

# 1981–2021: HIV and Our World

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🔗 See also Morabia, p. 1175, and the HIV/AIDS and Our World: 1981–2021 section, pp. 1231–1266.

In January 1981, Ronald Reagan was inaugurated as president of the United States following the appointment of Margaret Thatcher as prime minister two years earlier in the United Kingdom. Globally, it was an era of widespread conservatism. In the United States, this was an era of reduced funding for major safety net programs, such as food stamps, Medicaid, environmental protections, education, and, of course, health care spending.<sup>1</sup> US federal policy on addiction was branded by the slogan “Just say no.” Civil rights and women’s rights were largely ignored. And the rights of lesbian, gay, and bisexual people, let alone those of transgender people, went unheard of and unmentioned. In short, the federal government had launched an all-out assault on poor and marginalized communities.

It was into this political reality that a cluster of five cases of *Pneumocystis* pneumonia were reported among young “active homosexuals” at three Los Angeles, California, hospitals.<sup>2</sup> The documented occurrence of AIDS among gay and bisexual men even resulted in a short-lived moniker for the illness: “Gay-Related Immune

Deficiency,” or “GRID.” The modern gay rights movement that was signaled by the Stonewall riots in New York City in 1969 had not yet reached the halls of medicine as the HIV epidemic unfolded across the United States.<sup>3</sup> And as Ayala and Spieldenner show (p. 1240), the ongoing stigma, silence, and discrimination that gay men encountered in their daily lives was embedded in politics at the very time when these insidious characteristics could be even more destructive. In addition, Purcell (p. 1231) discusses how laws that criminalized the very existence of men who had sex with men contributed to the severity of the epidemic. Yet, he also explores the changes to the laws against same-sex sexual behavior and the rise of marriage equality and notes the creation and persistence of laws criminalizing HIV transmission.

## THE ROLE OF INTERSECTIONALITY

During the 1980s and 1990s, and in rapid succession, new groups of people were added to the list of those affected by HIV: people who inject drugs;

hemophiliacs; immigrants; women, especially Black and Brown women; transgender women; and infants born to women with HIV. Together, these groups of people comprised a vast quilt of names and stories of people affected and infected by HIV. For these diverse groups of marginalized people, the level of organization in some to advocate for government action on HIV was weak or nonexistent (i.e., transgender women, people who inject drugs). Although often overlooked, Black women organized at the grassroots level, with groups like BEBASHI (Blacks Educating Blacks About Sexual Health Issues) in Philadelphia, Pennsylvania; WEATOC (We’re Educators—A Touch Of Class) in Boston, Massachusetts; and TWC (The Women’s Collective, part of TheWellProject) in Washington, DC, to educate and advocate for women and youths of color.

We have witnessed this over these past 40 years, and we now recognize and acknowledge that HIV is an intersectional disease that disproportionately affects women of color, gay and bisexual men of color, and people of color who inject drugs. Organizations such as SisterLove (as described by Diallo, p. 1237) have given Black women a voice and a platform in the HIV response and have fought for the recognition of women’s sexual and reproductive rights as well as health justice as intrinsic to reducing the inequities that drive HIV among women of color.

Equally important, Amaro and Prado (p. 1246) discuss how Latinas who have been affected by HIV, including those who inject drugs, have been ignored or sidelined in HIV prevention and intervention efforts and how only a small number of evidence-based

interventions for HIV prevention or successful engagement and retention in care exist to serve Latina women. It is clear across these articles, including that of Ellis (p. 1249), that the needs and lived realities of women of color will not be addressed until their voices are acknowledged and acted on. Until this happens, we will not improve access to HIV research, care, and prevention services to meet the needs of racially and ethnically diverse people with HIV.

## EQUITABLE, INCLUSIVE STRATEGIES NEEDED

The early development and dissemination of a document known as “The Denver Principles”<sup>4</sup> and the associated creed “Nothing about us without us” helped to lay the groundwork for the participation of people with HIV at all levels of community and organizational activity to address the HIV epidemic. However, a critical look at the lack of racial or ethnic diversity in the leadership of those working to develop power-sharing structures may have sown the seeds of the continuing challenges that we face today in ending the HIV epidemic.<sup>5</sup> Consequently, Schmid (p. 1255) calls for targeting proper federal leadership and resources to the right jurisdictions—those most disproportionately affected—to meet the goals outlined in the federal Ending the HIV Epidemic plan. It is unproven whether the federal Ending the HIV Epidemic plan will support the interventions needed to reduce an annual US infection rate, which still hovers at approximately 37 000 new infections per year—the majority of which are among people of color.<sup>6</sup> What we do know is that localities with the greatest success in reducing new cases, such as San Francisco, California;

New York City; and Massachusetts, have done so by reducing barriers to health care and improving racial equity in access to health care.<sup>7-9</sup>

In short, we know that it is necessary to remove barriers that prevent people from accessing HIV testing, linking to HIV care, and accessing and consistently using antiretroviral therapy. As we look back at the lessons learned over the past 40 years, moving forward we must demand that approaches to addressing HIV prioritize equitable solutions. As El-Sadr (p. 1234) points out, we cannot have a one-size-fits-all approach. Prevention efforts need to be attuned to the needs of the community, the needs of the place, the needs of the people, and their lived realities. We cannot expect HIV prevention policies to work by having people adapt to them; these policies must be adapted to meet the needs of the unique and diverse groups of people they seek to serve. Thus, a combination of behavioral and biomedical approaches is required—and each combination will need to be calibrated to each diverse community it seeks to serve. For example, Beletsky (p. 1258) points to the longstanding carceral punishments for drug use in the United States and elsewhere as obstacles to harm-reduction programs that could be implemented to mitigate the spread of HIV among people who inject drugs. These barriers are significant, as both the opioid and stimulant epidemics have led to increases in transmission through needle sharing or among sex partners using methamphetamines for recreational sex.

## CHARTING A WAY FORWARD

As we begin the fifth decade of the HIV epidemic, let us reflect on and be

inspired by the mission of the #BlackLivesMatter movement to

build local power to intervene in violence inflicted on Black communities by the state and vigilantes. By combating and countering acts of violence, creating space for Black imagination and innovation, and centering Black joy, we are winning immediate improvements in our lives.<sup>10</sup>

Efforts to allocate resources, shape and reshape public policy, and create power-sharing structures must be made through a lens of racial equity. It is no longer acceptable to say, “We can’t find youths of color who want to be part of our advisory board.” Reflecting on this mission, and thinking about the next generation of rising HIV scholars and activists (Garcia-Wilde [p. 1261], Hanshaw [p. 1263], and Lopez-Rios [p. 1265]), we call for all people of good will who wish to make a contribution to ending the HIV epidemic to adopt an approach that is based on how those most affected lead their lives, pursue their passions, and seek to manage both their health and health care to build their resilience in the face of ongoing structural racism and threats of disease, discomfort, and danger. *AJPH*

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## PUBLICATION INFORMATION

Full Citation: Landers S, Kapadia F, Bowleg L. 1981–2021: HIV and our world. *Am J Public Health*. 2021;111(7):1180–1182.

Acceptance Date: April 17, 2021.

DOI: <https://doi.org/10.2105/AJPH.2021.306360>

## CONTRIBUTORS

S. Landers and F. Kapadia drafted the editorial. All authors conceptualized and edited the

editorial, and invited authors and edited articles as part of the “HIV@40” commemorative dossier.

## ACKNOWLEDGMENTS

We wish to acknowledge all people who have worked to prevent HIV infections and treated and cared for people with HIV as well as those who have died from HIV-related causes.

## CONFLICTS OF INTEREST

None of the authors has any conflicts of interest to report.

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