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INDEX

Origins of HIV

Colonialism and HIV

HIV Epidemic In USA
- Who did it affect in the beginning?
- Response to the epidemic
- Anti gay rights backlash
- How the government reacted
- Further readings

AIDS epidemic in sub-Saharan Africa (introduction)
- South Africa
- Government response
- Social epidemiology
- Child-headed households
- Uganda's ABC program
- Impact of US Policy of Abstinence

Further readings

Stigma and Discrimination

Health and human rights framework

HIV Criminalization Laws

HIV/AIDS Activism

Further Engagement

As of 2018[1], there are an estimated 37.9 million people worldwide who are living with HIV AIDS. The first cases of acquired immunodeficiency syndrome (AIDS) were recognized in the USA in 1981, although there is evidence to show that this disease has been around for longer. AIDS is a pandemic that has sustained itself for decades and presently has come to affect some of the poorest countries in the world. The sub-Saharan African region currently has the highest number of people living with HIV.

ORIGINS OF HIV

It is a commonly accepted belief that HIV originated in Kinshasa in the Democratic Republic of Congo between 1910 and 1920, when the virus crossed species from chimpanzees to humans. It is also accepted that bushmeat practices were the initial cause of transfer to humans. The virus may have been transmitted from an ape or monkey to a human when a hunter or a bushmeat vendor was bitten or cut while hunting or butchering the animal.

COLONIALISM AND AIDS

Several experts studying the epidemiology of the disease have also pointed out the link between colonialism and the emergence of this virus. This has also been termed as the 'Heart of Darkness' theory, named after the famous novella by Joseph Conrad. In the 1880s began the 'Scramble for Africa'—major European colonial powers began to establish cities, towns and colonial stations in the 'Dark Continent'. Exploitation of Africans was at its peak in the French Equatorial Africa during the early 20th century—they were engaged in forced labour (especially in the railways, construction projects, plantations and other colonial enterprises) and lived in conditions of extreme stress that could affect the immune system. There was also a rise in bushmeat hunting. At the same time, they were also subjected to unsafe vaccination campaigns as part of the colonial project, done using unsterilized needles.

In one particular campaign, French doctors used six syringes to inject 80,000 African workers with a medicine for sleeping sickness. Further, with the rise in industrial activities fostering the growth of cities, there was also an increase in casual non-monogamous sexual activities, as well as prostitution. Women also remained unmarried and divorced for a longer period of time, as they felt freed from the rules of the traditional tribal societies in the cities. All of these, along with the unprecedented increase in people's movements created the perfect conditions for the virus to make its jump into humans and to further spread through a large population. According to the book *The Origins of AIDS* (2011), the virus can be traced to a central African bush-hunter, with colonial medical campaigns using improperly sterilized needles playing a key role in enabling a future epidemic. However, it wasn't until the AIDS epidemic broke out in the USA in the 1980s that the world took notice, after which it steadily went on to become a pandemic that continues even today.

It was in the summer of 1981 that the CDC (Center for Disease Control) in the USA became aware of AIDS—the first official government report on AIDS came out on June 5, 1981 in the Morbidity and Mortality Weekly Report. The report acknowledged that between October 1980 and May 1981, five young gay men in Los Angeles were suffering from a rare lung infection called PCP (Pneumocystic carinii pneumonia). At the same time, there was also a group of men in New York and California suffering from Kaposi's Sarcoma, a rare type of cancer.

The particular strain of the HIV virus that unleashed the epidemic in the US is believed to have made its way from Haiti. At the initial stage, the people affected by the virus were those that the common public, as well as the government, did not deem worthy of any attention. In fact, there is credible research that shows the HIV virus had found its way to New York earlier than the date established by the CDC. According to a 2016 study published in the *Nature* magazine, the HIV virus first came to the US as early as the 1970s.

Who Did It Affect In The Beginning?

In NYC, the virus found a population that was ideal for it to infect enough people, grabbing the world's attention for the first time. In the 1970s, while 'disco fever' raged on in the US, there was also the lesser known 'Junkie Pneumonia' affecting those on the very margins of society—the homeless, people using IV drugs, hemophiliacs. Junkie Pneumonia, also known as 'the dwindles', was mysteriously killing a lot of them long before 1981, but none of these deaths ever made it to the CDC's reports because these were not recorded deaths. This did not make the news, despite there being several anecdotal accounts of Junkie Pneumonia, neither did any of the public health officials think these puzzling deaths warranted further attention. Besides their precarious access to healthcare, many of them also feared visits to the hospitals which they (rightly) believed could end up putting them in greater trouble. In 1987, by which time the epidemic was well advanced, NYC health officials found that AIDS had killed more intravenous drug addicts—nearly 53%—than homosexuals in the city.

These ignored deaths posit an important question: Do we as a society begin to acknowledge the threats of a disease only when it affects certain people who we believe have some kind of societal value? What is this value and who decides this? As it turns out, social biases were disproportionately affecting victims of AIDS long before we knew it was a pandemic.

> Steven W Thrasher wrote in the Guardian:
> *When Aids was only affecting homeless people and IV drug users in the US, there was not a critical mass of care about them to make it register. Aids began to come into some focus when it affected homosexual men, not because gay men's lives were valued by US society at large (they weren't), but because amongst them were some powerful, often closeted, white gay men who were raised to believe their bodies were important*

and infallible.

Response to the Epidemic

While the AIDS epidemic in the US was officially recognized in 1981, it took the US federal government nearly four years to make a public statement regarding AIDS. Among other things, the Reagan administration's initial reluctance to address the AIDS epidemic resulted in the worsening of an already terrible situation.

Anti-gay rights backlash:

In 1969, the Stonewall riots happened—this was the first ever protest by the LGBTQ+ community, after which significant civil rights advances were made by queer activists in several American states. Nearly two dozen states had decriminalized sodomy by 1980. It was also around this time that HIV cases began to pop up in LA and New York, leading to a reactionary backlash against the gay rights movement.

Jerry Falwell of Moral Majority, a religious fundamentalist group said, 'Aids is not just God's punishment for homosexuals, it is God's punishment for the society that tolerates homosexuals.' Boasting of 6.3 million members shortly after it was founded, the group found its ally in Ronald Reagan, whose victory in the 1980s presidential election is also partially credited to them. Reagan's election provided legitimacy to the anti-gay sentiments of the American conservatives which soon extended to open discrimination against people with HIV.

How the government reacted:

In 1982, the CDC for the first time released a description of the disease. That very year in October, Larry Speakes, press secretary for Reagan, laughed when asked about whether the President was tracking the spread of AIDS.

A 2015 documentary short by Scott Calonico called *When AIDS Was Funny,* has audio recordings of press conferences where Speakes and other members of the media can be heard joking about the AIDS epidemic, which they called the 'gay plague'. When a journalist, Lester Kinsolving asked if the President was aware of this disease, Speakes replied by saying, 'I don't have it. Do you?' This was followed by laughter. By 1982, more than thousand people in the US had died from AIDS.

Watch the documentary here: https://youtu.be/NkCddLFOdtc

It was only in September 1985, that Reagan mentioned AIDS publicly for the first time, calling it a 'top priority' and defending his administration against criticism that funding for AIDS research was inadequate. By this time, at least 3500 people had died from AIDS in the US. And by the end of 1985, at least one HIV case had been reported from each region of the world.

Reagan and his supporters were known to be culturally conservative, so the inaction and silence of his government on the issue of AIDS reflects the majority public opinion of the time—that victims of AIDS had brought the disease on themselves by their own choices (homosexuality, injection drug use, etc), which they believed was immoral.

The other aspect of Reagan's presidency is that he was opposed to an expansive role of government. His primary goal in this respect was to reduce government spending in every area except the military, and this included budgets that would soon become central to the national response to AIDS. For example, needle exchange programs were scientifically proven to help in the fight against HIV, especially since injection drug users were at a high risk of contracting the virus. Despite this, the federal government banned funding for needle exchange programs based on unsubstantiated claims that this would promote drug use. This moral counterargument in the face of scientific evidence continued to stymie efforts in AIDS research and prevention even under the Clinton administration. In 1998, Clinton upheld this Reagan-era ban, despite increasing funding in other areas of HIV related research and policymaking. The same year, when the epidemic's death toll had reached 400,000, the Congress, which oversees Washington DC's budget, banned the city from using its own funds for syringe exchanges. This ban stayed for the next nine years, and it was the gay, black and poor communities of the district that bore the brunt of this decision that was purely made for political reasons.

Clinton's predecessor George H.W. Bush signed the **Americans With Disabilities Act** into law, which prevented discrimination against people with HIV/AIDS. He also passed the famous **Ryan White CARE Act** in 1990, which became the largest federally funded program in the country for people living with HIV/AIDS. But despite this, he also refused to listen to WHO's suggestions on alternative methods of AIDS prevention, and often categorized prevention in terms of personal responsibility. This focus on behavior rather than funding for preventative measures such as safe-sex programs would end up harming those most affected by HIV and AIDS at the time—gay and bisexual men—because it portrayed being HIV-positive as a personal and moral failing. This further contributed to existing homophobia and stigma associated with the disease.

A similar approach was taken by Clinton's successor, George W. Bush, who supported funding for 'abstinence-only' education programs that completely downplayed the role that condoms played in prevention and undermined years of scientific research. Despite being extremely vocal about his support for fighting AIDS, especially in Africa, he continued the federal ban on needle exchange programs which worsened the rates of HIV in the country during his tenure, particularly among African Americans.

Also read:

Who Was Ryan White? https://hab.hrsa.gov/about-ryan-white-hivaids-program/who-was-ryan-white

Mass grave of people who died of AIDS: https://nyti.ms/2FuCytA

How AIDS remained an unspoken but deadly epidemic for years: https://bit.ly/2FuCJFg

These Posters Show What AIDS Meant In The 1990s: https://www.buzzfeednews.com/article/patrick-strudwick/these-1980s-aids-posters-show-the-desperate-fight-to-save-li

Looking at the response of the US government and NGOs to AIDS through posters: https://www.smithsonianmag.com/history/the-confusing-and-at-times-counterproductive-1980s-response-to-the-aids-

epidemic-180948611/

AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

Despite only 11% of the global population residing in sub-Saharan Africa, the region emerged as the epicentre of the HIV/AIDS crisis in 2002, with AIDS declared to be the leading cause of death there. In 2011, this region accounted for 70% of all AIDS related death in the world. Even in the 1960s, before the virus reached the West, nearly 2000 people in Africa had AIDS. In fact, the first ever AIDS epidemic is believed to have occurred in Kinshasa in the 1970s. This isn't surprising considering the fact that the very origins of this disease are proven to have been in this continent. Bushmeat practices, coupled with urbanization, colonial medical campaigns and river trade made it possible for infections to spread across regions. It is, however, unhelpful to speak of a single sub-Saharan African HIV/AIDS epidemic. The epidemics affecting this region are highly varied, with differences between and within regions.

The main transmission route of the disease in sub-Saharan Africa is unsafe heterosexual intercourse. The epidemic in the region disproportionately affects women, with young women aged between 15-24 being particularly vulnerable and four times more likely to be infected with HIV than men.

In the 1980s, the public health campaigns were designed around creating AIDS awareness to prevent the spread of the disease. However in an atmosphere of denial, stigmatization and few resources, this model failed to control and improve sexual behaviors of sub-Saharan Africans, which is greatly influenced by socioeconomic and cultural factors, none of which was taken into consideration. As a result of this, by the end of the decade there were multiple epidemics across the region, with infections increasing at alarming rates.

Van Niekerk wrote in *Moral Complexities of AIDS in Africa,* that poverty is the social context in which AIDS has been able to thrive in Africa. To quote Niekerk, 'Poverty has accompanying side-effects such as prostitution (i.e. the need to sell sex for survival), poor living conditions, education, health and health care. These are major contributing factors to the current spread of HIV/AIDS.'

However, Niekerk was also quick to dismiss the western ideals of 'development' and wealth as the only possible solution to this problem. Instead, he emphasized on the need for addressing the existing religious and sexual views, mass availability of condoms, comprehensive sex education and cooperation with multinational pharmaceuticals and foreign governments to make antiretroviral therapy more accessible and affordable in Africa.

South Africa

The epidemic exacerbated existing issues of inequalities and prejudice in several parts of the continent. As of 2018, there are 7.7 million people living with HIV in South Africa[2]. While the country has made significant progress in recent years towards fighting the AIDS epidemic, there was a time when the country's response to the disease was mired in pseudoscientific

claims and confusing stances that led to the loss and decay of many lives.

Government response

In 2000, President Thabo Mbeki wrote a letter to world leaders expressing doubts that HIV virus was the exclusive cause of AIDS and argued that socioeconomic causes must also be considered. He subsequently invited scientists who shared his view to constitute a panel that would advise him on how to deal with the epidemic. Mbeki questioned AIDS statistics, made statements on the dangers of antiretrovirals (a drug that helps with HIV symptoms), and also stalled the roll out of nevirapine, a drug which prevented vertical transmission of AIDS from mothers to their children. The international community's response to the AIDS crisis in South Africa was also largely confined to countering the President's claims. It was in July 2002 that the country's Constitutional Court ordered that nevirapine be made universally available to all pregnant women infected with HIV. Later that year, the South African cabinet also published a statement supporting wider access to antiretrovirals.

But it would be foolish to assume President Mbeki's denial of the epidemic and suspicion of Western drugs as just another case of science vs. pseudoscience/superstition. Didier Fassin and Helen Schneider, in their paper 'The Politics of AIDS in South Africa' pointed out how in the 2000 controversy created by Mbeki, there are two themes that could be explained by South Africa's historical context and political reality. The first was the racialisation of the issue, wherein the government accused opponents and activists of racism towards South Africans. The second was the theme of conspiracy against Africans, either from the country's white population or from the global pharmaceutical industry. These created a contradictory narrative that both AIDS and its treatments were a ploy to eradicate the Black populations.

This suspicion and conspiracy are rooted in the country's history itself. During the bubonic plague of 1900 in Cape Town, the epidemic was used to justify the mass removal of Africans from their homes to the first 'native locations' under the first segregation law passed in 1883, which was called the Public Health Act. South Africa has witnessed a history of epidemics being used to enforce racial segregation. In fact, when AIDS arrived in South Africa many white leaders chose to interpret it in racist terms, bringing up the trope of the 'promiscuous African' and rejoicing in the possible elimination of the Black populations(Didier Fassin & Helen Schneider, 2003).

Moreover, towards the end of the apartheid, there was also evidence which showed that government-backed laboratories were researching on chemical and biological weapons, and contraceptive methods to eliminate the Black populations of the country. So what appears to be unfounded suspicions and an aversion towards western knowledge, was actually the result of a violent past.

Looking at the epidemic through social lenses

In light of this history, Fassin and Schneider have argued for a **social epidemiology** of the AIDS epidemic in South Africa instead of the biomedical one. They mention three social factors that place South Africa at a high risk of HIV infections:

- **Social inequalities in income and employment status** leads to greater exposure to risky sexual experiences, lack of health information, delayed or absent diagnosis.
- **Mobility**: mass resettlement of populations under apartheid, labour migrations, refugees, return of political exiles since 1990. All of these increase the likelihood of infection spreading.
- **Sexual violence** in both commercial and conjugal sex, which is also linked with the common forms of political and social violence which are a part of everyday life in townships and inner city areas.

'Inequality, mobility, and violence are partly the legacy of centuries of colonial exploitation and racial segregation, culminating in the institution of apartheid in the second half of the 20th century. Epidemiologically this segregation translates as differential HIV seroprevalence between black and white groups and between social classes', Fassin and Schneider have concluded.

The problem of child-headed households

In the 'AIDS Belt' of sub-Saharan Africa, a peculiar phenomenon began occurring from 2000 onwards: the rise of child-headed families. The main cause for this was the large numbers of young men and women who were dying of AIDS, leaving behind children to fend for themselves as well as their younger siblings. This raises several legal and ethical problems where the child caregiver is often the one caring after sick parents as well, and without any adult support, they are often thrust into important medical decision-making and made privy to details about the patient's condition. The emergence of these households has deprived several children and youth of their childhood and education opportunities. Their precarious living conditions also mean that they are often susceptible to food insecurity and social vulnerability, despite the efforts made by government policies and NGOs. In a study[3] published in *The Open Public Health Journal*, it was found that these children are often driven out of their houses by greedy relatives who claim to have inherited their property after the death of the parent(s), and are forced to live in absolute poverty in rural settlements and shanties. As of 2016, the number of children who have been orphaned after losing one or both of their parents to AIDS in South Africa is 1.7 million.[4] In Mozambique, the number is 1.2 million, and 670,000 children in Malawi.

Uganda - ABC program:

By the 1990s, the public discourse on AIDS in sub-Saharan Africa had shifted from the narrow biomedical approach to a multi-sectoral approach that aimed at reducing vulnerability. Public health campaigns began to actively promote sexual behavior change. In Uganda between the late 1980s and mid-1990s, this approach was adopted through the ABC campaign which advocated that in order to avoid getting infected by HIV one must **A**bstain from sexual intercourse or delay sexual debut or if this wasn't possible then **B**e faithful to one partner and reduce

the number of sexual partners use **C**ondoms for protection during sex.

The next letter, D, stood for 'Death from AIDS', which would be the result if these behaviors were not adopted. The ABC campaigns have been credited with an impressive reduction in prevalence of HIV in Uganda. This was bolstered by a comprehensive national message that AIDS prevention is of national importance and the responsibility of every citizen. The country, under President Yoweri Museveni was also able to reduce stigma, promote discussions on sex out in the open, persuade couples and individuals to get tested and reduce discrimination against women in its fight against HIV. Beyond Uganda, other countries such as Cambodia, Thailand and Dominican Republic had also positively responded to variants of the ABC campaign (Susan Cohen, 2003).

Impact of US Policy of Abstinence:

In the early 2000s, the US AIDS prevention policy was still focusing primarily on abstinence. In a 2003 AIDS policy, it was mandated that one-third of all US assistance to prevent HIV/AIDS globally would be reserved for 'abstinence until marriage' programs, making it the single most important HIV/AIDS intervention of the US government. Conservatives were in favour of this because they believed that promoting condom-use would encourage people to be more promiscuous and sexually active. They also denounced programs that were targeted towards at-risk populations, such as the LGBTQ community, injection drug users, sex workers, etc., on the basis that this would give legitimacy to such 'immoral people'.

In a 2005 report released by *Human Rights Watch,* it was found that the US funded ABC programs in Uganda had pushed for abstinence and pro-marriage, monopoly-only strategies under the Bush administration.[5] The report also mentioned how crucial information about HIV prevention and condom use was eliminated from school curricula under President Museveni and his wife, First Lady Janet Museveni—the very people who were once spearheading effective AIDS policies in the country. In 2004, the government went on to impose restrictions on condom imports and decided to increase focus on abstinence.

Take a look at:

Present statistics of HIV/AIDS in South Africa: https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa

STIGMA AND DISCRIMINATION

In the late 1980s, Jonathan Mann pointed to three phases in the AIDS epidemic in any society. First, the epidemic of HIV infections silently enters a community and remains unnoticed for a while. Second, the epidemic of AIDS itself, which emerges when HIV triggers life-threatening diseases. The third phase is a combined reaction of stigma, discrimination, blame and collective denial. He says that it is the third phase that makes dealing with the first two so difficult.

Stigma is used to discredit individuals based on an 'undesirable difference' or deviancy. Stigmatization is a process by which a particular society responds to a person who has a 'spoiled identity'—someone who doesn't conform to the rules and sanctions of a particular society. The qualities on which stigma operates are essentially arbitrary—for example, the colour of skin or hair, ethnicity, sexual orientation, etc. The 'undesirable differences' based on which stigma functions are purely the creations of individuals and communities, they do not exist naturally.

Stigma does not magically appear out of nowhere. Stigmas play into and reinforce social inequalities, which become heightened in times of crisis. Much of the existing HIV and AIDS related stigma reinforces existing prejudices of communities. For example, in many countries, people with HIV are often viewed as engaging in illicit sexual activities with sex workers, especially if the person is male. On the other hand, women suffering from HIV and AIDS are seen as promiscuous, and of 'loose' morals. In Africa, young girls and women are at increased risk of contracting HIV because many of them cannot insist on condoms out of fear of being seen as 'promiscuous' by the men. The stigma around condom-use prevents them from accessing this tool which is proven to reduce risks of HIV infections. In parts of the West, HIV tends to only be associated with homosexual men and those who engage in drug abuse. This leads to increased homophobia and lack of resources at their disposal to fight the disease. While there may be varied perceptions of this disease, none of the stereotypes are random. All of them are the result of power dynamics—they are linked to our perceptions of which groups are devalued and who is considered superior.

Stigma causes both shame and discrimination. Internalized stigma may cause one to feel shame for being associated with the stigmatizing condition, and causes fears of being discriminated against. Alternatively, it is stigma that motivates individuals, communities, institutions, and governments to discriminate against a particular group without any objective justification. This can cause persons belonging to that particular group to face serious impediments in living a just and fair life.

All over the world, there have been countless instances where a person with HIV and AIDS has been discriminated against and denied their basic human rights. Apart from struggling with a life-threatening disease, many have had to fight long-drawn, expensive legal battles to ensure that they could go to school, live in an apartment, have a job, marry, and live a respectful life. In several situations the stigma is legitimized through state policies and discriminatory laws. HIV and AIDS related stigma and discrimination compound the suffering of people living with this condition. It erodes their human rights, thereby making them more vulnerable to the

disease and lessens their ability to cope with it. Not just that, stigma and discrimination towards *any* marginalized group increases their vulnerability to a larger scale of suffering, as well as increases their chances of being infected with HIV and AIDS. Thus, stigma and discrimination perpetuate this vicious cycle where vulnerable individuals have increased chances of acquiring the disease, and those already with the disease have lesser chances of getting adequate treatment.

HEALTH AND HUMAN RIGHTS FRAMEWORK

Early in the history of the disease, it was clear that HIV/AIDS was not simply a medical issue, but an issue of social justice. Jonathan Mann, director of Zaire AIDS Research Program (mid 1980s) and leading HIV activist, had argued that health is determined by social factors. He said, 'the human rights framework offers public health a more coherent, comprehensive, and practical framework of analysis and action on the societal root causes of vulnerability to HIV/AIDS than any framework inherited from traditional health or biomedical science'.

Mann's argument was that the traditional public health approach, with its emphasis on information and health services would prove insufficient in tackling the AIDS pandemic unless social problems such as inequalities were first dealt with. He, along with his colleagues has argued that despite different histories, perspectives and vocabularies, public health and human rights are 'synergistic', since both are concerned with advancing the wellbeing of human life. As we have seen, wherever discrimination has flourished, HIV/AIDS has followed.

The International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976), the International Covenant on Civil and Political Rights (ICCPR, 1976) and the Universal Declaration of Human Rights (UDHR, 1948) are together considered to be the International Bill of Human Rights. These two UN treaties, along with the UDHR form the backbone of the rights based approach towards public health.

Throughout the history of the AIDS epidemic, there have been several instances where the fundamental rights of individuals were infringed upon under the garb of tackling this infectious disease. Individuals have been segregated in schools and hospitals, kicked out of their apartments because they were HIV-positive. In prisons, this kind of degrading treatment is particularly prevalent where inmates may be forced into mandatory confinement and even denied their basic needs. This is not the result of illness, but rather a result of the stigma and taboo that surrounds HIV/AIDS. Hence to tackle this, one must look at the epidemic from the lens of social justice, and not just as a public health crisis.

In the 1990s as the pandemic surged, this approach was used to tackle controversial public health measures such as the United States' practice of detaining HIV positive Haitian refugees at Guantánamo, Cuba's practice of forcibly quarantining its own HIV-positive citizens. The health and human rights framework allows us to examine and critique discriminatory measures taken by states in times of public health crises as a justification for dealing with the disease.

HIV CRIMINALIZATION LAWS

In almost every corner of the world where HIV has made its presence felt, governments have desperately tried to tackle the pandemic by implementing laws that criminalize the transmission of the disease. These criminalization laws are an attempt at dealing with a public health situation as a law and order problem and have only further added to the stigma and misinformation surrounding the disease.

- There is no evidence that shows that HIV criminalization laws reduce the chances of contracting the disease. On the contrary, such laws discourage individuals from getting tested and even receiving medical treatment because of the added fear and stigma that comes to be associated with the disease due to such laws. These laws only criminalize an already vulnerable population and do nothing to provide them with medical support.

  Moreover, ample research done over the decades has shown how safe sex practices are effective in preventing the spread of the infection. Today, with a well-functioning antiretroviral treatment, it is possible to reduce the viral load of HIV and pass as undetectable—meaning that the viral load in the body becomes so low that it cannot be detected in a person's blood. For such individuals disclosure isn't necessary because there is no risk of contracting the infection from them during intercourse. According to the WHO, in 2018, 62% of all persons living with HIV had received antiretroviral therapy. All of these facts point to how ineffective and unnecessary HIV criminalization laws actually are.

- In the United States, HIV-positive individuals continue to be harassed and wrongfully sentenced to jail due to regressive criminalization laws that have been around since the early days of the epidemic in the country. At least 29 US states, mostly in the Midwest and Deep South, have laws that criminalize HIV nondisclosure, transmission and exposure. When the epidemic first started, being HIV-positive was as good as being dead. But with the advancement in antiretroviral therapies, it is now possible to live a normal life with HIV. However, the legal system in the USA has failed to keep up with these new scientific advancements. As recently as 2015, Michael Johnson, a black gay man, was convicted for not disclosing his HIV-positive status to sexual partners. He was released on parole in 2019. Despite the lack of evidence proving that Mr. Johnson had not transmitted the virus, and his repeated claims of innocence, the court of law was not convinced of it. These outdated laws do not help in any way to reduce HIV infections, but instead further marginalize those communities who are already disproportionately criminalized and prosecuted by the country's criminal justice system: black people, trans persons, migrants, sex workers, injection drug users and LGBTQ+ folks.

- In Canada, the campaign for the criminalization of HIV nondisclosure started in 1990, and was cemented through a series of landmark judgments. In the 1998 Henry Cuerrier case, the Supreme Court of Canada ruled that in the context of sex, HIV nondisclosure can be considered an assault as it poses a 'significant risk'. In 2011, Johnson Aziga, a Ugandan immigrant in

Canada became the first person in the world to be convicted of murder for infecting someone with HIV. It is worth noting that Black men make up 52% of the heterosexual males who have been charged, but only 6% of HIV-infected men in Canada, according to the Canadian Journal of Law and Society. It is also worth noting that racism and tropes of the sexualized Black immigrant have only further helped in hardening public opinion behind HIV criminalization. Moreover, despite Canada's nationalized healthcare, anti-immigrant sentiments, policy gaps have historically prevented vulnerable populations from accessing these resources.

� In Sarah Schulman's book *Conflict Is Not Abuse,* she writes how HIV criminalization ultimately takes the responsibility of protecting themselves away from the HIV-negative person and recasts them as victims who have been 'criminally wronged' by the HIV-positive individual. Schulman writes, 'Instead of seeing a negative person who has unprotected sex as a participant in the problem, the law recasts them as victims. This interpretation runs counter to the global message of the last three decades of AIDS prevention work emphasizing the role of HIV-negatives in protecting themselves. The status quo for years has been that negative men and women stay negative by insisting on 'safe sex', a concept built around the use of condoms, and more recently PrEP (Pre-exposure prophylaxis). In this way, communication between sexual partners has been the mainstay strategy of HIV prevention.'

Having said that, **disclosure of HIV-positive status is one of the first steps in learning to live with the disease**. Disclosure can allow individuals to receive emotional support from their partners and family, encourages their partners to get tested, and also allows for cooperation in preventive behaviours such as safe sex and proper medical treatment. In the sub-Saharan African countries, the median percentage of people living with HIV who know their status is less than 40% (WHO, UNAIDS & UNICEF, 2010). Nondisclosure is often cited as a leading cause of spread of HIV in these countries and research has shown that a large proportion of the recent infections occur within serodiscordant couples (ie couples where one partner is HIV-positive and the other is not). However, the HIV specific laws passed in several of the countries fail to take into account the issue of ethics and human rights violations. Almost 30 sub-Saharan states to-date have passed laws criminalizing HIV transmission or exposure in some form. It was after the 2004 development of Model Legislation on HIV/AIDS for West and Central Africa (also known as the N'Djamena Model Law) that the legislative landscape on HIV in sub-Saharan Africa was transformed. While this helped in the creation of anti-discrimination legislation in most of the countries, it was also accompanied by regulations on disclosure that could be viewed as violations of human rights. Critics of the Model Law have cited concerns about requirement to disclose HIV+ status to sexual partners and allowing health workers to notify sexual partners if the HIV-positive person does not. There are also instances where mandatory testing is required. While these are cited as exceptions to the principles of informed justice, the laws remain vague on what those exceptional circumstances may be. Without careful consideration by a court of law, these preventive laws can easily violate an individual's right to liberty, right to privacy and right to security. This sort of legislative practices can be found in the HIV specific laws of Uganda, Burkina Faso, Benin, Burundi, Central African Republic, Cape Verde, Chad, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Guinea, Mali, Niger, Sierra Leone, Senegal, Mozambique, etc. In some African settings, including

Zimbabwe, policy makers and women's groups have supported criminalizing transmission as a way to protect women, change male behaviour and punish men who transmit HIV to female partners (UNAIDS & UNDP, 2008). However, some researchers argue that in practice, women may be more likely than men to be prosecuted for nondisclosure or criminal transmission, because they are more likely to be HIV-positive, to be tested before their partner in ANC, and to have limited access to the legal system.

The UNAIDS Reference Group on HIV and Human Rights concluded that, 'in the overwhelming majority of cases, applying criminal law to HIV transmission or exposure does more harm than good' (UNAIDS Reference Group on HIV AIDS and Human Rights, 2008). Instead, it called for 'promoting a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status' as well as for expanding evidence-informed programs that prevent HIV transmission while 'protecting the human rights both of those living with HIV and those who are not infected'. These arguments have persuaded parliamentarians in some parts of the region to reject criminalization, but such provisions remain on the books or under consideration in many countries.

HIV/AIDS ACTIVISM

To understand why HIV/AIDS political activism is so crucial for those affected by the disease, one must understand the intersectionality of the suffering that its victims experience. As it is abundantly clear by now, the epidemic disproportionately affects people with marginalized identities, which in turn adversely affects their ability to access the resources which will help them in battling the disease. So, HIV/AIDS activism is as much about LGBTQ+ rights, the movement for the decriminalization of sex work, the anti-capitalist movement, as much as it is about the disease itself.

As Patricia Siplon wrote in 1999, for people living with AIDS, the question was not just about what to do about the problem posed by infection by a deadly disease, but where to place that one problem in a seemingly never ending array of other problems and confounding circumstances.

ACT UP (or, the AIDS Coalition To Unleash Power), was a revolutionary organization founded in 1987 in the USA that completely changed the trajectory of the medical and government response to the AIDS crisis. Their protests forced the FDA to fund experimental drug research, and their Wall Street demonstrations forced big pharmaceuticals to reduce the sky-high costs of AIDS medication, thereby making it easier for millions around the world to access these lifesaving drugs. Over the years, several ACT UP chapters sprang up in different parts of the world.

Read/Listen**:**

The personal testimonies of ACT UP activists Mike Petrelis and David Barr (https://bit.ly/2ZDuk98)

Watch**:**

United Colors of Benetton's use of one of the most popular AIDS photographs in an ad campaign and how that blurred the line between activism and branding. (https://youtu.be/jx-aCvvPr98E)

United In Anger: A documentary about the history of ACT UP.(https://youtu.be/MrAzU79PBVM)

Further Engagement:

The Cost Of Reagan's Fumbled Response To The AIDS Crisis: https://youtu.be/hyJ1JdnaSq

UK Media's Coverage of HIV/AIDS In The 1990s Is A Cautionary Tale For Health Journalists Today: https://bit.ly/3bY7MVI

What Lessons Does the AIDS Crisis Offer for the Coronavirus Pandemic? https://bit.ly/3huqfdx

AIDS and Its Metaphors, Susan Sontag.

How Poetry About AIDS Has Shifted Through The Years: https://www.poetryfoundation.org/articles/70183/in-time-of-plague

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The LGBTQ Health Clinic That Faced a Dark Truth About the AIDS Crisis: https://amp.theatlantic.com/amp/article/594445/#aoh=15937282202028&referrer=https%3A%2F%2Fwww.google.com&_tf=From%20%251%24s

The Reagan administration's unbelievable response to the HIV/AIDS epidemic: https://www.vox.com/platform/amp/2015/12/1/9828348/ronald-reagan-hiv-aids

'ABC' prevention is becoming 'AB' in Uganda, thanks to US influence against condom use, says report: https://www.aidsmap.com/news/mar-2005/abc-prevention-becoming-ab-uganda-thanks-us-influence-against-condom-use-says-report

AIDS IN AFRICA: FACTS, FIGURES AND BACKGROUND INFORMATION ON THE EPIDEMIC: https://www.sos-usa.org/about-us/where-we-work/africa/aids-in-africa

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The History of HIV and AIDS in the United States: https://www.healthline.com/health/hiv-aids/history#numbers

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