only a question of what we can learn from history. There are also numerous examples of how history is *made* useful.¹²⁷ In order to provide workable futures, various actors looked to the past.

Either by combining the past of the North American epidemic with potential, future scenarios in Norway or drawing on epidemiological data from other infectious diseases, momentum for action was created in action plans, preventive measures and increased funding. The message from the Minister of Social Affairs was that the plague will be stopped, 'money is not a problem (...) the necessary measures will be put in force in the fight against AIDS'.¹²⁸ '[I]t is necessary that our health authorities and politicians prepare for the enormous *economic burden* the AIDS epidemic will cause', Dr Frøland argued in a book about AIDS for lay people.¹²⁹ Politicians and the Storting (the Norwegian parliament) were forced to respond and put aside more and more money: 7 million kroner in 1985, 47.1 million in 1986, 90 million in 1987 and 105 million in 1988.¹³⁰ New positions were funded: a dedicated section at Oslo Health Council with seven new positions and a physician dedicated to AIDS work within the Directorate of Health in 1985 and two more positions dedicated to working with AIDS, youth and drugs in 1986.¹³¹ At the Norwegian Institute of Public Health, positions were reorganised to focus specifically on the epidemic.

¹²²*Ibid.*

¹²³Olav André Manum, 'Opplysning, Opplysning, Opplysning', *Positiv*, 2010, 4, 26–29; Alf B. Godager, 'Forbud mot tvang overfor AIDS-syke', *Aftenposten*, 8 August 1986, 4.

¹²⁴Jan C. Ulstrup, 'AIDS-epidemien i Norge', *Tidsskrift for Den norske lægeforening*, 1986, 106, 2545–47.

¹²⁵*Ibid.*

¹²⁶Hans B. Svindland in Robertsen, 'Tvangssjekk', 16.

¹²⁷Anne Kveim Lie, 'A Commentary', in *On Learning from History – Truths and Eternal Truths* (Oslo: Norges Bank, 2013), 45.

¹²⁸–'Penger er intet problem', *Dagbladet* 17 August 1985, 7. 'Penger er intet problem. Vi må bevilge de penger som trengs ... for å demme opp for AIDS'.

¹²⁹Stig Frøland, *AIDS: en utfordring til oss alle* (Oslo: Gyldendal, 1986), 208 (emphasis in original). 'Våre helsemyndigheter og politikere er likevel forpliktet til også å tinnstille seg på den meget store økonomiske belastningen AIDS-epidemien vil medføre'.

¹³⁰Helsedirektoratet, 'Tiltak for å demme opp for spredning av AIDS/HTLV-III-infeksjonen – økonomiske konsekvenser for 1987-budsjettet', AIDS-skriv nr. 15, May 1986, in *AIDS – samling av rundskriv om AIDS og HTLV-III/LAV* (Oslo: Helsedirektoratet, 1986); Sosialdepartementet, 'St. meld. nr. 29 (1987-88), Om HIV/AIDS-epidemien', 1988, 35.

¹³¹Helsedirektoratet, AIDS-skriv nr. 17, 1986, 15.

Futures of hope and resistance were used to mobilise funding for research or expensive medicines for patients too. The past futures included the narratives of medical progress and imminent scientific breakthrough in the public discourse. When azidothymidine (AZT) was released on the market, it created 'hope in the AIDS-darkness'.¹³² Even if AZT was no 'wonder drug', the press reported that it was shown to prolong patients' lives, maybe long enough for the many thousands of researchers worldwide who 'work all day long to find new AIDS medicines and a vaccine'.¹³³ Scholars have shown how HIV activism sped up the approval processes of new drugs.¹³⁴ AZT was the first promising drug, bringing hope not only to patients but to society as a whole. In February 1986, reporting on the first patients treated with AZT, a 33-year-old American man included a 'before and after' photograph in the early phase of his treatment to illustrate the improvement of his physical condition.¹³⁵ An AIDS expert described it as 'the most promising weapon against AIDS that we have at the moment'.¹³⁶ He continued, 'We need to break with the resigned attitude to AIDS'.¹³⁷ The prognoses and the figures of future deaths created potential futures, among them economic futures, futures to prepare for and futures to prevent.

During the AIDS epidemic, premature deaths and interrupted futures became a large part of what Koselleck defined as the horizon of expectation.¹³⁸ The death of young people also entailed the loss of a potential workforce, which in turn had economic consequences for society, which meant that increased spending on social benefits and healthcare services—for instance, on the construction of toilets separated from other patients in hospitals—had to be calculated on top of future economic losses.¹³⁹ But in the early years of the epidemic, this future endpoint was often indirectly addressed. The planning for work-force shrinkage, for the social-economic burden and for the caretaking of the many future infected were all examples of a society struggling with its inability to save its members from death. The prognostics of HIV/AIDS exemplify a more general point about historical time. The likelihood and validity of a prognosis depend on historical data, on experience. Prognoses not based on some sort of data or experiences extended into future predictions are mere speculations. On the other hand, the need for prognoses defines and confines possible expectations: Fear and hope, urgency and crisis enable expectations that are not derived from history or experiences alone. Past experiences (the space of experience) and future expectations (the horizon of expectation) are irreducible entities: they constitute a temporal difference in the present where past and future, in different ways, become entangled and are folded into each other.¹⁴⁰ Given the many

¹³²Arve Juritzen, 'Håp i AIDS-mørket', VG, 1 August 1987, 24–25.

¹³³*Ibid.* 'Flere tusen forskere over hele verden jobber på heltid med å finne frem til nye AIDS-medisiner og vaksine.'

¹³⁴Epstein, *Impure Science*; David France, *How to Survive a Plague: The Story of How Activists and Scientists Tamed AIDS* (London: Picador, 2016). For the history of activism and combination therapy of AZT and ddC, see Steven Epstein, 'Activism, Drug Regulation, and the Politics of Therapeutic Evaluation in the AIDS Era: A Case Study of ddC

and the "Surrogate Markers" Debate', *Social Studies of Science*, 1997, 27, 691–726.

¹³⁵Ron Laytner, 'Livshåp for AIDS-syke', *Dagbladet*, 26 February 1986, II, 6–7.

¹³⁶Stig Frøland to Heidi Egede-Nissen, '–Lovende AIDS-våpen', *Dagbladet*, 26 February 1986, II, 7. 'Jeg tror azidothymidin er det mest lovende våpenet vi har mot AIDS i øyeblikket'.

¹³⁷*Ibid.* 'Vi trenger å bryte igjennom den oppgitte holdningen til AIDS'.

¹³⁸Koselleck, *Futures Past*, 679–731.

¹³⁹Helsedirektoratet, AIDS-skriv nr. 17, 1986, 45–49.

¹⁴⁰Koselleck, *Futures Past*, 259–63.

layers of insecurity, panic and urgency, as well as the scarcity of available data and the need for workable futures in the midst of the AIDS epidemic, the prognoses materialised the tensions and compromises between past experiences and future expectations.

The Epidemic That Never Happened, 1987–1996

In the late 1980s, it slowly became clear that the dire predictions would not materialise. As the epidemic decelerated, panic slowly disappeared: 'HIV goes slowly' was the headline in a newspaper article in 1987 as it was reported that the fear of spread into the 'general population' had been overblown.¹⁴¹ In 1988, the Directorate of Health stated that 'there is no factual evidence in describing the spread of infection as explosive.'¹⁴² At the beginning of the new decade, researchers from the Norwegian Institute of Public Health stated in an article that, based on a simulation model and a questionnaire about sexual behaviour, 'the indigenous spread of HIV is not likely to sustain an epidemic in the Norwegian heterosexual population'.¹⁴³

With this slowed tempo and the epidemic silently fading away from the front pages of the newspapers, other stories emerged. Activist organisations in Norway highlighted compassion and care for HIV-positive people. A large-scale information campaign called 'Care is not contagious?' [Omsorg smitter ikke] included posters with slogans like 'I have HIV. Give me a hug' [Jeg er hiv-smittet. Gi meg en klem], 'It is the loneliness that kills me' [Det er ensomheten som dreper meg] and 'This child had AIDS, but died from the lack of skin-on-skin contact' [Dette barnet hadde aids. Men døde av mangel på hudkontakt].¹⁴⁴ Similar attitudes were mirrored in new public health strategies. The Ministry of Social Affairs' working group on HIV/AIDS saw it as important to put more emphasis on 'attitudes' in the population, including on 'sexual hygiene' and the need to reduce the number of sexual partners.¹⁴⁵

The earlier strategy of mobilising communities was still highly visible.¹⁴⁶ In the Directorate of Health's new action plan for 1990–95, measures towards 'risk groups' were seen as the most efficient way of reducing spread more generally. The philosophy was to 'follow the virus': 'It is what people do, not which group they belong to, that decides if a person is at risk of infection or spread HIV'.¹⁴⁷ This included supporting gay and lesbian organisations in reaching out to men who had sex with men, the distribution of syringes to injecting drug users and cooperation with sex workers in distributing condoms and information material.¹⁴⁸

¹⁴¹Magne Storedal, 'HIV går sakte', VG, 18 August 1987, 14.

¹⁴²Helsedirektoratet, AIDS-skriv nr. 28, 1988, 10. 'På grunnlag av de epidemiologiske data om HIV-epidemien i Norge, er det i dag ingen holdepunkter for å karakterisere spredningen som eksplosjonsartet'.

¹⁴³Hein Stigum et al., 'The Potential for Spread of HIV in the Heterosexual Population in Norway: A Model Study', *Statistics in Medicine*, 1991, 10, 1003–23.

¹⁴⁴Magne Storedal, 'Gir HIV et ansikt', VG, 4 November 1988, 10–11. The campaign was developed by Landsforeningen mot aids, a national non-profit organisation established in 1987 by an assembly of NGOs to promote information about AIDS.

¹⁴⁵Sosialministerens referansegruppe i kampen mot HIV/AIDS-epidemien (hereafter 'Referansegruppen'),

Innkalling til møte med vedlegg 'Holdningsskapende arbeid', 30 May 1988, PA-1216 Det Norske Forbundet av 1948/Landsforeningen for Lesbisk og Homofil Frigjøring, Db, box 2, AIDS (hereafter 'Referansegruppen AIDS folder'), NAN.

¹⁴⁶Anne-Lise Middelthun and Annick Prieur, *Mobilisering av stoffmisbrukere til HIV-forebyggende endringsarbeid i eget miljø. Rapport fra et prosjekt* (Oslo: Helsedirektoratet, 1992).

¹⁴⁷Helsedirektoratet, 'Helsedirektørens tiltaksplan mot HIV/AIDS-epidemien 1990–1995', AIDS-skriv nr. 41, 1990, 27. 'Det er adferden, og ikke gruppetilhørigheten som avgjør om et enkelt individ har risiko for å få overført eller selv overføre hiv-smitte'.

¹⁴⁸Helsedirektoratet, AIDS-skriv nr. 41, 1990, 32–43.

The new official strategy emphasised four key aspects: *empowerment* of the affected communities, *care* for infected and sick that includes highlighting the human need for physical and bodily contact, a *destigmatising* approach to avoid people not getting tested, and ultimately, the avoidance of *discrimination*, especially in the workplace.¹⁴⁹ Schools and teachers were increasingly seen as crucial not only to sex and AIDS education but also to the encouragement of ethical reflection, moral values and consciousness-raising work.¹⁵⁰ 'Many of the ideas children and adolescents have about HIV/AIDS stem from grown-ups and media, including unfounded fear of contagion and prejudices'.¹⁵¹ An important objective became to integrate education about HIV/AIDS in the curriculum, including in textbooks and information leaflets, but also to include it in the teachers' broader task of raising moral awareness.¹⁵² 'Schools have a crucial task in providing knowledge and bolstering attitudes which can prevent spread of the epidemic', the Minister of Education and Church Affairs wrote in a circular to the country's schools in 1988, as she declared that funding for education work in schools to fight the epidemic had been secured in the budget.¹⁵³ The notion of the epidemic being a social problem affecting the whole of society was high on the agenda in the Ministry of Social Affairs' official working group on HIV/AIDS:¹⁵⁴ 'What AIDS does to society', a bullet point in one of the group's minutes said, 'is at least as important as what contagion does to the body'.¹⁵⁵ In the revised official action plan on HIV/AIDS for 1990–95, the 'epidemic of fear and anxiety', with its prejudices and myth making was addressed explicitly.¹⁵⁶

An ethical framework was built and moral awareness was bolstered in public by breaking taboos around death or rather around 'death at the wrong time'.¹⁵⁷ The stories of children and youths infected with HIV and dying from AIDS further contributed to a diversified picture of the epidemic.¹⁵⁸ The increased visibility of the 'heterosexual epidemic' not only normalised HIV/AIDS but also solidified notions of 'us versus them' and of there being 'guilty' and 'innocent' victims of the epidemic that had circulated a decade earlier. In September of 1992, a journalist conducting an interview with a 'beautiful, well-spoken and career-driven mother' in one of Norway's biggest newspapers rhetorically asked 'who would have thought' that she was HIV-positive, since it was not 'visible from the outside'.¹⁵⁹

However, visualisation practices also imply making things unseen: As the epidemic diversified and new perspectives were made visible, others were rendered invisible.¹⁶⁰

¹⁴⁹Referansegruppen, Innkalling til møte med vedlegg 'Holdningsskapende arbeid', 30 May 1988, Referansegruppen AIDS folder, NAN.

¹⁵⁰*Ibid.*; Helsedirektoratet, AIDS-skriv nr. 41, 1990, 28.

¹⁵¹AIDS-skriv nr. 28, 1988, 18. 'Barn og tenåringer lærer mye om forestillingene om HIV/AIDS av voksne og gjennom media. Dette gjelder også den grunnløse smittefrykten og fordommene som knyttes til sykdommen'.

¹⁵²*Ibid.*, 19.

¹⁵³Minister of Education and Church Affairs Kirsti Kolle Grøndahl, circular, 'Undervisning om HIV-epidemien', 1988, Oslo helseråd, box 51, Aids, OCA. 'Skolen har en sentral oppgave i å formidle kunnskap og holdninger som kan forebygge utbredelse av epidemien'.

¹⁵⁴Referansegruppen, minutes, 21 April 1988, Referansegruppen AIDS folder, NAN; Referansegruppen, Innkalling til møte med vedlegg 'Holdningsskapende arbeid', 30 May 1988, Referansegruppen AIDS folder, NAN.

¹⁵⁵Referansegruppen, minutes, 21 April 1988, Referansegruppen AIDS folder, NAN. 'Hva AIDS gjør med samfunnet er minst like viktig tema som hva smitten gjør med kroppen'.

¹⁵⁶AIDS-skriv nr. 41, Helsedirektoratet, 1990, 7.

¹⁵⁷Referansegruppen, Innkalling til møte med vedlegg 'Holdningsskapende arbeid', 30 May 1988, Referansegruppen AIDS folder, NAN.

¹⁵⁸Jorunn Stølan, 'Lille, store Odd Kåre', VG, 19 February 1993, 3–5.

¹⁵⁹Karin Muri, 'Øver meg på å dø', VG, 26 September 1992, 24–25.

As the authorities radically downscaled the dramatic prognoses from only a few years earlier, the Director of Health saw the beginning of a new epidemic, an 'epidemic of ignorance', in which people denied facts and lost interest in and respect for HIV/AIDS.¹⁶¹ For instance, even if officials recognised that the early prognoses based on exponential extrapolations had failed to materialise, and even if the rate of infection was 'so low' that the epidemic among injecting drug users could be 'slowed down significantly in the coming years', they believed this could represent an interim period.¹⁶² A report published in 1992 stated that 'The Directorate of Health does not rule out another wave of HIV infection in the phase we are about to enter'.¹⁶³ For the authorities, it was crucial that the measures that had been taken and the progress that had been made, for instance, in changing people's sexual habits were preserved. But the distancing of the past, its 'unremembering', posed new risks to society at the turn of the century and threatened to tear down the preventive work of the preceding decade.¹⁶⁴

In his study of 'AIDS atlases', Lukas Engelmann convincingly showed that from the mid-1990s onwards, electron micrographs of the HIV virus accompanied by diagrams came to represent the visualisation of AIDS.¹⁶⁵ The models and pictures of the virus have become ahistorical, crystallised 'icons of HIV', detaching the epidemic from the numerous layers of metaphor and meaning Paula A. Treichler fittingly defined as 'an epidemic of signification'.¹⁶⁶ The gradual 'normalisation' of HIV/AIDS was also inevitably tied to the introduction of effective treatment. When HAART was announced at the Vancouver AIDS conference in 1996, it represented the beginning of a shift from deadly epidemic to chronic disease.¹⁶⁷ Treichler reminded us that we cannot 'look "through" language to determine what AIDS "really" is'.¹⁶⁸ She instead encouraged us to look where meaning is created, namely in language, with its symbols, metaphors and significations. In this article, I have argued that an analysis of time can also help us scrutinise the historicity of AIDS.

In the epidemic's early phase, when the first cases were diagnosed and ideas of old and new collapsed into each other; in its accelerated phase of panic and despair; and finally in its phase of normalisation, when HIV was transformed into a chronic disease and the epidemic began silently evaporating, AIDS followed different time rhythms. These rhythms are inseparable from the epidemic's life cycle, from how it came into being and faded away. The paperwork (policy documents, letters, working papers, circulars, guidelines, newspaper articles), images and prognostic curves created during these phases all

¹⁶⁰For analysis of how visualisation practices have rendered some aspects and groups of people in the AIDS epidemic seen and others unseen, see Lukas Engelmann, *Mapping AIDS: Visual Histories of an Enduring Epidemic* (Cambridge: Cambridge University Press, 2018).

¹⁶¹Helsedirektoratet, AIDS-skriv nr. 41, 1990, 7.

¹⁶²Ole-Jørgen Skog, *Prognose for AIDS-epidemien blant sprøytemisbrukere 1990–1999* (Oslo: Statens institutt for alkohol- og narkotikaforskning, 1990), 22.

¹⁶³Middelthun and Prieur, *Mobilisering av stoffmisbrukere*, 3. 'Helsedirektoratet utelukker ikke en ny bølge av hiv-smitte i den fasen vi nå går inn i'.

¹⁶⁴Castiglia and Reed, *If Memory Serves*, 1–37.

¹⁶⁵Engelmann, *Mapping AIDS*, 160–211.

¹⁶⁶Treichler, 'Epidemic of Signification'.

¹⁶⁷This of course was true only for some groups of people in some parts of the world.

¹⁶⁸Treichler, 'Epidemic of Signification', 31.

played a role in producing the temporalities of the epidemic. AIDS entered a society where different narratives of modernity were circulating: On the one hand, medicine in the post-war years was bolstered on the idea of incessant progress, and the era of the infectious diseases seemed like history. On the other hand, there were signs that technology, scientific development and biomedicine itself had contributed to new dangers, like antibiotic resistance, which rocked this narrative. These opposing ideas of medicine and modernity collapsed into one another when AIDS fundamentally challenged doctors' authority and ability of controlling disease and nature. Still, in the early phase of the epidemic, AIDS was seen mostly as a threat to certain constructed 'risk groups' and was not perceived as a major danger to the general population. Even if AIDS was dramatic, it did not cause public panic until the middle of the decade, when the antibody tests became available at the same time as focus was shifted to the risk for the general population. In this second accelerated phase of the epidemic, many people and experts argued for harsh measures against people at risk of infections or those who were sick. The panic and increased tempo caused a hardening of the public discourse where already stigmatised groups were singled out and targeted. In this phase, the non-stigmatising prevention approach based on thrust and involvement of the affected groups that the authorities had advocated was put under pressure. Eventually, however, Norwegian authorities decided not to depart from this line. Finally, in the third phase, AIDS slowly faded away from the public imagination. When it was realised that the dramatic prognoses would not materialise, the press generally lost interest in the topic. The fatigue was probably also caused by the lack of scientific progress on the development of effective medicines. This slowed phase of the epidemic, however, also enabled other and more complex stories to emerge in the public.

This story ends where it started, in 1983, when the first cases of AIDS were diagnosed in Norway. In January 1983, these were believed to be the first of their kind in Norway. As the AIDS epidemic developed, however, Dr Frøland was reminded of a peculiar immune deficiency in a family he had treated some 10 years earlier. Within a decade—Frøland saw the father of the family for the first time in 1968—they had all died due to an unexplainable disease. The parents and their young daughter gradually developed various signs and symptoms, which in retrospect were diagnostic for AIDS, including generalised lymphadenopathy, granulomatous encephalomyelitis, recurrent *Candida albicans* infections, leukaemia. Eventually they developed polyclonal hypergammaglobulinaemia with abnormal lymphocyte functions and died. Confronted with the deaths of young patients and the limits of medicine, archiving the patients' serum brought a tiny hope to the doctor that in the future, at least, the mystery could be solved. By archiving a part of the present, history was inscribed into the future. When commercial tests became available and the blood samples of the family were re-examined, they were all shown to be HIV-antibody positive.¹⁶⁹ All of a sudden, Norway's first cases of AIDS had arisen not in 1983 but a decade earlier. This, however, is true only on one level. When something new appears, Rheinberger argues, it is nothing more than an irritation. The new appears through its traces or past futures: 'The past is the trace of something that have not

¹⁶⁹Stig S. Frøland *et al.*, 'HIV-1 Infection in Norwegian Family Before 1970', *Lancet*, 1988, 331, 1344–45.

occurred'.¹⁷⁰ History, then, as it faces the historian of science, is nothing but a fictitious product of 'straightenings', a desire to order and add logic to past events and processes.¹⁷¹ At the time they were stored, the serum samples were nothing but traces—AIDS did still not exist. A decade later, when AIDS was retroactively—*nachträglich*—inscribed into the blood samples, into history, the disease was already something different. 'AIDS' of 1970s was very distant from the shame, ignorance, panic, stigma, rage and grief that made up the epidemic in the decade to come. The paradoxical situation is that, on the one hand, it is impossible to teleport AIDS away from its social and political context or to detach the epidemic from its significations and temporalities. On the other hand, however, as Rheinberger has demonstrated, it is precisely this 'epistemic thing'—AIDS as it appeared in the 1980s—that enabled AIDS to appear in the 1970s. Accepting that history can only be approached from a position in the present does not imply a return to 'whiggish' historical writing. The goal is rather to acknowledge the non-linearity of history, without 'origins', which takes the temporal transformations of events—in the past as well as in the present—seriously. *Historiality* attends to the recurrence of phenomenon, how things are implicated in time structures where the traces that remain create the origin of their non-origin.¹⁷²

Through the epidemic, numerous futures with various temporal horizons were created in the space between society, medicine, the press and the affected communities. The personal futures went from denial, isolation, grief, stigma and social death to survival with a chronic disease. The societal, political and medical futures went from desperation at being confronted with an epidemic of uncertain aetiology, to monstrous consequences for society, to relief when medicine once again seemed to have solved yet another natural mystery. Although AIDS fundamentally challenged medicine, ultimately, control was regained. In the period between 1983 and 1996, when effective medicines started to become available, around 1,500 people were diagnosed with HIV and 500 with AIDS in Norway.¹⁷³ A decade after the epidemic was declared a menace to society, people began coping with the new reality of HIV being a chronic disease. Many had been scarred for life by stigma and death or by the experiences of losing their patients, family members or lovers. Nevertheless, AIDS silently faded away from the public mind. 'The AIDS-epidemic Norway never got' was the title of a newspaper article in November 1996.¹⁷⁴ In the end, it was as if the epidemic had never happened.

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¹⁷⁰Rheinberger, *Experiment*, 49.

¹⁷¹*Ibid.*, 47–53.

¹⁷²Hans-Jörg Rheinberger, *Toward a History of Epistemic Things: Synthesizing Proteins in the Test Tube* (Stanford, CA: Stanford University Press, 1997), 178.

¹⁷³Norwegian Surveillance System for Communicable Diseases (MSIS), Webpage, available at: <http://www.msis.no/> [last accessed 8 November 2019].

¹⁷⁴Anja Hegg, 'AIDS-epidemien Norge ikke fikk', *Dagbladet*, 29 November 1996, 15.

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