HIV/AIDS in the United States, South Africa, and the Netherlands: A Focus on Stigma

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The world has hardly treated all people living with HIV equally. For those who are not white, heterosexual, or gender-conforming, an HIV-positive test brings a much heavier burden. These groups are not at a higher risk because of anything intrinsically about them, but instead because of the inequality and discrimination that they already face. This is an important and necessary distinction to make because the stigma created, costs lives. Usually, to obtain an accurate view of a state's response to the HIV/AIDS epidemic, it is necessary to focus on a decade or a government administration. However, looking at a state's response and outreach to the communities listed above is already a narrow enough scope of analysis and it is essential to analyze the response across time as attitudes have changed. First, the United States has possibly the most notorious HIV/AIDS response in the world and is important to a conversation surrounding public health. Secondly, South Africa has the highest percentage of people living with HIV/AIDS in the world and is plagued by economic, racial, and gender inequality. Finally, the Netherlands had some of the most widely praised initial responses to the epidemic and has been at the forefront of both HIV/AIDS research and human rights. Evaluating the commonalities and differences between these three cases will provide helpful insight on how to handle public health crises that acutely affect communities with little political capital.

The United States has the largest number of people living with HIV/AIDS in the developed world, with over one million people diagnosed with HIV (Padamsee). The U.S. response is well known in all the worst ways. The early response was riddled with misinformation and discrimination. Government officials commonly referred to HIV/AIDS as the "gay plague" or "gay cancer" (Bennington-Castro). Almost ten years after the first confirmed case, Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990. While this changed the landscape of AIDS response in the U.S. forever, advocates of this policy distanced the legislation from gay men and IV drug users by referring to those that this policy would help as "innocent AIDS victims" (Padamsee). Many studies have drawn clear connections between homophobia, violence, discrimination, and victim-blaming to higher rates of sexually risky behavior that contribute to HIV/AIDS. "Life experiences with oppression and homophobia often become internalized and can have detrimental effects on the development of positive sexual identity. Positive attitudes toward one's sexual identity have been shown to be protective against risky sexual behaviors, while elevated rates of internalized homophobia have been linked to exacerbated sexual risk-taking and other health risks" (Halkitis). President George

H.W. Bush passed the CARE and the Americans With Disabilities Acts, but also ignored World Health Organization's counsel on "other methods to reduce the spread of the virus, and often categorized prevention strictly in terms of personal responsibility" (Fayyad). President George W. Bush continued his father's approach by supporting abstinence-only preventive education programs. This approach has no success in decreasing the rates of sex or HIV as it downplayed the role of condoms. These policies and statements failed to recognize the social and health obstacles that the gay community faces.

Perhaps the most obvious and consistent blunder in the U.S.'s response to the MSM (men who have sex with men), IV drug use, and non-white communities was the Reagan era ban on federal needle exchange programs that persisted until 2016. A look into Washington D.C.'s HIV/AIDS prevalence illustrates how young African American men were affected disproportionately by the overall epidemic and the federal policies. Since Washington D.C. is a federal district and not a state, Congress decides its budget. This prohibited D.C. from instating its own local needle exchange program like many states were at the time. Washington D.C. is a little less than fifty-percent African American and was majority African American at the height of the epidemic. Furthermore, "eight out of 10 young residents diagnosed with HIV are black" and "black people, who comprise about 13 percent of the [total U.S.] population, accounted for 43 percent of HIV diagnoses in 2017" (Fayyad). In 2007, when D.C. was finally permitted to implement a needle exchange program "the city saw an 80 percent drop in HIV infections through injection-drug use" (Fayyad). Both people of color and the LGBTQ+ community have higher rates of IV drug use that are linked to poverty and inadequate health care access. The U.S. policies were reluctant and failed to make a direct impact on communities that were acutely feeling the effects of the HIV/AIDS epidemic. Furthermore, the U.S. government's attitude and public statements surrounding the LGBTQ community's relationship to the disease perpetrated homophobia and a stigma that directly impacted people's health.

South Africa has been experiencing a hyper-epidemic of HIV/AIDS for many years. "South Africa remains the epicenter of the HIV pandemic as the largest AIDS epidemic in the world—20 percent of all people living with HIV are in South Africa, and 20 percent of new HIV infections occur there too" (Allinder, Fleischman). Sex workers, men who have sex with men (MSM), and the black communities, specifically black women, having the highest rates of HIV/AIDS in the country in "some cases double the national prevalence rate of approximately 19

percent" (Allinder, Fleischman). Similar to the U.S., living conditions and health care access linked to socioeconomic status has a negative correlation with HIV/AIDS rates. This is illustrated in some studies that have shown higher HIV/AIDS rates in traditionally black townships than coloured townships. This can be connected back to South Africa's deep history of racism and 50-year apartheid that ended in 1991. Black townships have been underfunded and under research for decades. The South African government only began heavily funding education and preventive programs in these areas years into the epidemic (Mabaso, Makola, Naidoo, Mlangeni, Jooste, Simbayi). Poverty is the biggest indicator of HIV/AIDS risk in South Africa. Studies have shown how low socioeconomic standing forces women into situations where they engage in more sexually risky behavior as a means for survival. This includes consistent sex work, but can also refer to engaging in sexual behavior with older men leading to a higher rate of contracting HIV. Survival sex can also occur "outside the context of prostitution but within the culture of male violence" (Fassin, Schneider). The extremely high rates of HIV among particularly poor, black women in South Africa are directly connected to the social and economic situation they are stuck in.

While government programs on education and prevention are funded and the appropriate goals have been set, there is a massive gap between policy and implementation. For one, these programs and campaigns are not targeted toward men or young people. This is extremely dangerous because MSM contract HIV at almost twice the rate as heterosexual men in South Africa (Smart). Secondly, men in South Africa face incredibly high levels of discrimination if they do not express traditionally masculine aspects of gender. There is a common fear among gay or bisexual men in South Africa of getting tested because of the discrimination in both the health care system and the workplace. "Gender non-conforming MSM—i.e., their speech, movements, and dress are seen as feminine—experienced more harassment in health services settings, while "masculine" MSM could pass as "heterosexuals". The concealment of same-sex orientation through masculinity may protect them from homophobic experiences, but it may also prevent them from seeking appropriate sexual health information" (Nel, Yi, Standfort, Rich). The response among the South African government to the alarming numbers of HIV/AIDS in the MSM community has been practically non-existent. South Africa's National Strategic Plan (NSP) on HIV & AIDS and STIs for 2007–2011 recognized the country's lack of understanding of how this disease affects the MSM community by stating, "whilst HIV infection amongst

MSM was a focus in the early phases of the epidemic in South Africa, there is very little currently known about the HIV epidemic amongst MSM in the country. MSM has also not been considered to any great extent in national HIV and AIDS interventions" (Nel, Yi, Sandfort, Rich). Since this statement, no drastic action to directly confront HIV/AIDS in the MSM community has been made. HIV is a public health emergency in South Africa that shows no signs of slowing down and the country's leaders are ignoring it. There was no mention of HIV in the 2019 State of the Nation address (Allinder, Fleischman). The epidemic has gotten out of control to an extent that good-intentioned program funding is not enough. South Africa needs to address the underlying issues of poverty, misogyny, and homophobia alongside the aggressive implementation of intentionally directed preventive and education programs for multiple communities.

The final case study, the Netherlands, illustrates a positive model of how to appropriately respond to a disease that acutely affects already struggling communities. Right away the Netherlands was ahead of the rest of the world, most definitely the United States, by setting up the first needle exchange program extremely early in the epidemic in 1984 when less than 1,000 people in Europe were infected (ICASO). Since then, the Netherlands has implemented widespread testing, partner notification, and preventive education programs (Boender, etc). Moreover, the Netherlands' focus on human rights has made it the world's center for LGBTQ rights and research, among other things. The Netherlands understood from the beginning that an HIV diagnosis carried with it two viruses: a biomedical one and a social one of stigma (Sandfort). Because of this understanding, the Netherlands was hyper-aware that their response to the spreading disease would affect groups that already held marginal positions in society. This commitment could even be seen in the early days of the outbreak. In both the United States and South Africa, the communities most affected by HIV/AIDS were not even remotely involved in any decisions made on how to respond to the spreading disease. However, in the Netherlands, the municipal health services and the gay community had a long-standing relationship of trust (Dijstelbloem). This allowed the Netherlands' government to participate in unofficial talks with the gay community and other important stakeholders in the crucial part of the epidemic. Most importantly, these talks resulted in a response that would not further stigmatize the disease. Unlike the United States, the Netherlands did not close bathhouses, saunas, or other social spaces where men had sex with other men as the science was never clear on whether or how much they

contributed to the spread of HIV. The health officials believed it would add to the stigma by singling out social spaces of one particular group. Furthermore, the data did show that unprotected sex among MSM occurred mostly in the privacy of homes and that closing these social spaces would only limit where health officials could provide services to ensure preventive resources and education were available (Sandfort). Same-sex male couples were included, but not exclusively used, in government campaigns that focused on preventative measures, such as limiting sexual activities to monogamous relationships, in the images and examples, in hopes of normalizing MSM relationships and decreasing the stigma (Brito). Rights to bodily autonomy and health privacy are enshrined in their Constitution, limiting the fear of a person's HIV-positive status being revealed to an employer leading to a job loss (Sandfort). Today, the Netherlands is expanding its response to ensure that the increasing migrant population, mostly from Africa and the Middle East, are given the health resources they need. Action against HIV/AIDS in the Netherlands was and continues to be swift, sweeping, and compassionate which is everything a public health response should be.

HIV/AIDS is not just a biomedical disease. The stigma and discrimination that accompanies it both socially and politically have ruined, at times even cost, people their lives for decades. The communities that are most affected by HIV/AIDS are ignored by their governments for too long and left to die. "Gay and bisexual men account for about 1 in 5 new HIV infections, but they were only allocated 1% of the $57 billion in global donor funding" (Savage). Communities that have even less political capital such as sex works or IV drug users receive even less support. The Netherlands' response was and is not perfect. That being said, their focus on the non-biomedical aspects of HIV/AIDS and the research that has led them to hold a deep understanding of this stigma and how it affects certain communities more acutely than others has left the world a good example of how public health should function. HIV/AIDS does not affect all communities equally and it does not affect a person in exclusively a physical way. The United States took decades to grasp this first point and is still grappling with the second. South Africa is lost in a sea of economic, health, and social struggles and far too many people have been left behind whose haven't been struggles haven't been heard in years. It is well past time for, both in the United States and in South Africa, leaders of the communities that are most acutely affected to have a seat at the table where policy and public health decisions are made. That is the very least that can be done after all this time, and the best place to start.

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