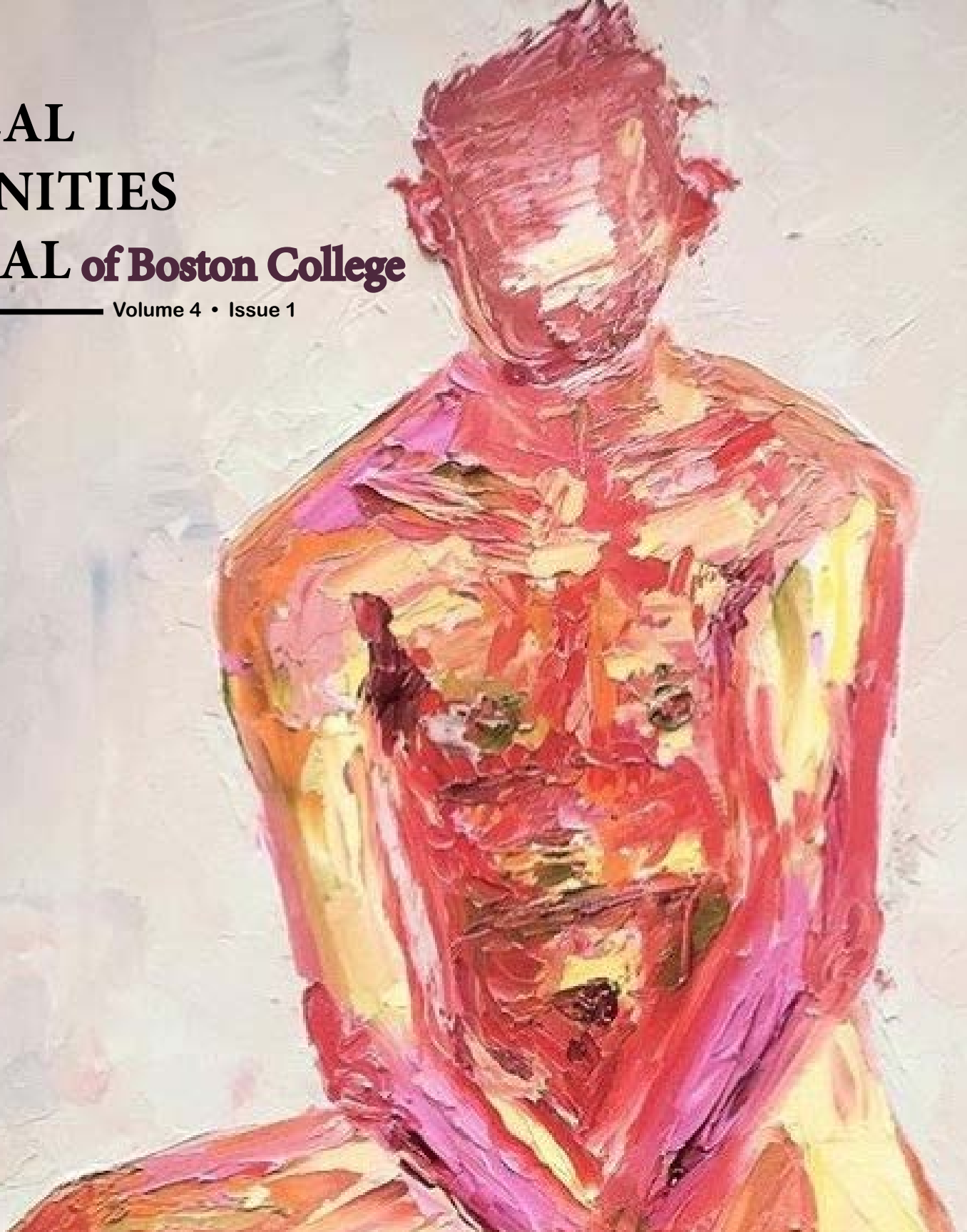


THE
MEDICAL
HUMANITIES
JOURNAL **of Boston College**

Volume 4 • Issue 1





MISSION STATEMENT

The Medical Humanities Journal of Boston College seeks to:

- Initiate and engage in conversation in the Boston College community and beyond about the emergent field of Medical Humanities, Health and Culture.
- Provide students at Boston College with the opportunity to publish original work.
- Feature a variety of work from several disciplines.
- Examine critically and represent creatively ideas of health, illness, caregiving, and medicine.
- Connect students with alumni, professionals, and other Medical Humanities programs to extend and to engage in conversation beyond Boston College.

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EDITORS' NOTE

We are thrilled to see our first issue as the new editorial board come together. It is exciting to hear the voices of the Boston College community and beyond as we engage in the rich conversation of the medical humanities. Whether through topics of medical education, patient experiences, epidemics, or policy, these subjects provide us with a chance to reflect on ourselves and the communities around us.

This edition involves a wide spectrum of pieces that showcase this interdisciplinary nature of medical humanities. Physical identity, age, chronic illness, and substance use are just a few topics that come together in our latest issue through visual art, poetry, fiction, and nonfiction. This diverse selection of pieces portrays many ways in which health can play a role in both individuals' everyday lives and of a larger society.

Our research pieces focus on an important yet stigmatized topic. Each piece explores HIV/AIDS and its role in interpersonal relationships, racial and sexual identities, and social groups. They evoke discussions that most times go unnoticed and ignored. Most importantly, each brings to light through research and real individuals' stories the continued effects and experiences of those living with HIV/AIDS in the U.S. and abroad.

Inside My Head and Spoken Out Loud: A Reckoning with Social Anxiety, by Mikayla Valdes, is a narrative that expresses the frustration, powerlessness, and confusion felt in one's experience with social anxiety. She discusses the judgmental and insensitive mindset society has had toward mental illness and how these illnesses tend to go ignored in light of others that are more visible. The narrative ends with an understanding of herself and the defiance to not let her mental illness and struggles define her.

Touched by Sarah Mia Duran shows a woman standing tall, with her back toward the viewer. The movement of the body is created by the movement of the artist's fingerprints shaping it into a powerful and strong posture. Each print shows the care in shaping the physical identity of the woman, depicting the human body as a fragile yet fierce form.

We are very grateful that these authors and artists have shared their work with us and for the time and care they have put into each piece. We would like to extend a thank you to our editorial board and advisors for all of their hard work and guidance that made this Journal possible. Finally, thank you especially to our readers who have supported us and who continue the conversation of the medical humanities beyond our pages.

Kaylie Daniels and Gayeon Lee
Editor-in-Chief and Managing Editor

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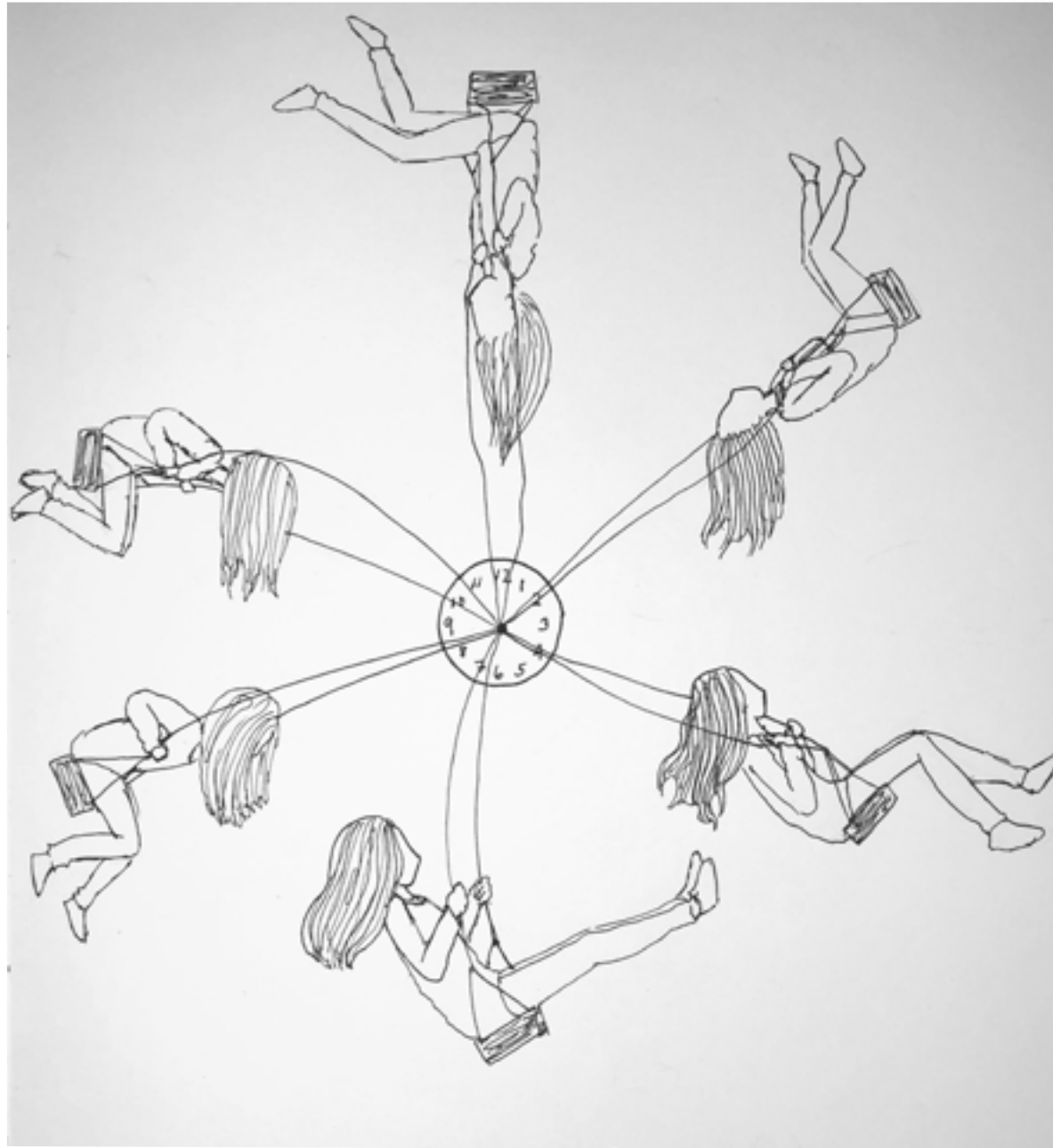
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MOOD SWINGS

EMILY ZHAO



A REGULAR TUESDAY

EMMA WINTERS

House. Recipe.
Saltine Crackers.
For soups and salads.
The flimsy packaging tells me all this
And breaks
And slips
Through my small fingers.

The crackers crunch but quickly become like uncooked dough
As they cement themselves to the
Backs of my teeth and the
Roof of my mouth.
The globs of thick dough slide down my throat,
Slowing gliding along its interior walls.
I turn the now empty packaging over to read the ingredients printed in small black lettering.
A few words catch my eye:
Soy.
Lecithin.
Flour.
A light hammer taps on the inside of my forehead, and I divert my eyes to the speckled table below.
Tap. Tap. Tap.
The saltines have settled into my stomach.

Not settled my stomach.
They found their place amid the rumblings.
My stomach tosses
And turns
And ignites once more.
Acid licks the walls of my stomach
And crawls its way to top of my esophagus

Begging to fan
Up
And out
Like a
Cat
That wants claw its way
Out.
Escape.

Tap. Tap. Tap.
Six crackers won't foot the bill for a day's work.
Tap. Tap. Tap.

My eyelids fall from gravity
And I'm back on the tiled floor,
Comforted by the smell of cleaning products
And fresh toilet water.
Elbows on the toilet seat,
Ass on the floor,
Head hanging above water.
And I can see the shit stains and limescale on the inside of
the bowl and
This of all things makes it
Stop.

Stop.
10:53am.
There's no time for such luxurious moments today.

I slide the packages between my fingers a few more times
And shove them into my pockets.
They will remind me later
That I am
Not
A
Superhero.

HOSPICE

KELSEY CONNORS

It's madness: frail wrists, whispers of a blizzard tonight,
a water glass with a clear straw. A snowman outside is sinking

into itself, air writhing in lungs weighed down, heavy
with mucus. This is what you breathe with

for your life that always, your life that never
collapsed. Don't go. Don't—go.

A cardinal flashes its red across the window.
Danielle climbs through snow to be

with you—just this one time. On the stiff couch
sits a furrowed brow. Her book of poetry is a sad song.

With so much to cry for, it is future
we settle on. The hours crack open like white eggshells. Your
dad

quietly cries in the hallway, thumbs on his temples,
looks at something none of us see. Outside the glass

doors at the hall's end, is a pure white
world. The earth beyond

these walls clambers with ribs
tired from laughing and crinkle-eye smiles—not
here. We wait over your starched linens and think dying
is all we know of heaven*. Your breath clings thin
to strands of air, we watch for your chest to fall
and rise, hang on each whisper of air.

We were together,
and that was good.

*from Emily Dickinson's "my life closed twice..."

NENA

CAMERON
FISHER



BLAME GAME

AFTER "DEGREES OF GREY IN PHILLIPSBURG"
BY RICHARD HUGO

EMMA WINTERS

I think I'll go home for Thanksgiving this year.
Say it's cause I'm lonely. The best two holidays
Were ones I don't remember. I drank six shots
Blacked out before the turkey, stuffing filled
With salmonella, plates stacked up, the suction cup
Of my great aunt's lipstick-covered kiss.
Only she died last year. So that's
One less mouth, that I need to avoid.

My recent change in physical health
Is unknown. Blaming myself for the cigarettes
Dad gave me, blaming myself for drinking,
Blaming my broken body, the part of myself
That I've never liked much anyway. One good
Thing is that I won't be explaining this.
The usual dinner, its drunken familial interactions,
A forced ritual better than nothing—
Forgotten by the time we're shopping,
In a glitzed out Christmas mall at 4am
To get a TV for spoiled me,
As a gift, that won't be a surprise
Because I'm seeing it in all its glory.

How will I die? Maybe the stress
Will do it before the vices? Isn't that question
A paradox, the stress happening also to be
A vice too: especially if it killed me?
What if I died? Would that
Or my body hold up a good turkey,
Not the cooking, but the
Eating that day, does death stop holiday
Feasts or coldly furnish forth the table
We've eaten at for the last six years?

Curse under your breath. The worst words, I
Know I'm a bastard, works well
Unless you get caught. Someday soon,
Dad says, You'll thank me for all I taught you.
I tell him no. You're lying to yourself
The cigarettes never made me into a man.
It was my fancy corporate job,
Even if it does suck, that made
And kept me the ideal ladies man
Sleeping around and telling no one about the chemo.

**YOU SEE
RIGHT
THROUGH
ME**

SARAH MIA
DURAN



HUMAN ANIMALS

LAUREN KEELEY

My body is cast like a George Segal sculpture. The orthotist's wet hands land on the jarringly bony protrusion of my hip. The casting material, three to four inches wide, is wrapped up into cylinders like tape, then unraveled and soaked in the murky water bucket. He places the sopping pinkish gauze onto the hipbone, holding it in place while wrapping the rest around my torso, the strip ending just short of the steep curve between my nascent hips and waist. My only job is to stay still and not take any deep breaths; I am mummified up to my sternum. It smells like latex and chalk, feels like a wet washcloth soaked in hot water and rested on the eyelids to ease a headache, all of the heat escaping in a matter of fifteen seconds. It is now cold and damp, but hardening.

Standing there at Shriner's Hospital for Children in West Philadelphia at age ten, I imagine what it would feel like to be completely set in cast, and what pose I would assume. Simply standing straight, I think. Seal up the potential energy of motion and wait for a crack in the mold. I look down and notice the slight bulge created by one of my left ribs, a result of my overgrown ribcage. It doesn't bother me at this moment; the casting holds everything tight and vertical, two things I realize I will never be. I stand, eyes forward, wait a few minutes. It dries like the bright white stucco on my neighbor's house and creates a sprinkled mess around my feet. He slices the casting with a swift vertical motion and my body cascades out of the stillness, no longer stable.

* * *

The summer after my junior year of college, I watch my grandfather use a walker that, for all of its brakes and safety features, rattles like a tin of loose screws. DME, durable medical equipment. The contraption is aluminum and four-legged; that makes six legs in total while in use. Its wheels are designed for any floor surface but not the sharp corners of a family home. Who decided to build this house with such a narrow doorframe to the bathroom? And whose grand idea was a staircase? The entire family is now aware of the glaring lack of foresight in construction. Who plans for getting old? My mom will plan for it, as will her two sisters and her brother.

He approaches the walker as an impediment rather than an assistive device, picking it up off the ground as if to move it out of his way rather than rolling it along. With each step the four legs hit the ground hard. The carpet absorbs the collision in a deep thump, but the linoleum in the kitchen echoes with the skidding wheels. There is no turning mobility for risk of compromising balance, so he comes up against the walls and corners fiercely, banging into table edges and dinging the paint on the wall. This sound is the clearest to me: it is desperate and fast. Slow methodical movements are dangerous in the same way that an inexperienced gymnast never lingers on the balance beam, but instead runs ahead swiftly, eyes on the other end, trusting in the familiar movements of her feet when they are on solid ground. I catch my breath and spring up from the couch every time, expecting something to catch hold of his loose clothing, or maybe nothing at all...

The four legs alternate with the clunk of his drop foot – the ankle brace corrects its laxity but impresses deep cuts into his already bruised skin. He looks like a puppet whose strings have been cut, the entire body too weak to resist the pull of gravity. We are destined to the ground, his wilting, heavy frame suggests. I

watch him clumsily navigate the kitchen but do not intervene. I've learned that the hand of assistance breaks his concentration and whittles away at something deeper inside. Cogito ergo sum. His mind is still sharp but he has come to resent it. A man who has worked in construction all of his life – he thinks it is the house that betrays him, not the hands that built it. Sacred hands. Walkers and wheelchairs and canes and beds keep us above ground for as long as they can.

* * *

My youthful body also compresses under the weight of gravity, just to a lesser extent and in a different way. I don't feel the imbalance until someone points it out in a bathing suit at the water's edge when I'm seven. Then I start to notice it in the mirror – how my shorts fall on my hips unevenly. And then doctor after doctor prods at my naked body, saying, "Oh yes, it's definitely there" but never actually defines what "it" is. It causes that, and that will possibly exacerbate this, so it should probably be treated. All this time I feel absolutely healthy and able so none of it really bothers me. Or maybe I simply refuse to acknowledge what is going on.

The C-shaped curve of my spine is malleable, so a hard-shelled back brace lengthens my torso in an upward direction. It is smooth and white like marble without the grain, extending from my pelvis to my breastbone, with an extra piece added to apply pressure to my protruding sternum, the first brace of its kind. At my last doctor's appointment, a photographer snapped a shot of me wearing it for a medical journal. My face was excluded, but anyone close to me would know my body anywhere. I wear the brace to sleep at night but tear it off around dawn; the house in Cape May, New Jersey, has no air conditioning, and the August heat is sweltering. The rippling, crunch of separating Velcro causes my brother to toss next to me, but he keeps his eyes closed. The right side of my sternum burns continuously for a minute as the protrusion resurfaces. I throw the brace on the floor and fall back to sleep, my newly freed body sinking into the mattress topper.

My grandfather is always awake at daybreak, moving from the bedroom to the hallway to the bathroom and back almost furtively, his footfalls making no sound. The smell of his "Mighty Cool" after shave aerates the second floor and betrays his movement. Eucalyptus and menthol hit the senses hard, but it is a welcome coolness, invigorating in the oppressive heat. I delight in the first deep breath I've been able to take in roughly eight hours. My lungs expand and my ribs are sore, but my sweaty body suddenly feels clean, detoxed.

For seven summers this was our routine. He sitting at the head of the breakfast table, eyes wandering over a bowl of Cheerios and a glass of iced tea, quiet as my parents asked me how I slept and assisted in taking off the brace. He never told them about my early morning escape, and deep down I knew he never would.

I'm back at the beach house and watch him lower into the wooden chair and throw back a shot glass of pills. Dry, chased with nothing, as always. The breakdown of his body coincides with the healing of mine, I think. I am suddenly aware of the fading scar on my chest, vertical and visible in my triangle swimsuit top. And the four slits on the sides of my kneecaps. Despite them, I have never felt healthier or more 'normal.

* * *

There is a falsehood that sits atop suffering – that you must do everything in your power to move past it, overcome it, recover, look back at it from an improved vantage point. As a teenager who frequented the operating table, I trusted in the resiliency of my young, albeit abnormal, body. But awareness of this transformation imposed a sense of obligation: have a fundraiser, start a new club,

become a doctor. I found myself standing behind a podium at a high school assembly on crutches with two full length leg immobilizers, asking for money for Shriner's Hospital for Children in Philadelphia, to give back. Still not quite sure what had just happened to me.

* * *

I stare at my grandfather's tremoring hands and try to imagine what it must be like to feel betrayed. We all know he will not move past it, overcome it, recover, or look back at it. The end is coming, and he knows it is coming, and I know it, and we can't host a fundraiser to cope with it. Aging is simultaneously the most personally shocking and universally accepted bodily transformation there is.

On the inside, we were two human animals undergoing transformations beside each other, bearing each other loose witness. In other words, we were aging. – The Argonauts by Maggie Nelson

"Where are my jumper cables? Go get my jumper cables from the truck," he yells at my brother, a tone of urgency in his voice.

Chris stares at the walker for a second, confused, half-smiling. "Umm..okay," he mutters.

My grandfather hasn't been able to drive in years so he gave his old green Dodge truck to my eighteen-year-old brother a few weeks ago.

"They are behind the passenger seat, make sure you bring all of them," he clarifies.

The whole scene is heartbreakingly comedic: my brother handing off the cables, my grandfather's feeble hands tossing them over the walker and bringing them to the back porch, setting them on the table, then shuffling back inside. Every movement is strained but intentional. Neither of us dares to assist, and the subject of jumper cables is never brought up again. He still has no idea what is happening to him.

My grandfather loses his sense of self in pernicious waves of bodily deterioration. His mind follows suit, sharp as ever but in denial. My transformation was a different type of struggle, a quest for the formation of an identity separate from a body of ailments. I was the sick girl who "gave back," because I wasn't sure how to fit these infirmities into my self-conception. I'm still not sure. But some of them have been healed and some remain the same, until one day I too will wake up and feel myself losing everything. Or maybe I won't – I'll merely note that something that was once there is no longer. The fallacy of a neat, seamless physical identity keeps my grandfather banging around with his walker four years after his projected expiration date. He is strong where it matters, but I fear that the process of aging leads him to believe he is exiting the world as a substandard model. He is not, and I am not. Just variations of the same human thing. In fact, his physical decline is the most organic, inevitable return to the origin.

Where do we begin and end? I don't think we'll ever know.

LOST STAR

PIMSIRI ROJANAPORN

The long wooden bench was beautifully crafted, carefully stained, sawed, and shined. I have sat on that bench countless times. I played on it, cried on it, and even hit my head on the front right corner of it, but this was the first time I honestly looked at it. It was long, long enough for me now to lay on it completely but not comfortably. The natural line of the wood, patches of beige and black, painted with hues of red like water painted sunset or dried blood stain. But now for the first time since 1998, there was a palm-sized white stain. It was different than the other marks; it was dull, dented, circular, white, and unnatural. A scar on the once pristine masterpiece.

A wrinkled hand ghosted over the patch. Spindly fingers vigorously rub and rub and rub, over and over and over again. The fingertip became sweaty, warm, hot, and eventually burning. She would pause for 10 seconds, eyes staring at mine glazed but shining. Ten seconds later she returns to the bench. She continues to rub, determined to remove the white patch she didn't realize she was causing. Her fingertips were raw, skin red.

My dad snatches her hand away from the bench. Held it tightly and yelled, "Stop!" My eyes widens and latch on to the scene in front of me. My dad almost never yelled--happy, angry, calm, or sad, he has always spoken with loud voices of passion, but he never yelled. My eyes are lost black dots that needed to find their guide. I look straight into her eyes. They widened just like mine, but I didn't think it was out of fear like mine. Her eyes look into my dad's, dark soft brown, circular, but not dull. It was full of little stars twinkling but not orbiting anywhere, no gravity, no direction. My dad slowly let his hand fall, held his grip gently, rub and rub and rub again but this time with a gentle caress on that now fragile wrist. No matter how comforting and apologizing that touch might be, he couldn't look into her eyes. My eyes relax but I didn't look away, I couldn't. That eye full of stars never used to be lost, it used to be hard, strong, beautifully crafted, stained by time, sawed by hardship, and shined with wisdom. She used to tell me when I laid on that bench with my head on her lap that your eyes should never sparkle without purpose, like a ditz (she did always say whatever she wanted), it should be warm but hard, kind but determined, never lost. She used to hate that I wore glasses, she said it hid my most important feature, she didn't comment on it at all today. I don't know if she liked my new glasses or if she just didn't like glasses.

To me, she was always a beautifully crafted masterpiece. My grandmother was the strongest person I know. Her body, short but steady, her grip was rough and strong. That five foot tall lady that raised five boys almost entirely by herself never once looked lost. She was everyone's guiding star, even in the most literal sense, blinding and held together by its own gravity. Slowly she lost her light, snippets of memory floated away. It was first random facts, then name, then direction, then who we were, and slowly but surely, who she was. She can no longer speak. Sounds made, but no words formed. The lady who once yelled from her front door for all her kids, then eventually her grandkids to run home, no longer did. The stars in her eyes didn't hold direction. They were floating stars. Glimpses of herself remain, the stars are still there, strong but lost. Lost as she may be, she was shining all the same. She was smiling, happy. At first, I was devastated when she forgot my name but now as my eyes reach hers she is still my star. My eyes began to warm and shine again, this time not for guidance but for love. My dad and uncles sometime can't bear to look at her, to see the remnants of their old mother. But I don't just see the remain of her former self. Alzheimer's is only a small dull stain that is denting this masterpiece. Nevertheless, that masterpiece still remains, strong, sturdy, and beautiful. She returned back to her bench. Rub and rub and rub again.

STUDY OF A WOMAN DANCING

SARAH MIA
DURAN



INSIDE MY HEAD AND SPOKEN OUT LOUD: A RECKONING WITH SOCIAL ANXIETY

MIKAYLA VALDES

My social anxiety played me like a deceitful little game, except I spent the last 15 years pretending like I wasn't on the court. The painful shyness I faced as a child, my inability to smile at any adults except my parents until the age of eight, the meeting with my fourth-grade teacher that my concerned mother sat through, afraid her daughter wasn't voicing her needs; it's always been you, dear social anxiety. Conviction in middle school that my friends didn't care about having me around; that was you, too, wasn't it? And you pushed it. You pushed and pushed with such excruciating force until that stupid conviction became my reality; as did tears, insecurity, and the lack of reassurance I desperately needed. In high school you hid behind black skinny jeans, punk rock band t-shirts, and an eating disorder that wasn't glamorous like they show in the movies. You danced around obsession, meticulous numbers, and crippling self-judgment. This is the reality for millions more, and they are being ignored.

What if our society ignored the number of people who suffered from cancer each year? What if we claimed that cancer wasn't real and its effect on lives was simply a conjugation of one's imagination? If we stigmatized any form of this illness, how would it impact those 15 million Americans who live with it? How would it make them feel? We don't ignore those battling a physical illness because it's easy to see how the disorder manifests itself, yet mental health poses a more complicated threat.

The number of people who live with cancer every year is equivalent to the number of North Americans who live with social anxiety. That's roughly 7 percent of our continent's population. The disorder possesses even more prevalence among teenagers and college students. It is estimated that roughly 10 percent of college students suffer from significant social anxiety disorder, while anxiety as a whole affects an astounding 25 percent of teenagers. So why is it that the second most commonly diagnosed form of anxiety disorder is also so commonly overlooked? It's challenging enough to live with a mental illness, but overcoming the reputation thrown on top of that struggle is an entirely new obstacle to overcome.

The reputation American society has so carelessly placed upon those struggling with mental illness, in particular social anxiety, is rooted in insensitivity and continuous judgment. The ignorance that drives this stigma not only discourages people from seeking help but attempts to convince them they have no problem to begin with. The pressure to break out of the shyness and nervousness becomes debilitating. When someone is repeatedly told their struggles don't exist or their social awkwardness is just something they need to suck up and get over, we begin to believe it. I know I did.

People encourage teenagers to question, except my social anxiety made me question all the wrong things. I questioned the value of my curvy physique. I questioned my ability to be alone for hours at a time and not crave any verbal exchange. I questioned why people assumed I was so shy when I didn't raise my hand in class, even though I always knew I had something to offer. At the time, I didn't know what kept restricting me. I had the audacity to question why everyone I knew was making friends at college, and why mine kicked me out of their roommate pool instead.

My first semester drained me. The pressure of constant socialization and having to present my best, bubbly, and agreeable self to everyone I confronted took a toll on my mental health. If I were anything but outgoing and always eager to go out on a weeknight, I was afraid my worst internal fear would come true—people would only pretend to be my friend because they felt a sense of pity towards me. I spend an exorbitant amount of energy and time rehearsing what tone I would use to respond to my name during attendance or considering which shoes would make the least noise when I walked into a 300-student lecture. One night my roommate asked me to make a phone call to the residence hall janitor because our window was jammed. I knew exactly the look I shot her, the one brimming with such nerves and astonishment that makes someone wonder if they've suddenly sprouted a second head. She stared back at me quizzically and within seconds quickly muttered, "Never mind, I'll do it." The conversation ended abruptly. Why couldn't I do it? Social anxiety, my conclusion was you.

Now you've wrapped yourself around my mind and have chosen to stay. Things make sense now: why I overthink the most basic social interactions, why I can't present a decently accurate first impression no matter how hard I try, and why making friends is a hurdle I never fail to trip over. I need constant reassurance from the people in my life that I matter to them, that they want me to be there, and I haven't just shoved my way in. I understand now that you are the driving force behind that heavy weight of insecurity, and, don't worry, you haven't fallen short of making it known to me throughout my first year of college. But in case you interpret this differently, I want you to know that I am not afraid of you. Coming to college has given me the courage to speak openly about the daily challenges you so lovingly provide. Because of you, I have discovered my passion of advocating for mental health awareness. I have overcome that eating disorder. I have made a friend or two, and I'm working on making some more. Thank you for being a constant in my life, my dear social anxiety. Yes, you might be a piece of me, but a definition of me? You are so painfully mistaken.



TOUCHED

SARAH MIA
DURAN

THE WEIGHT OF A CRISIS

OLIVIA IVANOF

On May 16, 1969, a sixteen-year-old boy named Robert Rayford died in Deaconess Hospital in St. Louis. Baffled by the multitude of symptoms he had exhibited, doctors attributed his death to the generic “loss of vitality,” trying to describe how the young boy had gone pale and skinny. According to one of his doctors, Dr. Memory Elvin-Lewis, eventually “his entire body constituted almost one wave of hard lumps and watery swellings” (People) but no one knew why. I can’t imagine how frightened and alone he must have felt among the rows and rows of hospital beds, like stark-white rows of gravestones in progress. Robert had appeared to be stabilizing in late 1968 after nearly a year in the hospital, but with the new year came a vicious return of his symptoms. His body was swollen and aching, and he exhibited genital warts, a septic chlamydia infection, and shortness of breath in addition to his increasingly pale complexion and loss of weight. When he died, his doctors had no idea what killed him.

In 1984, a thirty-one-year-old man named Gaëtan Dugas died of a new virus that was cutting a swath through the gay community of the United States. Canadian-born himself, Dugas had begun working for Air Canada as a flight attendant in 1974, at age 20 or 21. Working for the Canadian airline meant that he spent much of his time in his native country, but by his own admission he did travel to San Francisco and New York City: hotspots for what was colloquially referred to as “gay cancer” in the late 1970s. Mysterious purplish lesions would appear on gay men, a hallmark that they too would soon fall deathly ill. Gaëtan was first diagnosed with Kaposi sarcoma, the official medical designation for “gay cancer,” in 1981. When he died, blood samples he had donated were preserved in a Centers for Disease Control study of this new epidemic: AIDS.

I first came across Robert Rayford in October 2017, completely by accident. My sister, Juliana, is studying to be a nurse. She loves medicine and medical facts, and loves to report the weird or gross or just plain interesting ones to me whenever she can. In October, in the midst of a conversation about schoolwork, I asked her in passing if she had any good “fun facts” for me. It was only her first semester in nursing school and I knew she loved to talk about it, so I was expecting some disturbingly detailed account of a dissection in her anatomy lab. What I got instead was this:

“Did you know AIDS was first called GRID? Gay related immunodeficiency?”

My stomach physically rolled and my mouth dropped open a little. I didn’t know much about the history of AIDS, so this was shocking to me. Even beyond that, I knew I was having such a visceral reaction to the not-so-fun fact because I identify as part of what we now call the LGBTQ+ community. My sister knows this; it’s why she thought I might be interested in this particular fact, and she wasn’t entirely wrong. The AIDS epidemic is an important part of LGBTQ+ history, and one I had never studied too far in depth. While we continued to text about classes and schoolwork, I pulled up Google on my computer and headed to my favorite, reliable information source: Wikipedia. As I was skimming past the scientific medical information I didn’t understand, I stumbled upon an interesting tidbit under the “History of Spread” section. One of the subheadings was “1969: Robert Rayford” and contained exactly three sentences. I learned three things from those

three sentences: first, Robert Rayford was black and sixteen years old when he died; second, doctors did not know that it was AIDS that killed him until 1987, almost twenty years after his death; and third, the doctors who treated him “suspected he was a prostitute or victim of sexual abuse.” He was, according to this timeline, the first patient in the United States confirmed to have an AIDS diagnosis. But these three sentences about Robert, the meager few paragraphs on his page, and the select few articles that cover his case are very nearly irrelevant compared to the library of information about Dugas.

The first study on AIDS was conducted in Los Angeles by the CDC, and its goal was to find out what exactly the mysterious illness killing gay men was. As part of that study, Dugas had willingly reported the names of more than seventy of his sexual partners and admitted that he generally had around 250 partners per year. He offered blood samples for the CDC researchers to run tests on. Scientists and doctors definitively diagnosed him with Kaposi sarcoma, but had no explanation for why he had developed this cancer. In the write-up of the study, men were grouped by their location of origin. Gaëtan, the only non-American, was labeled “Patient O” (pronounced oh, not the numeric value zero) for “Outside of California.” For the next three years, he was essentially unknown to anyone outside of the CDC--until Randy Shilts stepped into the picture of the AIDS crisis.

In 1987, Shilts published *And the Band Played On*, a book claiming to detail the movement of AIDS through the United States during the ongoing crisis. In the book, Shilts mislabels Gaëtan with the numeric “zero” instead of the alphabetic designation “O” and refers to him throughout as “Patient Zero.” Shilts admitted that he was confused by the labeling, and when he heard some people at the CDC refer to Dugas as “Patient Zero” he thought that it was catchy and decided to use it. While the book never outright claims that Gaëtan was the man who brought AIDS to the United States, it doesn’t do much to refute the idea. Shilts mentions Gaëtan’s profession as a flight attendant and the fact that he had sexual partners in nearly every city he visited. On top of that, “patient zero” is used by the medical community as a colloquial way to refer to index patients: the patient who is the first recorded case in an outbreak. This language and implied connection caught on in the public like wildfire. Gaëtan Dugas became one of the most hated dead men in the world; the *New York Post* wrote a front-page story about him with the headline, “The Man Who Gave Us AIDS.” The public’s anger only rose when they learned of Gaëtan’s sexual promiscuity and heard tales of his flamboyant personality. The gay community at the time condemned the single-patient zero angle that Shilts’ book seemed to promote, arguing that it would lay blame, and subsequently hatred, on the gay community as a whole. Inevitably, that’s exactly what happened. The gay community was bashed in the media and in everyday conversation, incorrectly identified as the sole carrier of AIDS. “AIDS patient” became synonymous with “homosexual,” to the point where the disease was thought of largely as a “gay disease” even when it began spreading into heterosexual individuals. But what if history hadn’t gone like that?

“He was the typical 15-year-old who is not going to talk to adults, especially when I’m white and he’s black,” Dr. Elvin-Lewis remembered in a 1987 *Chicago Tribune* article. She was one of the doctors assigned to Robert’s case in St. Louis, Missouri, way back in 1968. Closed into the hospital for over a year, dying of a disease that had no name, tumult seemed to surround Robert at every turn. According to census records, he and his family lived close to or on St. Louis’ infamous Delmar Boulevard, just blocks from City Hospital where he initially checked himself in. The east-west line Delmar creates as it runs across St. Louis is sometimes referred to as the “Delmar Divide:” black people live mostly to the south, white people live mostly to the north. This housing divide runs sharply along the line of Delmar Boulevard and tensions would have been at an all-time high with the rising power of the Civil Rights Movement.

Sometime during 1968, Robert was moved out of City Hospital, first to Barnes Hospital and then to Deaconess Hospital, all of which were in St. Louis. I can’t help but wonder if his movements were timed with the upheavals of 1968. Martin Luther King, Jr. was assassinated in April 1968; was that when Robert was moved to Barnes Hospital, tucked a little further south of Delmar, deeper into familiar territory? Was it the rising threat of race riots that sent Robert to Deaconess, deeper still into St. Louis’ black neighborhoods? Did his doctors move him to improve his care, or was his mother Constance afraid that staying too close to Delmar might mean an attack on the hospital protecting her young son?

Based on census records, Constance Rayford was around twenty-one years old when Robert was born in 1953. Rayford is her family name; she appears in census records as the daughter of Percy and Sadie Rayford of St. Louis. They might have all lived together, crowding into one too-small apartment to save money and have more hands to raise the young Robert. The neighborhood they lived in, now called Skinker DeBaliviere was comprised of mostly low-income black families. Robert came from modest means, to say the least. There is a chance Robert grew up in one of the city’s new public housing units, which went up in the 1950s and were known nationally for their low-quality construction and high crime rates. He may also have grown up in a small, run-down apartment with his mother and his grandparents, all struggling to make ends meet. Doctors from the time of Robert’s hospitalization suspected that he might have been slightly mentally disabled, based on how little and how simply he spoke; I wonder if the time he spent in the hospital was something of a relief to his mother. With Robert under lock and key in City or Barnes or Deaconess, Constance wouldn’t have had to keep an eye on him while she worked to support him.

After Robert’s death in 1969, two of his doctors, Dr. Elvin-Lewis and Dr. Marlys Witte, took blood and tissue samples from his body. They had been utterly perplexed by the sheer number and strength of diseases Robert had been carrying in his body; they hypothesized that something was suppressing his immune system, but had no way of knowing what. Dr. Witte took her samples with her when she accepted a job in Tucson, Arizona; Dr. Elvin-Lewis took a job at Washington University in St. Louis and kept her samples there with her.

When AIDS rose to the front of medical research in the early 1980s, Dr. Witte thawed her samples and tested them in 1984. She remembered Robert’s symptoms and wondered if this new virus might have been what killed him. She found evidence of “Herpes simplex, Cytomegalovirus and Epstein-Barr disease” (*Tribune*), three opportunistic infections that were common in AIDS patients. But at the time of Witte’s test, there was not yet a test for AIDS. As Gaëtan Dugas died and was immortalized in the CDC study, Witte had to sit back and wait for medicine to progress far enough that she could get the final answer to the question of whether or not Robert had died of AIDS.

By 1987, the Western Blot test had been developed and could finally give a definitive diagnosis of AIDS. Dr. Witte called her old colleague, Dr. Elvin-Lewis, to ask if she had any samples remaining in St. Louis. Dr. Elvin-Lewis dug “a half-teaspoon of Robert’s blood and a few specks of tissue” (*Tribune*) out of her freezer and let Dr. Witte send them to a microbiologist friend at Tulane University in New Orleans. Lo and behold, Robert’s samples tested positive for AIDS. He was officially the earliest confirmed case in the United States.

No one remembers Robert Rayford as the first AIDS patient because he is hardly spoken of at all. Other than a few newspaper articles from 1987, there is little mention of Robert Rayford in the history of AIDS. One reason could be the issues surrounding the scientific tests of his samples. Dr. Witte’s results from the 1987 Western Blot test were never published in a peer-reviewed journal before being leaked to the press, so some in the scientific community are skeptical of them. On top of that, Hurricane Katrina destroyed whatever remained of Robert’s tissue in 2005, when Tulane’s labs, and more importantly their freezers, lost power and many of their frozen samples were defrosted and contaminated.

But still, this story is undoubtedly sensational. Robert was just sixteen when he died, compared to Gaëtan’s thirty-

one. In fact, Robert and Gaëtan were born in the same year: 1953. If things had gone differently, if AIDS had never carved through the United States, perhaps they would have met. Perhaps one of Gaëtan's flights would have landed him in St. Louis and he would have taken a stroll down Delmar Boulevard to see the great race divide of the city and run into a black man named Robert, the same age as him. They could have talked about politics or the state of the city, or they could have walked right past each other without even noticing one another. Gaëtan might never have gone to Robert's neighborhood, or made it to St. Louis at all. But AIDS made it so we will never know.

Gaëtan Dugas has been highly publicized and politicized. A flamboyant, gay man infamous for sexual promiscuity made for the perfect scapegoat in the AIDS epidemic. He was easy to categorize and easy to warp into a villain, whether he was one or not. Robert's case is not so easy. He was only sixteen and insisted he had only ever participated in heterosexual sex. During the autopsy, however, the pathologist found anal scarring that indicated otherwise: was he gay but closeted? Or perhaps, as Dr. Witte theorized, he was a child prostitute? Is it possible that he was abused? And Robert's sexuality wasn't the only mystery about him; his reticence with his doctors meant that little personal information about him survives. It is difficult to scapegoat someone when no one seems to know anything about him. He was also black at a time when race was as much of a hot-button issue as AIDS. Would AIDS have been seen as a "black disease" instead of a gay one?

I know firsthand the way AIDS has changed not just the way outsiders look into the LGBTQ+ community, but the way the community looks at itself. While most people no longer assume that being non-straight automatically means you have AIDS, the fear of the virus is now embedded in the community's DNA. After years, decades of attacks and accusations from the outside, we have internalized others' fears of AIDS and turned them inward. I know there are a multitude of reasons for why the most comprehensive sex education I've ever received is from older LGBTQ+ friends, but I also know that AIDS is one of them because the phrase "safe sex" is tossed out at every available opportunity. I am intensely conscious of all STDs, not just AIDS, in a way that I know is different from many of my straight friends. My roommate often asks me questions about all kinds of topics, including health, sex, and sexuality, and when I ask why she's coming to me she tells me that I am the person she trusts to know the most about all of these topics. My community has been scarred by the AIDS epidemic; we are distrustful of each other in a way that would have been alien to Dugas during the sexual freedom of the 1970s. Our community was characterized by freedom and excess in the 70s, but it has changed to the caution and fear I see now, and AIDS and Gaëtan Dugas are the reasons.

Robert, on the other hand, was not openly queer; he never claimed any identity other than heterosexuality. But he was black. I can't help but wonder if, had his case been publicized and accepted the way Dugas' was, AIDS would have been known as a "black disease" more than a "gay disease." Or maybe it would have had neither of those identities. Maybe, had flamboyant, promiscuous Dugas and quiet, young Robert both been presented as the "first" victims of AIDS, Americans would have been forced to reconsider their prejudices and avoid attaching the disease to one group or another. Maybe if Robert had gained the same publicity that Dugas had, the LGBTQ+ community wouldn't have been hurt the way it was.

Robert Rayford and Gaëtan Dugas may not have been hurt by history in the same way, but that doesn't mean they weren't both hurt. Robert was forgotten, set aside in favor of a better, easier face for a disease: Dugas was attacked viciously and unwittingly became the symbol of the hate and stereotypes intertwined in the AIDS crisis. Putting them next to each other feels strange. Their legacies were disparate but they are unshakably connected by four little letters that changed, then ended, their lives. Perhaps it is not an accident that two such different people have both been placed at the beginning of AIDS in America. Together, Robert Rayford and Gaëtan Dugas have reminded me that nothing is as one-sided or simple as it seems. Knowing that the

history of AIDS has been rewritten and might go through more change in the future gives me hope that maybe one day my community can step outside the fear of AIDS and can heal from them is trust that has been cultivated by the weight of a crisis.

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JUST SAY NO

MILLER KRESS

For my classmates, it was a day to escape from the monotony of seventh grade, a respite from standardized test prep, history projects, and math exams. They sat at cold, stiff desks- the kind that never offer any comfort, and require near-constant shifting and readjusting to avoid losing feeling in one's body. But that day my peers didn't move an inch. Only the sound of the overworked air conditioning, struggling to combat the Texan heat, broke the silence. Officer Miller was an enormous man with an even larger voice- a voice that commanded attention. He was the type of man who would be preaching emphatically about gun violence one moment and making fun of himself for sweating at room temperature the next. The perfect combination of sincerity and humor, for gaining both the respect and adoration of middle schoolers. Today, he had come to speak to the class about the dangers of drug and alcohol use- and he'd come with visual aids.

For almost two hours, not one of my classmates removed their wide, horrified eyes from Officer Miller as he narrated the shocking images on the screen- women just a shell of who they used to be, their faces hollowed out by years of meth use; cars wrapped around poles; needles sticking out of lifeless bodies. I sat with them, tucked as far back into the room as I could be, shifting nervously every few seconds, my leg tapping the floor as if keeping tempo. If you'd taken one look at me- donning a mouth full of braces, a head full of braids, and my new mint-colored converse shoes- you'd never guess how connected I felt to these nameless victims. Neither Officer Miller nor my peers knew that the week prior I had received a diagnosis that had knocked my stable, happy seventh grade existence to the ground. The events of the week before still ran on loop in my head- the jarring swiftness with which they pushed me to the top of a usually 6-month long pediatric rheumatology waiting list. The way my doctor's cold, freshly sanitized hands felt as they delicately traced the marks on my body as if reading braille. The sadness in her eyes and overuse of the word "sweetie" that contrasted with the blunt reality she was revealing to me- that the disease they had thought was just a dermatological condition was in fact an autoimmune disease ravaging my connective tissue. That it was called linear scleroderma. That I would need to start a course of chemotherapy and steroids the next day.

As Officer Miller finished up his presentation, he left us with this closing remark- "When it comes to drugs and alcohol, you always have a choice. Just say no". My mouth tasted of metal and my stomach ached, inescapable reminders that in that very moment I had drugs coursing through my body. Drugs so potent my mom had to wear gloves when administering my pills and even nurses cringed at the sight of the fluorescent yellow fluid as it wound its way down the IV and into my young body. I was a competitive gymnast at the time, putting in upwards of 8 hours of gym time a week, and coming home to fulfill my mother's doctrine of eating at least one "green vegetable" a day. I was also an avid rule-follower. A week earlier, Officer Miller's speech would have been a redundant (but welcome) waste of my time- a reminder to continue doing what I had always planned to do.

Soon, my fidgeting wasn't enough to keep the tears away. The harsh overhead lights became a lone spotlight- any second, it seemed, my secret would be exposed. I cried not because I was nauseated or scared for my future or embarrassed of the skin markings taking more of my body from me each day- although these things were certainly true. In that moment, I cried because I wanted so badly to "just say no". I wanted so badly to spare my body from the fates of the people on the screen. I hadn't shot up in an alleyway the way the woman being displayed in front of me had and yet here we were, sisters in the toxic chemicals flowing through our blood-streams.

MY QUEEN

CAMERON FISHER



WILDFIRE

SHANNON LALLY

Have you ever made a mistake? I bet you have, even if you don't remember it. Maybe it was something small, like locking yourself out of your house and having to use the spare key you hid under the flower pot. Maybe it was something a little bigger, like saying something to a friend you can't take back. Those mistakes are like rain. For a while, the outside world is gray and bleak and wet; but soon, the sun pushes out from behind the clouds, and all is well again. These are not the kinds of mistakes I have made. My mistakes are like wildfires: disfiguring the entire landscape, forests turned black and flat and charred beneath my feet. After something like that, people will always look at you like a walking natural disaster, will always be smelling the air for smoke. I guess that's my fault, but I would do anything to take it back. Anything.

It all started where most mistakes happen in high school: a party. The summer before I started high school, my dad and I moved to a stereotypical small town in rural Oregon. It was deceptively picturesque with a little historic downtown and snow-capped mountains lining the horizon. My dad said it looked like a Christmas card, but to me, it felt like a snow globe. "Come on, it's a fresh start in God's country. It'll be good for us," he said. I knew the divorce hadn't been easy on my dad, but this didn't feel like a fresh start. It felt like a life sentence.

From the minute we moved there, the town felt barren. Untouched. Lonely. Of course, there were other kids my age in the town, and I went to school with all of them. You'd think this would help with the overwhelming feeling of isolation, but it had the opposite effect. Throwing together a few hundred chronically bored, desperate-for-trouble teens is about as good of an idea as it sounds: it's an awful idea. It became us against the world, a case study in desperation and mob mentality. Without that anger and desire for more, what did we have? There was nothing for us to look forward to besides escape. Every day in that tiny school and that tiny town felt the same, like we were living in a time loop. It would almost be cool, like a science fiction movie, if it wasn't so abysmally boring. So we determined that if we couldn't get to the outside world just yet, we would bring the outside world to us. Like the stupid kids we were, we thought the outside world was like one giant rager, so we threw some pretty killer parties. I never understood how the word "killer" could both mean something good and bad at the same time. Now I do.

Flash forward to a Friday night sometime during my senior year. We had survived yet another week of classes and teachers and homework, and graduation was just around the corner. We were so close to being done. So close. Naturally, we decided to celebrate the only way we really knew how: we threw a party. We kept the house dark and the music loud and the blinds drawn. For those few brief hours in whoever's house we were crashing that weekend, we weren't trapped in rural Oregon. We were living the life in L.A. or New York or some other far away city with places to go and people to meet. Our hearts slammed inside our chests, echoing the beat of the music and chanting for more, more, more. For those few brief hours, we were free.

Freedom has a price, though. That's the part they skip in the movies. The characters have a crazy night, something goes wrong, chaos ensues as the characters try to fix whatever sticky situation they had gotten themselves into, the problem works itself out, and the characters laugh about it afterwards and have a sentimental moment. Cue happy music. Roll credits. The end. That's not how it happens in real life. That night, we made a mistake. We started a wildfire. The moment my friend set down a beer bottle for a pill bottle, I should have known to walk away. I should have said no, but that night, I felt invincible. I thought nothing would hurt me, not when I was so close to my life finally starting. I looked around at all my friends, drunk and high and so alive, and I took one. Oxycodone didn't sound scary, not like heroin or cocaine or meth. They gave it to kids when they got their teeth pulled, so how bad could it be? One pill wouldn't hurt. I had stopped saying no a long time ago.

If only I had known that one pill would turn into a habit, and a habit would turn into a full blown addiction. Soon, I had pills in my locker, in my car, in my bookbag, in my purse. Any space I inhabited on a regular basis became my drug cabinet, my hiding place. It became increasingly difficult, however, to keep my addiction going. I was in high school, and my dad would obviously be furious if he found out. I didn't have nearly enough money to keep buying the pills I wanted. No. Needed. So I found myself at

a new low. Hooked on the high and stupid enough to keep my problem a secret, I bought heroin for the first time. It was just from a kid at my school, and the deal was cheap and quick. The needle was intimidating at first, but not as scary as the thought of withdrawal. The tremors, the sweating, the chills, the pain. Itching for a high in the tiny bathroom attached to my bedroom, I closed my eyes and didn't focus on the pinch of the needle. I didn't think about what would happen once this high wore off, too. I just let the wave of euphoria wash over me and felt a sudden calm. Looking in the mirror, I could see my first bruise already beginning to show. I changed into a sweatshirt before my dad came home. I would wear long sleeves for years.

If taking oxycodone for the first time was crossing a line, shooting up with heroin for the first time was obliterating it. There was no line anymore. Every day, the drugs worked less and less, and I had to buy more and more. At this point, I was covered in bruises. Anywhere that could be hidden with jeans or long sleeves was a canvas of blue and brown bruises and puncture marks. If there was something drugs had taught me, it was that I was a good liar. I could hide anything from my dad, and he never figured it out. At least, he didn't figure it out for a long time. It took three years for me to hit rock bottom. When I overdosed for the first time, a lot of things changed.

I was in college. I mean, I was enrolled in college, but I wasn't in my classes more often than not. My grades were slipping, and my attendance was a disaster, but I could never seem to make it through the day. Not without getting high. I'd gone home early that day, exhausted and ready to add another bruise to the collection. If I had counted how many times I had felt the sting of a needle, it probably would have been enough times to have given myself a full tattoo. Countless. One minute I was in the bathroom, pulling my sleeves down to hide the shameful thing I had just done, and the next, I had stumbled into my room. I laid down and closed my eyes, which is apparently how my dad found me. Prone. Unresponsive. Barely breathing. I woke up a day later in the hospital, my dad sitting next to the hospital bed with his head in his hands. He lifted his head and looked at me, eyes clearly red and bloodshot. He didn't say anything. He just looked at me. I told him it wasn't his fault, but I could tell he didn't believe me, that he felt the burden of my secret as much as I did as he sat there and looked at my arms, a stark picture of my addiction. He checked me into rehab the next week.

Rehab was not like the hospital. The hospital was cold and smelled like rubbing alcohol and formaldehyde. It was sterile and final feeling. The hospital felt like death. Rehab, on the other hand, was filled with warm colors and art classes and friendly faces. Withdrawal felt like dying, but at least it wasn't death. It was resuscitation. Revival. Resurrection. I left a month later detoxified and rejuvenated, ready to pick up the pieces of my life and live as if that night at that fated party never happened. Too bad good things almost never last.

I would overdose three more times. Each time, my dad sent me back to rehab with a little less hope in his eyes. I could tell he was giving up hope a little. I had given up a little, too. It was at my fourth trip to rehab when I met Rachel. She was nineteen, bone thin, and pregnant. It turns out that if you do heroin while you're pregnant, the baby gets addicted, too. If the mom tries to go cold turkey and stop feeding their addiction, the baby also goes through withdrawal and can die. So there sat Rachel, medicated on methadone and just waiting until her nine and a half month wait was up so that she could get her act together. When I asked her about her situation, she said, "If it was just me, I probably would have never gotten clean. But it's not just me anymore, and Child Protective Services can get involved at any time. My family doesn't think I'll make a good mom. I need to prove them wrong. I just made a mistake. It was one time." It was this heartbreaking admission that made me see that if I didn't get clean, I could easily be in Rachel's shoes in five, ten, maybe fifteen years. I could never drag my kids into this. Never. That was my last trip to rehab. I never touched a needle again.

Five Years Later

"And that's how I got here. I'm almost five years clean, and I'm finishing community college in a couple of months. I already have a job lined up after I graduate." Claps and congratulations filled the room as I announced this news, a success story that the other recovering addicts in the room could aspire to. Heroin Anonymous had taken up my Monday nights for the past four years, and every meeting attended felt like I was earning my place back in society. Rachel sat across the room with her daughter, who was fast asleep in her lap. I wondered if Rachel would ever tell her what these meetings were, who she used to be. My father sat next to me, smiling and proud at my recovery. It is true that some mistakes are like wildfires. They burn down everything that was once familiar, and you are left with only the ashes. But that's the incredible thing about wildfires: after the flames have died down and the heat no longer persists, the scorched ground becomes green again. Life always finds a way. Things grow back. It may never be the same, but it sure is something.

A VISUAL ANALYSIS ESSAY:

FEMALE CORPSE, BACK VIEW BY HYMAN BLOOM

MADLINE
JENKINS

Upon first glance, the bright colors and sensuous, swirling brushstrokes elicit awe from the harrowing technical beauty of Hyman Bloom's *Female Corpse, Back View*. Yet this ethereal beauty becomes almost violent in sight of the subject matter. The jarring contrast between Bloom's technical skill and the grotesque focus leave the viewer wondering, "why use an abstract expressionist approach to death?" However, the answer to this question must be situated within the cultural context of Bloom's Jewish upbringing and the development of his theosophy. Abstract expressionism is not meant to be realistic, it is meant to evoke the feelings of an experience, and in this instance, a new perception of death.

The composition of the painting is certainly one element that contributes to the expressionist depiction of death. *Female Corpse, Back View* (Bloom) stands at approximately five and a half feet tall, so that a viewer that walks up to the painting feels as if one could almost walk into it. This is complemented by the way that the corpse faces backwards with crossed legs, mimicking a position of movement. The background is a swirl of creamy green color and thin brown lines, enveloping the figure in a comforting form. The simple background can be looked at as perhaps a death shroud, but the depth of the colors and the relaxed waviness of form suggest something more dynamic and delicate, such as a reemergence of life or soul, yet nonetheless still comforting. I think that together, these are both possibilities, because of the abstract technique that Bloom uses. Thus, the background is not meant to stand alone but to help express the focus on the corpse at the center of the work. Bloom encloses the figure so as to draw attention to the fact that the viewer cannot avoid confrontation with the corpse. This figure is stripped of its identity and even sexuality, as the face and the front of the body are hidden, forcing the viewer to avoid the humanity of the figure and face the sheer subject of death in this simple yet elegant method. Therefore, by composing the painting this way, Bloom urges the viewer to adopt a new perspective of death, one that is not purely morbid.

The next element that contributes to the expressionism of *Female Corpse, Back View* (Bloom) is the lucid use of color that characterizes the corpse. The lurid jewel tones and churning strokes capture the viewer with the level of minute detail that flowers the body. But the colors become dark and muddled towards the bottom of the painting, especially around the legs, drawing the attention upwards and more towards the center of the body, where the colors are boldest. The red spots on the figure's bottom and the darkness of the legs indicate the process of decomposition, but also symbolize a sense of something more powerful, such as the smoldering of fire and ash that precede rejuvenation. The paint is also laid thickly on the canvas, addressing itself to the literal embellishment of the figure, adding another dimension of beauty. Although these techniques may strike the viewer as uncomfortable and out of place, I believe that this is Bloom's aim. He ushers the viewer towards a new perspective of death, one bridled by a simultaneous vision of new life. This forces the viewer to contemplate the beauty of the artwork and what it means to find beauty in death and beyond.

Upon a visit to a morgue, Bloom proclaimed in an epiphany, "I had the conviction of immortality, of being part of something permanent and ever-changing, of metamorphosis as the nature of being. Everything was intensely beautiful, and I had a sense of love for life that was greater than any I had ever had before" (Museum of Fine Arts). His new investment in Jewish mysticism becomes prominent in his series of corpse and autopsy paintings through his abstractionist technique. These paintings, although a depiction of the human body, are not meant to be copies of anatomical structures. Rather, it seems that Bloom desires to express a metamorphosis, and at the same time a marriage of the old and new, especially considering the context of his career. Bloom's family had emigrated from Latvia in 1920 out of fear of the looming prejudice and war (Holland). In his adult life, the horrific speculations finally materialized and infringed upon his strong Jewish identity as World War II progressed. Suddenly, the imminence of death felt closer than ever and spilled over into Bloom's work. The nameless, faceless victim (painted from Bloom's memory of autopsy rooms) in *Female Corpse, Back View* (Bloom) suddenly takes on an amorphous identity in light of the longstanding history of brutality against the Jewish culture. His interpretation of death and decay memorializes the dead but also speaks to the living. Bloom harkens back to his orthodox roots while

incorporating his new attachment to Jewish mysticism and the Vedanta school of Hindu philosophy in his expressions of death (Holland). *Female Corpse, Back View* (Bloom) is to be seen as a work of longing placed within a historical context, as of something that is lost that can never be regained but also as a work of hope and anticipation of something timeless.

Ultimately, I believe that the only way to truly express the experience of Bloom's theosophy of life and death is through a technique of wild color and bold application. Yes, death is to be mourned for, but Bloom hopes expressionism will show that death can also be an experience of beauty, however unnatural this tension may be. More time spent with *Female Corpse, Back View* (Bloom) lends to more appreciation of the composition, artistic skill, and sheer force of Bloom's voice that speaks through the work. This perspective of death is meant to be celebrated, and what better way to do so than through art?



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GUEST WRITER: EMILEE HERRINGSHAW



I work as a medical assistant in dermatology and aspire to become a physician, with a focus on procedural practice. I graduated from the Morrissey College of Arts and Sciences with a Bachelor of Science in Biochemistry in 2016. I earned the honor of induction to Alpha Sigma Nu and The Order of the Cross and Crown. While at Boston College, I co-founded The Medical Humanities Journal of Boston College, as an initiative to illicit recognition for the power of the patient voice. In addition, I served as an Orientation Leader through The Office of First Year Experience, and General Education Tutor at The Suffolk House of Corrections through 4Boston. Currently, I serve as Co-Chair of the Membership Committee for the Young Leadership Committee of JDRF, a group oriented to treat, prevent and cure Type 1 Diabetes. Through the convergence of my roles as a provider and a patient, I have developed an enduring desire to advocate for individuals managing various medical conditions.

TWO COOKIES AT MIDNIGHT

EMILEE
HERRINGSHAW

Living with diabetes presents a collection of complex challenges. Embedded within the regimen are competing, and often contradictory, forces that make control very difficult. The nature of an autoimmune disease, through which the body performs a self-destructive act, represents the innate conflicts that surface in management, control, and lifestyle.

I've learned how type one diabetes is much more of an art than a science. As a biochemistry major, I studied and comprehended the discrete molecular phenomena that influence my blood sugar levels. While able to understand the mechanistic basis for individual factors, I'm still in awe about the integration of such forces and how they shape the essence of the disease.

Age 5. 12 am. Instead of waking up to "Rise and shine," I hear my mom whispering, "Hey Emmy, eat this," while streamlining an extra gooey chocolate chip cookie toward my buck-toothed mouth. While this would be classified as a lucid dream for many kids around age 5, this was a typical and unwelcomed experience for myself. I was jailbound for playing a few extra rounds of Cops and Robbers. It always showed up later. Tag, you're it.

Funny, the same cookie that caused a high blood sugar (or was it the cookie?) earlier that afternoon brought me reprieve a few hours later. This is an inherent facet of diabetes; what helps in one moment may harm in the other. The conglomerate of factors that influence levels on a daily basis are unquantifiable. Through experience, trend analysis, and a little bit of faith in the system, a personal management style emerges.

In time, I've learned how to integrate my condition into my lifestyle and strongly claim my resilience, confidence and ownership of management. Not long ago, close personal friends, much of my community, was alien to the reality that I was managing Type 1 Diabetes and all the factors it contained. Would they support me had I elicited awareness? Undoubtedly, but I was barren in my reality. I became shackled by the idea that not letting anyone know, by silently accommodating the demands a defunct organ, I was maintaining my prerogative to keep things going the way I thought I best could.

There is a continuous process of negotiation, and sometimes, you wonder who you are bargaining with. At age 20, I still have the cookie battle—and not in the conventional oatmeal versus peanut butter sense. Just this morning, I encountered a series of problems with my medical equipment. Subsequent changes in my infusion site, which delivers insulin from my pump, failed. Just failed. If the equipment that is supposed to save you, serve as your lifeline, dies—then what? It can be frightening, and elicit a fear of "What if this never works again?" It never gets less scary, or less frustrating.

And then there is the invisibility factor. But it's more like a ragged cloak with holes. Sure, I can test in private and filter the publicity of my medical diagnosis as much as I wish. But the heavy bags under my eyes, the persistent cough, the small scars left on my finger tips from countless rounds of testing are clear. Staying up extra late to cover material presented in a lecture when your blood sugars just weren't right, or encountering an unexpected delay to studying, has an impact. And it's not just physical. It's tiring, emotional, intertwined, and conflicting. There's no sugar coating that.

THERESA

EMILEE
HERRINGSHAW

“Em.”
Hi Sue.
“No, come here.”

I look back.

“Your 1:40 can’t complete her paperwork. I’ve helped her through the insurance portion, but I’m wondering if you can do the medical history.”

The schedule is skewed towards over-crowded, and I need to room the 1:00. The group in the waiting room consists of anyone from restless teens glued to their iPhones (growing i irritable from our office’s lack of wi-fi) to anxious elderly patients, desperately hoping to complete their appointments in time for their assigned ride.

“She’s legally blind.”
Be right back.

My eyes glaze over in conflict, considering how to juggle my impending clinical responsibilities with the care of this patient, who needs help. I walk towards the waiting room door. Stop. Pace towards the medical assistant room. Stop. Consider the best approach to take, then room Theresa ahead of schedule.

Theresa.
The grey, feathered bob facing the opposite wall migrates upward in the chair.

Yes??
Hi, how are you. Right this way. We’ll be right down the hall, in room six today.

As we walk down the hall, questions about the weather help pass the time. Theresa remarks about how large the office is and a bolus of guilt rose in my chest. I am taking her all the way down the hall.

I’m going to help you with your paperwork.

She looks up, furrowed brow strewn in a line that pointed to another string of questions. Why isn’t there anyone with her? How did she arrive here? Does she have kids, a family, an aide? Anyone?

I’m going to help you complete your paperwork, to inform Miss Simons of your medical history.

[Gasping: relieved, maybe exhausted, or some combination of the both] **Ohh, okay.**
What is the reason for your visit?
Huh?
Why are you here?

She recounts a history of an itchy back that bothers her from time to time. Then conveys the discomfort with her ear, which she doesn’t want me to have to look at because it is gross.
No diabetes. No breast cancer. No asthma. No allergies.
A tick falls into the “Yes” category for eye problems: macular degeneration. Ultimately, the culprit for her being unable to complete the paperwork.
Heart problems? Again, yes. A heart valve had been replaced in 1988. The year she quit smoking.

And what about your family?
Well, I have two daughters, aged fifty-six and fifty-eight.
Okay. All done with the paperwork. Let’s have you undress to expose your back for Miss Simons to examine.

I walk towards the drapes, grabbing one only to toss it to the side so I can help (or refrain from helping) Theresa remove her shirt, intervening minimally to preserve her dignity.
She pulls the shirt over her head, stretching the left sleeve over the crimson Christmas-colored bracelet that sports her key. The doorknob cocks to the right, and Meg walks in.
Time moves quickly as I room the next patient—then slowly, I wait for Theresa’s appointment to come to a close. I stand outside the door, waiting for something to signal the end of the appointment, wondering if she needs help redressing.
Meg walks out and we both move towards her office so I can hear my instructions.

<<So, she’s having a hard time remembering... I’ve told her a couple of times... the medications we are sending in will be processed by a home delivery service. Can you review them with her again? Then write up some instructions in layman’s terms so she can review them when she needs to apply the topicals we are prescribing?>>

Sure!
Hi, Theresa... I am coming back to check in and review the medications Meg is prescribing.
[Looking longingly] **Medications, what medications...**

The repertoire of info is dispensed one more time. Then I call it time to walk to check-out, where Theresa will have the written instructions provided.
I stand behind the check-out desk, watching the appointment get scheduled, making sure it is on a Monday when her daughter Kara would be free from work.
Done.
As I walk to room the 2:00 appointment, I see her standing back in the waiting room.

[Panicking] I can't find my keys.

Let me help you.

I suggest we come back in the office to look through her purse and gently ask her if the keys are on her arm.

No. I would know if they are on my arm. [Angrily] I would know.

Okay. I can take a look at your purse...

No, they aren't there. Let's go back to the room.

As we start to move in that direction, she pats her arms. I see her hand land across her left arm, where I had a strong suspicion her keys would be, but I knew she needed to find.

[Frowning] Oh.

It's okay! You have them and that's what matters.

I can't do this alone. I'm ninety-three. This is my first time here. Maybe if it was my second, I'd be okay. But I can't do this alone.

Broken. She stands looking worried, disoriented, upset she might miss that ride that will take her back.

Let's go to the elevator.

I can't do this alone.

The walk to the elevator, she doesn't have to do alone—and hopefully her next appointment wouldn't be alone, either. She shouldn't do it alone, and to her disbelief, she did. She can do it alone. But ninety-three, heart beating to the satisfaction of the mechanical valve and eyes giving up before she would, she had to today.

I call her around four, making sure she was home and in a calmer disposition.

I'm sorry for being so frazzled today.

As I tell her not to apologize, I can still feel the sinking disappointment in her voice.

And your prescriptions will be delivered tomorrow, I called the pharmacy to verify the drop-off.

What prescriptions?

WOMEN'S MARCH

CAMERON FISHER



INTIMATE PARTNER VIOLENCE AND THE SPREAD OF HIV/AIDS

MADDY KARSTEN

Vickie's Story:

"I can still vividly remember that day. He's screaming on the phone at my mother, and he hangs up with her and he starts to close the curtains in the house...and I knew what was about to happen. So I ran towards the front door and that's when the billy club came down across my face. I just wanted to get out of there. I just wanted to leave. I didn't feel like I had choices and couldn't make decisions on my own and had to do whatever he told me to do which put me at greater risk of HIV. Once I found out I was living with HIV, that put me at greater risk for intimate partner violence. I went to therapy for a very long time and I was able to deal with some of the issues that I didn't want to deal with; issues that I had stuffed so far down in my soul is how I put it. Understanding that I am worth it. Even though I have been through what I have been through, I can have an amazing life and there are a lot of caring people who can help you move past what you're going through."¹

Introduction:

Vickie's story will come as no surprise to many women living in the United States today as she is a part of the 35.6% of women in the United States who will experience intimate partner violence (IPV) in her lifetime². Violence against women in the United States frequently manifests as intimate partner violence which is defined by the CDC as, "physical violence, sexual violence, threats of physical or sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former inti-

mate partner."³ Intimate partner violence and the spread of HIV share a unique relationship because not only does IPV perpetuate the spread of HIV among women, but also HIV-positive women are more likely to experience IPV, oftentimes as a direct result of their diagnosis. Women who experience intimate partner violence are more vulnerable to HIV for two distinct, but equally important reasons. Primarily, women who lack autonomy in their sexual relationships are at higher risk of being infected by their partner because modes of protection are not in their control. Secondly, the psychological impact of IPV will cause women to engage in more high-risk behaviors such as precarious sexual behavior and drug use--behaviors where HIV infection is more likely to result.

The reciprocal nature of the relationship between HIV infection in women and IPV insinuates that regardless of having experienced IPV before, women who are HIV-positive are more likely to experience IPV, sometimes explicitly due to their HIV status which is used against them as a means for shame and leverage of power.

The following analysis of the interconnectedness of IPV and HIV transmission is generalized to assume that men are perpetuating the violence against women. It is important to note however that violence exists in all forms of relationships, both heterosexual and homosexual, and can also be perpetuated by women. However, the specific form



1 "Empowered: Women, HIV & Intimate Partner Violence" Greater Than AIDS, Vickie's Story <https://www.greaterthan.org/campaigns/empowered/empowered-women-hiv-intimate-partner-violence-about/>

2 "Intersection of Intimate Partner Violence and HIV in Women." Center for Disease Control and Prevention, February 2014, 1

3 "Intersection of Intimate Partner Violence and HIV in Women." 1

of IPV that will be analyzed in this paper is violence perpetrated by men against women. Furthermore, it is important to note that there are various demographics of women who are more vulnerable to IPV, and these distinctions will be made later on in the paper.

How Does This Issue Come About?

Vickie's story is representative of the larger issue at hand, namely, the interconnectedness of IPV and the spread of HIV. This issue, however, is a manifestation of the power differential that exists in society today between men and women. Rachel Jewkes writes that, "It is not a new idea that among the key drivers of the HIV/ AIDS epidemic in women are gender inequalities- i.e., differences in social value, power, opportunities, and behavioral expectations of men and women- and consequent violence."⁴ Gender based violence is visible evidence of the unequal society that currently exists, and this has put women at a greater risk for contracting HIV. Women are at risk of contracting HIV as a result of violent relationships, and women who are living with HIV are more likely to experience IPV, sometimes specifically related to their diagnosis.

Thus, women find themselves in a vicious cycle, in which violence puts women at risk of HIV that often leads to contraction of HIV that often leads to more violence, as indicated by figure 1.⁵

Victims of IPV Are More Likely to Contract HIV

Women experiencing IPV are four times as likely to contract an STI (including HIV) than their female counterparts in healthy relationships.⁶ Why does violence perpetuate the spread of HIV? Primarily, women are at risk of being infected by their partner. The CDC reports that "forced sex occurs in approximately 40-45 percent of physically violent intimate relationships and increases a woman's risk for STIs by 2-10 times that of physical abuse alone."⁷ Thus, sexual

4 Jewkes, Rachel. "Gender Inequities Must Be Addressed in HIV Prevention." *Science*, New Series, 329, no. 5988 (2010): 145, accessed November 18, 2017, <http://www.jstor.org/stable/40731917>

5 "HIV, Intimate Partner Violence, and Women: New Opportunities Under the Affordable Care Act." The Henry J. Kaiser Family Foundation. <https://www.kff.org/hiv/aids/issue-brief/hiv-intimate-partner-violence-and-women-new-opportunities-under-the-affordable-care-act/>.

6 "Intersection of Intimate Partner Violence and HIV in Women." 2

7 "Intersection of Intimate Partner Violence and HIV in Women." 3

abuse is a common manifestation of IPV and increases the likelihood of contracting HIV up to 10 times. Additionally, men who are abusive towards their partner are more likely to be engaging in sexual relationships with multiple other partners. This puts them at increased risk to contracting HIV themselves and thus passing it along to their partner.⁸ Some might say that the easy answer to this is for women to demand use of protective measures, such as condoms, in their violent relationships as a means of protecting themselves. Unfortunately, this solution is neither viable nor realistic. The reality is that women often are not in a position to be able to demand that their partner use a condom in violent relationships because "condom use also requires the active participation of the male partner, who may be uncooperative."⁹

Furthermore, the second reason women are more likely to contract HIV when they experience IPV is due to the psychological impact it has and the subsequent behavior women exhibit as coping mechanisms for their abuse and diagnosis. Women who have experienced IPV are more likely to resort to dangerous coping mechanisms to deal with their trauma, such as "using drugs, engaging in sex work, initiating sexual activity at a younger age, drinking alcohol before having intercourse or having intercourse with multiple partners."¹⁰ Thus, abused women find themselves in situations in which contracting STDs (including HIV) is more common, and women run the risk of becoming HIV

Experience of Intimate Partner Violence and Women, Overall and with HIV



Lifetime Experience of Intimate Partner Violence (IPV)
Among All U.S. Women
(0.8 in 10)
Among HIV+ U.S. Women
(2.5 in 10)

abuse and diagnosis. Women who have experienced IPV are more likely to resort to dangerous coping mechanisms to deal with their trauma, such as "using drugs, engaging in sex work, initiating sexual activity at a younger age, drinking alcohol before having intercourse or having intercourse with multiple partners."¹⁰ Thus, abused women find themselves in situations in which contracting STDs (including HIV) is more common, and women run the risk of becoming HIV

8 Moore, Melissa. "Reproductive Health and Intimate Partner Violence." *Family Planning Perspectives* 31, no. 6 (1999): 304. Accessed November 18, 2017, <https://www.jstor.org/stable/pdf/2991541.pdf>.

9 Moore, "Reproductive Health and Intimate Partner Violence." 304

10 Moore, "Reproductive Health and Intimate Partner Violence." 304

positive as a result of these behaviors. Specifically, women who have existed in a pattern of abuse throughout their lives become more tolerant of abusive partners and may enter the sex trading market because they are financially and emotionally limited in their opportunities.¹¹

For women in violent relationships who are not infected with HIV, these behaviors increase their chances of becoming infected as drug use, sex work and having multiple sexual partners all increase one's risk for contracting HIV. For women in violent relationships who have already been infected with HIV, these behaviors increase the risk for infecting other people, as well as offer no long term relief or solution for the abused and infected woman. As written by Karen McDonnell, women resort to "the use of drugs and other substances, that may provide a temporary relief from the stressors of IPV and HIV, but in the long run may serve to exacerbate an already demanding environment."¹² The implications that this has is that women who enter into the vicious cycle of HIV infection, HIV risk factors, and IPV have little hope of exiting.

Women Infected With HIV Experience Higher Rates of IPV

As previously articulated, what is unique about the interconnectedness of HIV and IPV is that it is a reciprocal relationship. This means that in addition to IPV putting women at risk for HIV, Figure 2 also illustrates that HIV-positive women experience IPV at higher rates.¹³ In one particular study, since their diagnosis with HIV, 20% of women experienced violence and half of those women claimed their abuse to be explicitly connected to their diagnosis.¹⁴ Additionally, while violence manifests in all relationships, "women living with a male sexual partner vs. a female sexual partner were nearly 3 times more likely to report violence since their HIV diagnosis."¹⁵

11 Jewkes, "Gender Inequities Must Be Addressed in HIV Prevention" 146.

12 Karen A. McDonnell, Andrea C. Gielen, Patricia O'Campo, and Jessica G. Burke. "Abuse, HIV Status and Health-Related Quality of Life among a Sample of HIV Positive and HIV Negative Low Income Women." *Quality of Life Research* 14, no. 4 (2005): 955. Accessed November 18, 2017 <http://www.jstor.org/stable/4039358>.

13 "HIV, Intimate Partner Violence, and Women: New Opportunities Under the Affordable Care Act."

14 Zierler, S., W. E. Cunningham, R. Andersen, M. F. Shapiro, T. Nakazono, S. Morton, S. Crystal, M. Stein, B. Turner, P. St Clair, and S. A. Bozzette. "Violence victimization after HIV infection in a US probability sample of adult patients in primary care." *American Journal of Public Health*, February 2000: Table 1, 209. Accessed December 03, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446146/>.

15 Zierler, "Violence victimization after HIV infection in a US probability sample of adult patients

Why are women with HIV at greater risk for IPV? Well, there are two specific reasons. Primarily, and arguably more importantly, women with HIV are often vulnerable to other factors that contribute to IPV. In a study done by the CDC, the highest rates of HIV transmission in women persisted in communities where there were higher levels of poverty, lower levels of education, median household income levels below \$36,000, and lower levels of employment.¹⁶ Additionally, the CDC identifies factors that increase a woman's likelihood of experiencing IPV, namely low levels of education, low income, poverty, unemployment, substance abuse and many others.¹⁷ Notably, the risk factors for HIV almost identically resemble the risk factors for IPV. Thus, women who are HIV-positive are more likely to also experience factors that render them vulnerable to IPV. Thus, the first reason isn't a direct result of their HIV status, but rather the combination of many factors that lead women to falling victim to violent relationships.

The second reason why HIV-positive women are more likely to experience IPV is directly related to their HIV status. Some examples of abuse that women face after disclosing their HIV status to their male partner include, "denial of communication, accusations of infidelity, blame for "bringing the virus"; abandonment following status disclosure; sexual coercion (refusal to use condoms); and withdrawal of material support."¹⁸ Their HIV status is used against them and as leverage for men to justify violence and manipulative behavior. More common in homosexual relationships, but certainly still prevalent in heterosexual relationships, is the dynamic that the HIV positive partner is threatened by their partner that they will "out" them as either being gay, or as being HIV-positive unless they do what the partner wants. Thus, a person's HIV status is used against them in **an abuse of power.**

in primary care." 211

16 "Social Determinants of Health Among Adults with Diagnosed HIV Infection in 18 Areas, 2005-2009," Center for Disease Control and Prevention, Volume 8, No. 4: 7. https://www.cdc.gov/hiv/pdf/statistics_2005_2009_hiv_surveillance_report_vol_18_n4.pdf

17 "Violence Prevention." Centers for Disease Control and Prevention. August 22, 2017. Accessed November 30, 2017. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html>

18 Colombini, Manuela, Courtney James, Charity Ndwiwa, Integra Team, and Susannah H. Mayhew. "The risks of partner violence following HIV status disclosure, and health service responses: narratives of women attending reproductive health services in Kenya." *Journal of the International AIDS Society*. 2016.

Who is Most Vulnerable?

An important topic to breach when analyzing the connection between IPV and HIV transmission is which demographics of people are most vulnerable. That way, more effective policy changes can be implemented to directly help the demographics of people most vulnerable to IPV and HIV. Primarily, women are most vulnerable to IPV during their reproductive years.¹⁹ Additionally, physical abuse manifests most frequently in women who are "young, unmarried, nonwhite, less educated and with low household incomes."²⁰ Like many other issues in the world, racism and socioeconomic status are big determinants of what problems one is more likely to face. Jonathan Mann articulates very well that the marginalized, stigmatized, and discriminated populations that existed before HIV became the most vulnerable to contracting it, and "thus in the United States, the epidemic has turned increasingly towards minority populations in inner cities, injection drug users, and women."²¹ Thus, the most vulnerable and hidden populations become even more exploited and endangered in terms of IPV and HIV.

Why Do Women Stay in these Relationships?

A common response that is proposed regarding violent relationships, is that the abused partner should simply leave the abusive partner. Unfortunately, this is not always possible as oftentimes the abused partner does not have an option to leave for various reasons. Karen Rosen identifies five social reasons why women stay in abusive relationships: external orientation, socialization to violence, socialization to abuse of power, caretaker identity and cultural factors.²²

In simpler terms she describes external orientation as women's inability to see their worth independent of their partner, and thus any abuse they suffer is justifiable. She

19 Moore, "Reproductive Health and Intimate Partner Violence." 302.

20 Ibid., 303.

21 Michelle Teti, Mariana Chilton, Linda Lloyd, and Susan Rubinstein. "Identifying the Links between Violence against Women and HIV/AIDS: Ecosocial and Human Rights Frameworks Offer Insight into US Prevention Policies." *Health and Human Rights* 9, no. 2 (2006): 42. Accessed November 18, 2017. <https://www.jstor.org/stable/pdf/2991541.pdf>.

22 Few, April L., and Karen H. Rosen. "Victims of Chronic Dating Violence: How Women's Vulnerabilities Link to Their Decisions to Stay." *Family Relations* 54, no. 2 (2005): 271-272, <http://www.jstor.org/stable/40005254>

describes socialization to violence and abuse of power as how women who experience violence and abuse of power throughout their lives begin to see it as normal. She describes women who identify as caretakers as more likely to fulfill that role even with abusive partners. Lastly, she describes how cultural factors make women more likely to stay in abusive relationships because in cultural minorities, women are trying to protect themselves and their partner from labels like "dysfunctional" or from institutional discrimination. There are also some very practical reasons why women are forced to stay in abusive relationships, namely a woman's financial dependence on the abusive partner and the fear of losing a custody battle for children.²³ These sorts of restraints are common reasons for not leaving a partner, even someone who acts violently or abusively.

What Can Be Done to Combat This Issue?

Gender based violence, and the intersection of IPV and the transmission of HIV are somewhat daunting concepts that are complex and seemingly impossible to solve. However, there have been many policy initiatives that have been successful in combating this overwhelming topic. As in all circumstances where there is victimization and violence, the primary societal shift that needs to happen is reverting the blame and responsibility away from the victim. By slut-shaming, victim blaming, and putting the responsibility on women to fix their own circumstances, sexism and male dominance is perpetuated in society. Perpetrators of IPV demonstrate that "male sexual behaviors, attitudes, expectations, and violence flow from underlying ideas of masculinity, differential valuation and power of men and women, and culturally based expectations for men to demonstrate their 'manhood' in relations with women."²⁴ By changing this mentality and instead addressing the underlying power differentials and toxic masculinity that exist in society, then progress can be made. To combat this issue, South Africa implemented a very progressive program called "Stepping Stones" which essentially educated both men and women about what it means to live in a gendered society. As a

23 "Understanding and addressing violence against women." WHO. Accessed November 30, 2017. http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/.

24 Jewkes, "Gender Inequities Must Be Addressed in HIV Prevention." 145

result, “men significantly changed their sexual behavior, including less perpetration of IPV.”²⁵ Melissa Moore argues similarly that just as important as providing more resources to women is educating men about IPV and teaching anti-violence behaviors.²⁶

Additionally, screening for IPV at doctor and clinic appointments is an important way to help women escape the vicious cycle of IPV and HIV transmission. Not surprisingly, abused women are going to require more visits to clinics and doctors offices to seek treatment for signs and symptoms of their abuse, both physical and psychiatric.²⁷ Thus, by screening for IPV at doctor’s appointments, it will be easier to connect women to resources and hopefully get them out of dangerous and risky situations.

Finally, the Affordable Care Act has made progress in addressing IPV: actions which have and will continue to help women in this vicious cycle. Primarily, the ACA has eliminated IPV as a pre-existing condition to which insurance companies can refuse coverage for, provided free screenings and counseling for victims, and implementation of a visitation program for women and youth to focus on domestic violence.²⁸ All of these actions specifically will help identify women in dangerous situations, offer a lasting way out, and provide resources for recovery. Not only will this lower numbers of IPV victims, but will in turn prevent HIV transmission in these cases the earlier they are identified.

Conclusion:

In conclusion, the interconnectedness between IPV and the transmission of HIV is a major issue facing women across the United States, as well as on a global scale. The transmission of HIV as a result of IPV is manifestation of the power differential that exists in today’s society resulting in gender-based violence against women. Risk of HIV transmission is one of the many consequences that women face resulting from IPV. As indicated previously in the paper, women who are HIV positive are twice as likely to experience IPV as the national average.²⁹ While it is clear that this abuse is a direct

result of their HIV status in some cases, what is even more convincing is that women who are vulnerable to HIV share many of the same characteristics of women who are vulnerable to IPV. Thus, the pattern of abuse has more to do with which vulnerable population is being targeted, more so than the actual HIV status itself. Additionally, IPV can result in HIV transmission from an infected partner as a result of forced and/or unprotected sex, as well as behaviors exhibited after experiencing IPV such as risky sexual contact, intravenous drug use, and prostitution.

At the end of the day, IPV and the transmission of HIV are manifestations of gender based violence and power dynamics that exist between men and women. While certain policy initiatives are going to be helpful in mitigating the transmission of HIV in violent relationships and helping women get out of dangerous situations, the underlying issue here needs to be addressed for this cycle of violence and HIV transmission to be broken for once and for all. Until society can resolve power differentials between men and women and until women have access to enough opportunities and resources, we are faced with the inevitable reality that IPV and HIV transmission will persist.

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²⁵ Ibid., 145

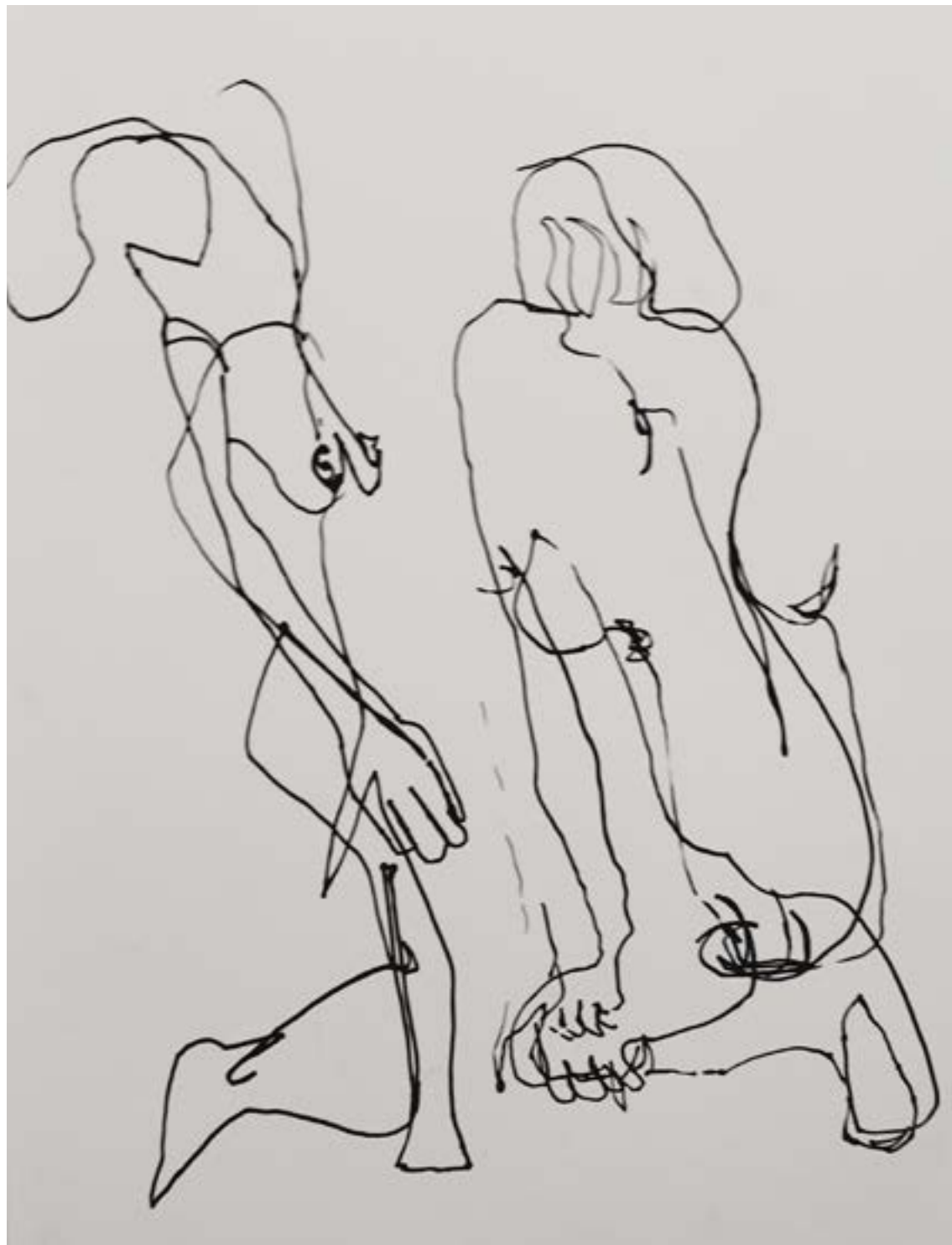
²⁶ Moore, “Reproductive Health and Intimate Partner Violence.” 305-306.

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STUDY OF TWO WOMEN KNEELING

SARAH MIA
DURAN

GANG VIOLENCE AND HIV TRANSMISSION

ALLISON HILL

SAN ANTONIO, Texas — A street gang that requires young women to have unprotected sex with AIDS virus-positive males as part of its initiation has recruited at least five girls, ages 14 and 15, officials said Monday. Joann King-Sinnett, spokeswoman for the city's Planned Parenthood, said her agency recently came across the five girls when they came in to undergo AIDS testing. King-Sinnett said she 'got chills' when she listened to the girls tell their story. 'These girls were terrified and wanted to be tested for HIV through our counseling sessions. They said fellow gang members told them they should have unprotected sex with those who are HIV-positive to become members.' The spokeswoman said the girls tested negative for the virus, but she warned that medical research shows that sometimes it can take months after such a sexual encounter for the virus to show up. 'It is very possible there may be several more girls who have had similar experience but haven't come forward like these five. It is also possible that the gang members were lying about it just to entice these girls. It is really horrifying, shocking that these girls would subject themselves to such a deadly risk. 'For reasons of confidentiality and the need to protect the privacy of these girls, we cannot reveal the gang's name. There may be other such gangs doing similar things.' Police Sgt. David Ramos said promiscuous sexual activities do sometimes occur as part of gang initiations. He cited a case in Dec, 1992, in which a young girl told of being sexually assaulted by 10 gang members. Ramos said the first police heard of that incident, however, was when it was reported by Planned Parenthood. 'If both the girls and the boys were underage and the girls voluntarily sought out AIDS-infected partners and knew they had AIDS, I'm not sure any law would have been broken,' Ramos said. King-Sinnett said it is difficult to pass judgment on the girls since they come from poor families, have 'extremely low-self-esteem,'

and 'are afraid because they are caught in a very terrible situation where they face risk either way -- by belonging to gang or being attacked for refusing to belong.' King-Sinnett said some of the girls refuse to use condoms because they insist on having babies through the gang members. 'We just can't get through to them that they are not invincible, that they are taking a horrible risk by seeking gang membership,' she said.

The case outlined above demonstrates the immense risk of HIV transmission faced by girl gang members. These girls are young, usually uneducated, and come from extremely poor backgrounds — adding to their vulnerability. As shown in the case, these girls are victims of extreme sexism and sexual abuse, yet oftentimes willingly subject themselves to this treatment due to their highly volatile home lives. Their status as gang members makes them part of both an incredibly unstable and invisible population. As part of a hidden population, there is no published data or academic literature on the prevalence of gang members living with HIV/AIDS and their increased risk of infection. As such, gang members remain ignored by the public health community and targeted with heavy moral judgmentalism by the general population. In this essay I hope to explicate the social factors underlying female gang members' heightened predisposition to HIV/AIDS within a framework of instability and structural violence, analyze the public health issues at stake, and discuss the obligation to aid this population using a fabric of Catholic social teaching.

According to the FBI, around 33,000 gangs exist in U.S. territories with more than 1.4 million active members.¹ Of these, many operate as “street” or “neighborhood” gangs,

¹ “2015 National Gang Report (NGR).” (FBI, 1 July 2016).

which vary in demographic, composition, and structure. However, many of these gangs function in a similar fashion. Street gangs tend to be oriented towards drug distribution, robbery, and other crimes, as well as perpetuating violence throughout their associated neighborhoods. Though we traditionally consider gangs to be male-dominated, women and girls play an active role in gang structure, and their rates of membership are increasing. Currently, female membership is estimated to be around 10 - 30%. According to prior studies, females account for an estimated 14% of violent offenses, with more than a third described as Black. Furthermore, around 28% of these women are under the age of 21.² At the same time, girls between the ages of 12 and 18, experience the highest rates of victimization: including sexual assault and intimate partner violence.³ This data demonstrates the simultaneous risk girls face toward violence as both perpetrators and victims, especially in the context of gangs. The extent to which these girls are involved in instigating violence is often as a “last-resort” and should be considered within their situations as highly economically disadvantaged individuals, under the intersecting oppressions of racial and gender exclusion, and the intense social pressure operating within the gang structure.

A critical way in which female gang members are at risk for contracting the HIV virus is by means of their incarcerated male counterparts. Due to the US government’s “War on Drugs,” the correctional population has increased dramatically due to mandatory minimum sentences. These inmates are disproportionately represented by poor, disenfranchised men of color. It has been well-established that incarcerated men are at a 5 times higher risk of contracting HIV than the general population.⁴ In fact, 25% of all people living with HIV pass through the correctional system each year.⁵ Though the majority of these people acquire the virus prior to their incarceration, there is a significant population

2 G. Hunt, et al. “Situations Of Violence In The Lives Of Girl Gang Members.” (Health Care For Women International, 2001): 365.

3 Ibid.

4 P. Denning, et al. “HIV/AIDS & Economically Disadvantaged” (CDC, 2017).

5 S. Springer, et al. “Managing HIV/AIDS in correctional settings.” (Current HIV/AIDS Reports, 2005): 165.

that will become infected during their sentence. Inside the prison systems, inmates may engage in high-risk behavior such as consensual or nonconsensual homosexual sex, injection drug use, commercial sex for contraband items, and the sharing of needles for piercing and tattooing.⁶ This is extremely problematic for a variety of reasons. First, men of color who engage in consensual, “companionship” sex during their sentence, often do not consider themselves to be gay or bisexual and assign their homosexual encounters as purely situational. Therefore, they ignore HIV prevention campaigns that target homosexual individuals. Secondly, the intense stigma of HIV positive individuals in prison creates a fear around being tested. In such a closed environment, confidentiality is often impossible, so inmates will avoid being tested and will remain in the dark about their status until after release. Finally, the availability of condoms in prison is extremely scarce.⁷ Less than 1% of all jails and prisons in the US allow access to condoms. Taken together, this poses a large cause for concern when these inmates are released and return to their respective communities — many of which are gang-oriented. Inmates who experimented in homosexual sex will often return to female sexual partners or relapse into substance abuse. Furthermore, their ability to access antiretrovirals is often obstructed by social barriers such as poverty and unstable living conditions. This creates an extraordinary high risk scenario for the women living in their communities.

The structure of gang communities allows for increased transmission of the HIV virus due to de facto racial segregation and the imbalance in gender ratio from street violence and incarceration. A long history of racial prejudice and structural violence against people of color in the United States severely limits upward economic mobility in these populations. The lack of economic opportunity promotes the formation of low-income and often racially segregated neighborhoods within cities. In terms of HIV, these isolated residential communities promote

6 S. Lane et al. “Structural Violence and Racial Disparity in HIV Transmission.” (Journal of Health Care for the Poor and Underserved, 2004): 324.

7 R. Braithwaite, et al. “Male Prisoners and HIV Prevention: A Call for Action Ignored.” (American Journal of Public Health, 2003): 78.

viral infection because they severely limit mate selection.⁸ Constrained sexual networks are even more prevalent within the structure of gangs. Gangs operate over defined geographic boundaries or “turfs.” Social pressure and intimidation prevent people from entering turfs in which they do not reside. Thus, young adults are unable to form relationships with people outside of these very specific communities and the virus is able to rapidly spread in a closed environment.

Demographically, gangs are also associated with a low male-to-female sex ratio. This is primarily due to the fact that many male members are incarcerated at a disproportionately high rate. Furthermore, the prevalence of lethal violence among male gang members on the streets leads to an imbalanced structure wherein girls dominate. This is exceptionally problematic because communities with low pools of men and high pools of women often promote polygamy.⁹ Relationships are less secure because there are more women for the men to choose from. As a result, women lose bargaining power in their sexual encounters and men are able to become sexually abusive. In this environment, women may feel unable to initiate a discussion over condom usage and therefore may accept risky conditions. Alternatively, these women may willingly choose risky sex in order to secure stable relationships. As shown in the presented case above, many of the young women in these situations refuse to use condoms in their sexual encounters because they want to conceive with the gang members - potentially a naive attempt to achieve stability. Moreover, men who have a variety of sexual partners are unlikely to disclose this fact to the women they sleep with. This creates a situation wherein women are unknowingly victims of HIV transmission as a result of an abusive imbalance in power. Drug dependency in gangs — as both users and sellers — is also a strong mechanism by which HIV can propagate. It has been well established that gang members display higher rates of alcohol and substance abuse than non-gang members: 20% compared to 6% in the general population.¹⁰ In

8 S. Lane et al. 325.

9 Ibid. 326.

10 R Brooks, et al. “HIV Testing, Perceived Vulnerability and Correlates of HIV Sexual Risk Behaviors of Latino and African American Young Male Gang Members.” (International Journal of STD & AIDS,

fact, joining a gang actually increases frequencies of drug use and delinquent behavior.¹¹ As outlined before, gang oriented communities are often victims of intense de facto segregation from mainstream society. This isolation skews members toward gang-sustaining activity in order to support the gang as a primary institution of social support, economic opportunity, and protection. Drug sales become a fundamental source of financial security, and oftentimes an avenue toward higher gang status. Newly initiated members may fill jobs in drug dealing as a way of demonstrating their affiliation. This exposure and hands-on interaction with drugs increases their likelihood of experimenting and becoming substance dependent.¹² Furthermore, gang members also rely on substances such as drugs and alcohol as a lubricant during social gatherings or ritual behaviors. As stated by Jeffrey Fagan in his analysis of drug involvement among urban gangs; “drug use provides a means to social status and acceptance, as well as mutual reinforcement, and it is a natural process of gang life.”¹³ Regardless the level of usage, individuals are much more likely to engage in high-risk sexual behavior under the influence of drugs and alcohol. If these are activities are normalized — or even rewarded — by the surrounding group, the chances of transmitting the virus increase dramatically. The final element by which specifically girl gang members are at risk for HIV is through explicit sexual violence from their male counterparts due to hypermasculinity within the gang dynamic. Given that youth gangs are predominantly male-dominated, it would make sense that their adopted cultural norms are masculine oriented. Similar to dynamics within fraternities or sports teams, these norms influence gender interactions and the ways in which male members treat young women. According to personal accounts, girl gang members traditionally take on one of two roles: a tomboy, in which they internalize learned masculinity, or a “sex object.”¹⁴ However, the former is deemed less ac-

2011): 20.

11 U. Gatti, et al. “Youth gangs, delinquency and drug use: a test of the selection, facilitation, and enhancement hypotheses.” (Journal of Child Psychology and Psychiatry, 2005): 1178–1190

12 J. Fagan. “The Social Organization Of Drug Use And Drug Dealing Among Urban Gangs.” (Criminology, 1989): 636.

13 Ibid.

14 J. Miller et al. “Gender dynamics in youth gangs: A comparison of males and females accounts.” (Justice Quarterly, 2000): 423.

ceptable by the gang because it deviates from expectations of female behavior. This puts the girl members at risk for sexual victimization, abuse, exploitation and assault. Despite this, many girls willingly join gangs because of the protection it affords them, and the refuge it provides from their potentially violent home situations.¹⁵ In these communities where poverty and unemployment are high, many girls have abusive relationships with their parents who may or may not be present. In order to escape tension and disruption at home, girls opt to join a gang to create a sense of family. Furthermore, in many of the gang related activities, male members will protect the girls from potentially violent encounters as they believe it is inappropriate for girls to be involved. This results in a “double whammy” situation — where the girls rely on the male gang members for protection from the streets but are also subject to sexual victimization from these same “protectors.” Taken together, girl gang members are at an immensely high risk for HIV due to substance dependency, isolated sexual networks and gender ratio imbalances, as well as intense sexual victimization from male gang members with a potential history of incarceration. These girls live of extreme instability, lacking adequate support institutions and relying on gang structure as their source of social influence. In the case above, we are shown that these girls are often stuck between a rock and a hard place — risking potential sexual victimization within the gang or the possibility of home trauma or getting attacked by refusing to belong. Now that the social factors leading to the vulnerability of this categorically ignored group have been identified, we can begin to construct an argument to respond to this public health issue using principles of Catholic social teaching.

In order to be able to respond to this issue, we must disrupt the moral judgmentalism and stigma surrounding female gang members. Key to this stigma is the conception that girl gang members are at fault for their HIV infection due to their involvement in perceived delinquent activity. Young women are stereotyped as reckless “bad

girls” for their association with “thugs” and deviation from traditional gender roles, and “lazy” for their reliance on public assistance programs. Missing from these notions grounded in racist rhetoric is the fact that girl gang members live a reality that is inherently violent. As discussed, these girls lack agency in their choices. They do not seek out violence and delinquency, but rather pursue a place at home within a highly unstable community, and may have to resort to crime in order to protect themselves. Their social mindset and moral outlook is created by existing laws that are structurally violent and lead to residential segregation, social and economic exclusion and genuine harm. Despite this, we still place blame on female gang members when these multiple layers of structural oppression result in an HIV infection. Analyzing this issue reveals a great deal of implicit voluntary ignorance. Choosing not to know about the specifics of these cases puts us in a position of moral accountability. From a Catholic perspective, we therefore ought to respond to this issue in order to prevent the systematic abuse of these individuals and uphold human dignity.

Two principles particularly useful in describing the Catholic responsibility to address the HIV vulnerability faced by girl gang members include the preferential option for the poor and the commitment to the common good. The preferential option for the poor comes from the Biblical tradition which shows us that God has a special interest in the needs of the poor and the suffering. If we are made in the image of God, then we have an obligation to exercise this same interest. The Scriptures also show us that Jesus has an inclination to reach out to those who are socially despised or ostracized in his call to widen our scope regarding who we call our neighbor and who we allow ourselves to attend to. Gang members, specifically girl gang members, represent a cohort of people almost exclusively economically disabled and always socially looked down upon. Therefore, if we are to act with moral conscience, we must reach out to this ignored population and establish a productive HIV education and prevention strategy, as well as provide better access to HIV relevant resources, such

as testing. A reflection on the commitment to the common good is particularly relevant to the issue of providing access to HIV services. The common good defines a set of universally beneficial conditions to all people, including access to health care and the right to know about one’s HIV status. To deny these conditions is to deny the humanity of another human being. It is therefore crucial to include gang members in our scope of care and concern, and to address their heightened vulnerability as a fundamental public health issue.

In addition to direct HIV related prevention services, indirect measures should also be taken to reduce social risk factors. Structural interventions like school engagement could be employed to reduce gang related violence while community support groups could be used as a means to address turbulent family issues. Changing social norms around risky behavior would target the root cause of vulnerability in gang members’ lives. Importantly, we need to raise a collective conscience about the structural violence surrounding girl gang members in order to remove their invisibility. More field research should be conducted on the prevalence of HIV/AIDS among this specific population in order to gain more representation in academic literature. HIV is a social disease and targets isolated groups affected by instability. Gangs, therefore, represent the perfect breeding ground for the virus.

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¹⁵ G. Hunt, et al. 375.

SO, WE SHUT THEM AWAY

THE FAILURES AND DANGERS OF THE CRIMINALIZATION OF HIV/AIDS

MICHAELA
SIMONEAU

When “deliberate transmission” becomes a misnomer: A Case of HIV Criminalization in Zimbabwe¹

“In Zimbabwe, a 26-year-old woman from a township near Bulawayo was arrested last year for having unprotected sex with her lover... she was living with HIV. The crime of which she was convicted was ‘deliberately infecting another person’. Her lover however tested HIV negative. The woman was receiving antiretroviral therapy, so that is not entirely surprising. Before sentencing her, the court tried to get a further HIV test from the lover – even though he reportedly didn’t want to proceed with the charges at all. She was eventually sentenced to a suspended term of five years’ imprisonment. The threat of imprisonment, and the shame and ordeal of her conviction, will continue to hang over her. The statute under which she was convicted, s79 of the Zimbabwe Criminal Law (Codification and Reform) Act 23 of 2004, is an extraordinary piece of legislation. It doesn’t make it a crime merely for a person who knows that she has HIV to infect another. It makes it a crime for anyone who realises ‘that there is a real risk or possibility’ that she might have HIV, to do ‘anything’ that she realises involves a real risk or possibility of infecting another person with HIV’. In other words, though the crime is called ‘deliberate transmission of HIV’, this is a misnomer. You can commit this crime even if you do not transmit HIV. In fact, you can commit the crime even if you do not have HIV. Stranger upon strange, this statute offers a defence when a person really does have HIV... [where] if the other person knew this, and consented, then the accused is exempt. But, the way the statute is drafted, this defence can not apply where the

accused does not in fact have HIV, or does not know that she has HIV – by definition, in that case she cannot engage the informed consent defence by telling her partner she has HIV! In short, this law creates a crime not of effect and consequence, but of fear and possibility.”

HIV/AIDS is currently the most devastating epidemic on the planet, and its destruction wreaks greater havoc and suffering in Southern Africa than anywhere else in the world. In 2016, Eastern and Southern Africa accounted for 43% of the global total of new HIV infections, on top of the 19.4 million people already living with HIV, over half of them women and girls.² Zimbabwe itself had 1.3 million people living with HIV, a 13.5% adult prevalence rate, with 40,000 new HIV infections and 30,000 AIDS-related deaths in 2016.³ While infection rates have dropped in recent years, 74% of adults are now on antiretroviral treatment (89% were receiving any sort of treatment, 81% of whom were virally suppressed), and 75% of adults are aware of their HIV status, Zimbabwe retains the sixth highest prevalence of HIV in Sub-Saharan Africa.ⁱⁱⁱ Furthermore, social issues, notably gender-based violence, remain pervasive throughout the state. In one survey, 17% of women said they believe their husband has the right to beat them if they refuse sex.ⁱⁱⁱ

In an attempt to lessen the burden of HIV, Zimbabwe has adopted a few key provisions of HIV-specific criminal law. It is very broad and indiscriminate, prescribing sentences that can stretch as long as twenty years.ⁱ It even covers pregnant women who know or fear they may have HIV, if they give birth, breast-feed, or do anything that could be construed

as deliberate transmission, regardless of whether their baby was infected.ⁱ The language from The Zimbabwe Criminal Law (Codification and Reform) Act, Section 79, as referred to in the case study above, is the principal piece of criminalizing legislation.⁴ The true danger is in its language that criminalizes risk alone, and the realization of that risk, which presents those offences as comparable to deliberate transmission. Thus, it leaves far too much room for discretion, and further burdens already vulnerable populations.

However, this tendency to criminalize HIV is not a new development limited to Zimbabwe, but is a long-enduring facet of the attempt to counter the HIV/AIDS epidemic as a whole. According to the HIV Justice Network, “HIV criminalisation describes the unjust application of the criminal law to people living with HIV based solely on their HIV status – either via HIV-specific criminal statutes, or by applying general criminal laws that allow for prosecution of unintentional HIV transmission, potential or perceived exposure to HIV where HIV was not transmitted, and/or non-disclosure of known HIV-positive status.”⁵ In 2016, a new report showed that 72 states around the world have adopted legislation that criminalizes HIV, including 30 states in the United States.^v Of these states, 61 have prosecuted individuals on the basis of non-disclosure, potential or perceived exposure, or unintentional transmission, using a mixture of specific HIV laws and general criminal or public health laws.^v While there was no HIV criminalization as recently as 2000, now 30 Sub-Saharan African countries have broad criminal statutes incorporated into their HIV-laws, most of which also include provisions for protection and nondiscrimination along with compulsory testing and involuntary partner communication.^v Other cases from places as different as the United States, Egypt, Singapore, and Sierra Leone highlight the fact that this criminalizing approach is not unique to Zimbabwe.

In theory, criminalization seems like an appropriate deter-⁴
⁴ “Zimbabwe.” Global Criminalization Scan. September 9, 2015. Accessed December 4, 2017. <http://criminalisation.gnplus.net/country/zimbabwe>.
⁵ “NEW REPORT SHOWS HIV CRIMINALISATION IS A GROWING, GLOBAL CONCERN BUT ADVOCATES ARE FIGHTING BACK.” HIV Justice Network. May 10, 2016. Accessed December 4, 2017. <http://www.hivjustice.net/news/new-report-shows-hiv-criminalisation-is-growing-global-problem-but-advocates-are-fighting-back/>.

rent response to help quell the epidemic and to limit its proliferation. Two of the most commonly cited reasons for criminalizing HIV transmission include punishing harmful conduct and preventing HIV transmission by deterring or changing risk behaviors.⁶ The first rationale is reasonable, for if someone acted with the intent to transmit HIV, out of malice, their punishment is absolutely justified. Yet, the vast majority of these cases do not fall under those specific circumstances, and rather fall under cases where there are other compounding factors which must be considered to understand how the punishment is being applied, and whether it is being applied justly or indiscriminately. The preventative intention of the criminal statutes is a noble attempt to try to protect the population at large, particularly women and girls who are already vulnerable. However, this idea that criminal penalties should be imposed against those who risk passing on the virus as a result of their negligence or recklessness, to promote behavior change, actually has ripple effects that impede other methods of prevention, testing, and treatment for HIV, and inhibit proper public health practices more than they help to limit the spread of the virus. Governments want to send the right message to disincentive risky behaviors, but in doing so they defy legal standards of legality, causality, and proportionality, while placing a heavier burden on already stigmatized populations, and through this mismanagement of justice impeding broader public health initiatives to counter the virus.

The criminalization of HIV is flawed at its core because it relies on moral judgementalism to encourage behavior change, a method that has been proven to fail and to actually degrade efforts to achieve tangible improvements in the rate of HIV transmission. These arguments, put forth by people such as Michael McDermott, attempt to villainize and alienate people in order to justify and protect themselves, placing blame and ostracizing those who are truly the victims, the infected.⁷ This judgementalism is the

¹ Burris, Scott, Edwin Cameron, and Michaela Clayton. “HIV is a virus, not a crime: ten reasons against criminal statutes and criminal prosecutions.” *Journal of the International AIDS Society* 11, no. 7 (December 1, 2008). Accessed December 3, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2635346/pdf/1758-2652-11-7.pdf>.

² “FACT SHEET – WORLD AIDS DAY 2017.” UNAIDS. 2016. Accessed December 4, 2017. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf.

³ “HIV and AIDS in Zimbabwe.” AVERT: Around the World. October 16, 2017. Accessed December 4, 2017. <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe>.

⁶ “Policy Brief: Criminalization of HIV Transmission.” UNAIDS. August 2008. Accessed December 4, 2017. http://www.unaids.org/sites/default/files/media_asset/jc1601_policy_brief_criminalization_long_en.pdf.
⁷ McDermott, J. Michael. “Is AIDS God’s Punishment?” *Homiletic and Pastoral Review*: 32, 50-58. Accessed December 4, 2017.

root source of stigma, and it serves to overly simplify the problem at hand by placing the entirety of the blame on the victim, rather than acknowledging the larger forms of inequality and structural violence which were likely also conspiring against them. The language of innocence and guilt is not helpful when addressing HIV, as it precludes us from descending into the particular nuances of the situation, and judging it based on their entire picture.⁸ It is a coping mechanism, and the fact that it has snuck its way into codification in criminal law is a despicable reflection of how we care for our fellow human beings, and especially those who are infected, and in need of aid and support.

At times, the law does monitor and regulate individual behavior, showing adherence to certain values and trying to bring out the best in society. However, there is a stark difference between laws that attempt to regulate behavior as it affects the general population, and paternalistic laws which assume they know what is best for the entire population, without particularity. There is a difference between allowing for lawless autonomy and attempting to regulate how individuals choose to live their own lives, and these laws, in selectively targeting already vulnerable populations, seem to be contributing the scapegoating of those groups, further ostracizing them and placing barriers to care. Allowing for the criminalization of HIV is effectively allowing for the criminalization of suffering, and is saying that those who have contracted HIV deserve it, by singling them out as the ones at fault. This is an unproductive attempt to curtail transmission, simply making people less likely to want to face that ostracization, and more likely to avoid treatment. It truncates the question of cause, obscures the real issues, prevents the discussion of the important particularities of the situation, and therefore impedes productive interventions which could actually combat the epidemic.

In this particular case and for the Zimbabwean laws in particular, this idea of judgementalism comes further into focus because the tangible threats criminalized by the law do not

⁸ Martin, Leonard M., C.Ss.R. "I Fed You With Milk": Missionary Morals in Brazil in a Time of AIDS." In *Catholic Ethicists on HIV/AIDS Prevention*, 128-35. New York, NY: The Continuum International Publishing Group Inc, 2005.

truly amount to more than being infected, in and of itself. The woman from Bulawayo did not infect her partner, they were having consensual sex, she was on antiretroviral therapy (ART), and her partner wanted to drop the charges. Still, she was made to go through the whole criminal proceeding, because she simply had the risk of infecting another person, even though they both had informed consent and had accepted that risk by entering into a relationship with one another. This shows the paternalism involved regardless of the particular parties, and the court's willingness to place all of the blame on the victim, who now has a double burden as she is already infected with HIV. Even though she never actually went to jail, and was given a suspended sentence, the case is clear about how her conviction will hang over her, and how that stigmatization will burden and challenge her in all other aspects of her life, from personal, to educational, to occupational. She was only allowed release, on suspension, because her lover's second test came back negative, and even then the trial was repeatedly postponed, hanging over her. Many other cases involve individuals who actually are sent to prison, (including one where a man's saliva was called a "deadly weapon")⁹ so her case highlights the absurdity of these laws. She was prosecuted not for actually causing harm, but for being infected in the first place.

It is important to consider the precautionary principle here, and whether the magnitude of the epidemic justifies such violation of personal liberties and human rights. There is a question to be answered about whether the given proceedings and the requirements for prosecution are too harsh, and whether the law has the right to restrict such consensual individual behavior, especially when doing so is causing stress and harm to the parties without showing that it is producing any additional public health benefits. Some experts have said that it was actually a good thing that public health officials were not given free reign at the start of the epidemic, to punish those infected through quarantine or other more extreme means, because that would have driven the entire epidemic underground, where it would evade inter-

⁹ Kovach, Gretel C. "Prison for Man With H.I.V. Who Spit on a Police Officer." *The New York Times*. May 16, 2008. Accessed January 20, 2018. <http://www.nytimes.com/2008/05/16/us/16spit.html>.

vention and flourish dangerously below the surface, garnering more stigma and becoming unapproachable by public health.¹⁰ There are times when such measures are more justified, not because the outcome they produce is greater, but when they are the only interventions available and they act with a respect for some human rights, in a way that suspends civil liberties without violating any individuals. However, HIV is an emergent case that has other alternatives that respect human rights, which could be pursued as an alternative.

The unfair, irregular application of HIV-specific law is a substantive issue of criminalization, for by criminalizing intent law enforcement is vulnerable to natural biases, which further stigmatize infected populations. This placement of blame compounds the evil rather than serving to limit its spread. Most people do take precautions to avoid spreading the virus, and this can prove their intentionality to acquit them in a criminal case. Other individuals who do not take these precautions likely do so because they already have inadequate access to care, information, or the agency to pursue safer behaviors as a result of being structurally marginalized. These groups may include sex workers, men who have sex with men, injection drug users, and women. Since the establishment of who transmitted HIV to who is often nearly impossible to tell, even with phylogenetic testing that looks at the relatedness of the virus samples, testimony usually is the only evidence to determine guilt. In such cases, people may be found guilty in error, and almost always, the person who is already marginalized, already more likely to be biased against be it for race, gender, class, or anything, will be found as the guilty party.

Criminalization is founded in stigma, and it serves to exacerbate vulnerabilities and discrimination for already marginalized populations. It is even more deeply founded in the moralism discussed above, particularly in relation to HIV's sexual transmission. The People Living with HIV Stigma Index measures this discrimination in 65 countries, and in

¹⁰ Bayer, Ronald, and Amy L. Fairchild. "The Genesis of Public Health Ethics." *Bioethics* 18, no. 6 (2004). Accessed December 4, 2017.

22 states, over 10% of people living with HIV reported that they had been denied healthcare, or denied employment.¹¹ This proves that stigma and discrimination result in real, tangible losses to quality of life, and the threat of criminalization or the weight of convictions only add to that burden of being stigmatized as a result of one's HIV diagnosis. A different case found that individuals reporting high levels of stigma were over four times more likely to have poor access to care.¹² In another 2015 survey in over 70 countries, in 35% of countries with available data, over 50% of people reported having discriminatory attitudes towards people with HIV.¹³ Be that a result of misinformation, moral judgementalism, or something, else, the cause does not deny the fact that such stigma is a reality for those living with HIV, one that criminalization only exacerbates. In Sub-Saharan Africa, as with the woman from Bulawayo, heterosexual sex is the main route of infection, and so it is infidelity and sex work which are most often associated with the stigma of HIV. As Michel Sidibé, Executive Director of UNAIDS said, "Whenever AIDS has won, stigma, shame, distrust, discrimination and apathy was on its side." Criminalization is simply governmental stigmatization of people living with HIV, but it serves the same effect. It goes further when it locks people away in prison, or even deports them, sometimes to places where they cannot receive care.

The ones who are oppressed and endangered the most from this stigma are women and girls, the very ones whom the criminal laws are attempting to protect. In Africa in particular, women are far more likely to know their HIV status because they get tested at ante-natal healthcare sites. Therefore, when it comes to criminal cases, it is assumed that they are the ones who ought to know their status, and they are prosecuted as a result. Oftentimes, they will not have disclosed their status for fear of abandonment, making them even more susceptible to conviction under criminal law. Especially in places such as Zimbabwe,

¹¹ "Global AIDS Update 2016." UNAIDS. 2016. Accessed December 4, 2017. http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf.

¹² Sayles, Jennifer N. et al. "The Association of Stigma with Self-Reported Access to Medical Care and Antiretroviral Therapy Adherence in Persons Living with HIV/AIDS." *Journal of General Internal Medicine* 24.10 (2009): 1101-1108. PMC. Web. 4 Dec. 2017.

¹³ "HIV Stigma and Discrimination." AVERT: Social Issues. August 29, 2017. Accessed December 4, 2017. <https://www.avert.org/professionals/hiv-social-issues/stigma-discrimination>.

where, as was discussed earlier, so many women consider domestic violence to be the norm, and lack the negotiating power to advocate for their own sexual health within their relationships, women are often subject to the will of men and traditional patriarchal systems. This makes them even more vulnerable to HIV, as they will often be deterred from seeking treatment, prevention, and care services.¹⁴ For example, women in South Africa avoided a clinical trial that could help prevent them from becoming infected with HIV because they were afraid the gels and pills would mistakenly have them be identified as having HIV, and subject them to discrimination.^{xii} Ultimately, this fear led them to adapt more risky behaviors.

Criminalization of HIV also does not protect women and girls in that it ignores the larger problems of coercion, abuse, and violence which lie at the root of their vulnerability and suffering.^{xiii} The better way to protect women is not putting a band aid on a bullet hole by attempting to punish the men who infect them, but by enacting and enforcing laws to protect them from sexual violence, discrimination based on gender and HIV status, and inequalities in employment, education, property, custody, and more.^{vi} As Mark Miller enunciated in a different case, simple fixes, like that of a condom or in this case, criminalization, will only obscure the larger problems at play.¹⁵ Criminalizing the virus only puts a disincentive on the effect, where criminalization of these more systemic behaviors could create a larger change in society that alleviates not only the burden of infection, but of inequality. Perhaps then, women such as the lady from Bulawayo would not be targeted by law enforcement in the first place.

Another question is whether individual physicians should have the autonomy to decide whether they disclose a patient's HIV status to their partner on an individual basis. This debate over individual primacy versus public good is a

14 "10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women." 2009. Accessed December 4, 2017. <http://www.athenetwork.org/assets/files/10%20Reasons%20Why%20Criminalization%20Harms%20Women/10%20Reasons%20Why%20Criminalisation%20Harms%20Women.pdf>.
15 Miller, Mark, C.Ss.R. "Unmaking a Hidden Epidemic Among First Nation Communities in Canada." In *Catholic Ethicists on HIV/AIDS Prevention*, 84-91. New York, NY: The Continuum International Publishing Group Inc, 2005.

question of professional integrity,¹⁶ but also of moral necessity when silence is kept.¹⁷ The issue of mandated reporting is a moral question, but it is also a practical one, which must be considered in concert with its effects on overall treatment. Many people, especially women in male-dominated cultures, like Zimbabwe, would be very hesitant to seek out testing, and with it ante-natal care and the like, if they knew their status may be disclosed. Here, counselling must be employed in order to try to ensure that partners are honest with each other without it being mandated by law.

All of these factors contribute to a culture of silence that deliberately harms public health objectives and hides the evidence-based solutions necessary for HIV treatment, as a result of fear of stigmatization and criminal suits. The repercussions people could face under criminal law create too much fear, and they would rather be ignorant of their status and risk infection than risk the consequences that could come if they do have the virus, know about it, and no longer have that defense to use in a criminal suit. Criminalization is "a blatant disinducement to testing" making people so afraid to do the rational thing and come forward.ⁱ In the end, what is needed is not more disincentives for risky behaviors, but more access to treatment for the marginalized who lack it, and who therefore keep spreading the virus.ⁱ HIV is a manageable disease, and while it must be prevented, that must not be through the further stigmatization and suffering of those who are already afflicted. Furthermore, when the end result of criminalization is imprisonment, it leads infected individuals to settings where they have far less access to treatment, and are left neglected and vulnerable.¹⁸ This consideration of the end result of criminalization may shed light on how it is not at all an effective strategy for achieving good public health outcomes in the fight against the HIV epidemic. The real lives, reasonable fears, and behavior of infected **persons must be taken into account.**

16 Higueroa, Jose Carlos Bermejo. "A Spaniard Resists Disclosing His HIV Status to His Girlfriend." In *Catholic Ethicists on HIV/AIDS Prevention*. New York, NY: The Continuum International Publishing Group Inc, 2005.

17 Rojas, Orlando Navarro. "Women's and Children's Risks of Contracting HIV in Costa Rica." In *Catholic Ethicists on HIV/AIDS Prevention*. New York, NY: The Continuum International Publishing Group Inc, 2005.

18 "Prisoners Most Neglected by Global HIV Response." *Dispatches: Criminalization Drives Global Rise in HIV Infections*. July 18, 2016. Accessed December 4, 2017. <https://www.hrw.org/news/2016/07/18/dispatches-criminalization-drives-global-rise-hiv-infections>.

In the end, criminalization is an ineffective strategy for combatting the spread of the HIV epidemic. People often transmit the virus very soon after they are infected themselves, and therefore they have no way of knowing they should become more risk-averse. Antibodies can take up to three months to become evident in tests, meaning that in reality, criminal law has no substance to prosecute, and just adds to a culture of fear.¹⁹ The laws are so poorly drafted that their clarity and evidentiary burdens should not hold up under normal standards of law, and they therefore lack the specificity needed to be effective legislation.ⁱ As UN-AIDS reports, "There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining health and human rights."ⁱ There is a difference between criminal sentencing

19 Fauci AS and Clifford LH (2001) "Human immunodeficiency virus (HIV) disease: AIDS and related disorders", p. 1852-1913. In Braunwald E, Fauci AS, Kasper DL, Hauser SL, Longo DL, and Jameson JL (eds.), *Harrison's principles of internal medicine*, 15th international ed. New York: McGraw-Hill Companies, Inc.

and civil litigation, and criminal punishment is certainly not the answer public health demands.

Only by reinvigorating the fight against HIV with this consideration of human rights can public health effectively analyze and attack the epidemic. Criminalization fundamentally infringes upon human dignity, placing blame over human life, and it does so in a way that does not at all accomplish its objectives of changing behavior for the better, but rather changes it for the worse. Criminalization serves to make the infected hide, and buries the epidemic under the surface, making couples dishonest with each other and individuals unwilling to seek treatment. Through education and sensitization about the realities of the epidemic and those who are suffering, a radical new empathy can be employed to guide a human rights approach to prevention. Then, a court would respect the situation of the woman from Bulawayo, and her and her partner's decision as consenting adults. Then, society may break away from paternalism to craft more effective

NEW TREATMENTS, OLD PREJUDICES: FIGHTING HIV/AIDS IN THE URBAN SOUTH

EMMA
WINTERS

CHARLOTTE, NC (2009): *The Mecklenburg County Commissioners passed a controversial domestic partner benefits policy during its meeting Tuesday night. Under the new policy, a Mecklenburg County employee who is in a same-sex relationship where both partners live together and share financial responsibilities, will now be eligible to receive county benefits for their partner as long as one of them is a county employee. The discussion over the issue led to a contentious exchange of words between county commissioners Bill James (Republican) and Vilma Leake (Democrat). During the public meeting, a conversation between the two was picked up by the microphones as they sat in their chairs. We caution you that what was said may be considered offensive by some.*

It all started after Leake made an impassioned speech about her son dying of AIDS.

“A son that I birthed and died of AIDS and I did not know that... in 2010 I would be sitting here... to defend his lifestyle,” Leake said.

After that revelation, tempers flared when James leaned over and whispered something to Leake about her late son and it was caught on the microphone...

James: “Your son was a homo, really?”

Leake: “I’m going to hit you, don’t talk about my son that way.”

It may be hard to hear on tape, but after reviewing the tape several times, James used a term that many consider offensive to gays. Again, this provocative exchange occurred in the open public meeting just before the commissioners voted to approve the policy.

On Wednesday, WBTW News requested an interview from James and in his email response, he did not apologize for the comment he made Tuesday night. In his statement, James said that Leake was “a religious hypocrite”

who “used her son’s ‘lifestyle’ and his death from HIV/AIDS to justify voting for benefits to allow individuals to use tax dollars to engage in the same behavior that resulted in her son’s death.” He also said “it is akin to someone whose son is an alcoholic and died from the disease, using his death from drinking as justification to have the taxpayers pay for more booze.”

Leake told us she expects an apology and the community deserves one, as well. “To literally say what he said was unacceptable,” said Leake. “I grieved because of it” (WBTW).¹

As an African American gay male in the South, Vilma Leake’s late son, DJ Leake, was part of one of the most at risk groups in the United States for HIV/AIDS. His sexual orientation put him at risk for the virus. Although men who have sex with men make up only about 2% of the population, they still made up 70% of new infections in the United States in 2014.² Not only did DJ Leake’s sexuality put him at risk for HIV, but his race also made him increasingly vulnerable to the infection. In 2015 in the United States, African Americans made up about 40% of people living with HIV, even though they account for only 12% of the population.³ In addition to his race and sexuality, where DJ Leake lived also contributed to his susceptibility to getting the infection. About 44% of people living with HIV in the United States are located in the South, even though only 37% of the population resides there.⁴ Furthermore, only eight states and the District of Columbia have higher rates of new diagnoses for HIV than North Carolina.⁵ Although Leake’s son died years ago, the layers of vulnerability that

1 WBTW. “Contentious Exchange at County Meeting.” WBTW, 16 Dec. 2009, m.wbtw.com/story/11684780/contentious-exchange-at-county-meeting.
2 <https://www.cdc.gov/hiv/group/msm/index.html>
3 <https://www.cdc.gov/hiv/group/raciaethnic/africanamericans/index.html>
4 <https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa>
5 <https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html>

affected him remain prominent risk factors today for HIV today. The risk factors that led to DJ Leake’s demise are facts that County Commissioner Bill James distances himself from through false comparison, exaggeration, and epithet. James’s language is infused with heterosexism, racism, and moral judgmentalism. If, as Albert Jonson argued, “the public language...of AIDS is as important as the science,” then public officials in Charlotte, North Carolina need to put far more effort into how they talk about the virus.⁶ As long as heterosexism, racism, and moral judgmentalism remain part of the public discourse around HIV/AIDS, the city of Charlotte will be unable to control the virus.

Although extreme in content and context, these remarks are not the only examples of Bill James publicly shaming the LGBT community and working to create an environment hospitable to the spread of HIV. James subscribes to a particular worldview in which gay people are not only seen as sexually immoral but as dangerous sexual predators. In response to the considered repeal of Don’t Ask Don’t Tell, James said, “Homosexuals are sexual predators...The US Government would not allow Hetero men and women to share showers.”⁷ The false assertions that one’s sexual orientation makes one a predator creates an environment in which stigma can thrive. Creating shame among gay people is James’s expressed goal. When North Carolina debated Amendment One in 2011, under which no union besides heterosexual marriage was acknowledged by the state, James said “The purpose is not just to prevent Massachusetts people coming down. It’s also to put a big letter of shame on the behavior.”⁸ James’s goal for the marriage amendment was to marginalize the LGBT community of North Carolina in hopes that they would stay away or leave. The HIV problem in North Carolina, and in the Charlotte area specifically, is not going anywhere without real intervention. While it is impossible to know exactly how many new infections are caused in part by this type of rhetoric, the CDC, AVERT, and UNAIDS all cite stigma

6 Keenan, James. “Four of the Tasks for Theological Ethics in the Time of HIV/AIDS,” Regina Ammicht-Quinn and Hille Haker, ed., AIDS (Concilium 3/2007) (London: SCM Press, 2007) 51-63.
7 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-re-election-seven-worst-moments/>
8 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-re-election-seven-worst-moments/>

and discrimination as significant factors that fuel the spread of the virus.⁹ James damages public discourse about the HIV/AIDS epidemic not only by making homophobic comments, but also by silencing healthy discourse about HIV/AIDS. In 1996, Tony Kushner chose Charlotte as one of the locations to perform his play *Angels in America*, which sought to capture the AIDS crisis in the 80s. Unhappy with this decision, James led the charge to cut funding from the arts program responsible for the performances. He won that charge in a 5-4 vote that stripped \$2.5 million from the Arts and Science Council.¹⁰ James has a history of targeting gay men and those suffering from HIV/AIDS that extends both before and after his comments about Commissioner Leake’s son.

These comments about DJ Leake not only exploit the vulnerability of his sexuality, but of his race as well. Commissioner James is a racist. As an outsider to the situation, he made inciting comments about the Michael Brown shooting on social media.¹¹ From a distant position, James likes to fuel the fire of race related issues. As an insider, James uses race as a way to absolve himself of responsibility for problems in the county. In what he claimed was an effort to start a dialogue about Charlotte Mecklenburg Schools (CMS), James said, “most people know why CMS can’t teach kids within the urban black community. They live in a moral sewer with parents who lack the desire to act properly.”¹² Rather than dealing with the complex reality of an education system that has experienced radical re-segregation since the end of bussing in the 1990s, James made a blanket moral judgement about African American parents.¹³ This racist statement allowed James to avoid the complexity of the school system and to avoid doing anything about it. Furthermore, comments like these perpetuate “the stereotypical way in which Blacks have been portrayed in the United States” and make “the issue

9 http://data.unaids.org/publications/fact-sheets03/fs_stigma_discrimination_en.pdf, <https://www.cdc.gov/hiv/group/msm/index.html>, <https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa>
10 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-re-election-seven-worst-moments/>
11 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-re-election-seven-worst-moments/>
12 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-re-election-seven-worst-moments/>
13 <https://www.theatlantic.com/politics/archive/2016/09/charlotte-race-history/501221/>

of sexuality...a very difficult one for the Black Church.”¹⁴ By demeaning the African American community, James makes it even more difficult for that community to talk openly about HIV prevention and treatment. James’s racism prevents him from taking the HIV crisis in the black community of Mecklenburg County seriously. Commissioner Leake represents District 2, an area of West Charlotte with a large African American community. According to data from 2015, part of what is still considered Leake’s district has an HIV prevalence of 2,580 per 10,000 people, and 70% of people living with an HIV diagnosis in Mecklenburg County are African American.¹⁵ James’s callous comments to Commissioner Leake reflect not only his lack of concern for DJ Leake, but also his disregard for all black lives. James’s discrimination is as layered as DJ Leake’s vulnerability.

Behind all the prejudice of Commissioner James is a deep sense of moral judgmentalism. James called Commissioner Leake “a religious hypocrite,” and said she “used her son’s ‘lifestyle’ and his death from HIV-AIDS to justify voting for benefits to allow individuals to use tax dollars to engage in the same behavior that resulted in her son’s death.”¹⁶ By calling Commissioner Leake a religious hypocrite James tried to make the issue about orthodox belief regarding homosexuality. He wanted to avoid addressing his insensitive comments about a colleague’s deceased son and his lack of concern about high HIV rates in Mecklenburg County. By addressing the issue in this way, James showed that he has a childlike need to blame and did not want to descend into the specifics of the situation. James blamed Commissioner Leake for the problem directly, stating that the policy she voted for would increase AIDS related deaths. James assumed the policy of granting benefits to the same sex partners of county employees would increase AIDS related deaths. If James had cared about the details of gay men infected with HIV, James might have asked himself: How many tax dollars does a gay couple need to have sex? Do people have riskier sex if the state recognizes their relationship? Would granting benefits, such as health insurance, to county employees’ partners make them

more or less likely to seek lifesaving treatment for HIV? James does not care about the answers to those questions. The only detail he needed to know about the circumstances of DJ Leake’s death was that he was gay. This knowledge allowed James to feel safe from the disease and safe from his responsibility in prevention as a public official.

By this point, Bill James’s flaws should be clear, but James’s comment to Leake and his attitude about HIV/AIDS indicate larger problems. James’s comments about HIV matter because he is in a position of power. According to the Mecklenburg County government website, county commissioner’s jobs include “establishing priorities of the many community needs, especially those related to health, education, welfare, mental health and the environment.”¹⁷ With each comment, James neglects his duty to establish HIV as health priority in a county that has more than double the national average in new diagnoses.¹⁸ Even more problematic than James’s neglect is his continued reelection. He remains in office in his 11th term, and has been reelected four times since he insulted DJ Leake for his AIDS related death. The fact that James continues to win elections reveals that a significant number of other people believe what he does about HIV or do not care about the epidemic. As an elected representative, James represents common misconceptions about HIV and its prevention. It is tempting to paint a narrative of pure progress on this issue in Charlotte. The other four commissioners who voted to cut funding over the Angels in America production have all since been ousted from the commission by LGBT activists, and the meeting at which James made the comment ended in a vote in favor of the county recognizing LGBT relationships.¹⁹ While those details are positive, looking to the national stage, it is clear that brash, bigoted statements—like the ones James has made—are becoming more acceptable in public discourse. When CMS stopped allowing transgender students to use their choice bathroom, James tweeted a derogatory comment about transgender girls, using the term “tranny.”²⁰ In response to an article about this incident,

one commenter said, “Bill James is Mecklenburg County’s very own Donald Trump.”²¹ James’s hateful language is increasingly being legitimized by politicians and public figures, like Trump, who see the norms of political correctness as too constrained to allow for debate. Some of these concerns are legitimate, but that does not mean derogatory comments by elected officials are acceptable, good, or helpful. Negative comments about gay men and transgender women are a serious threat in the AIDS epidemic. In the United States, we need to take the impact of language into account, not so we can take more offense, but so we can recognize its true power. Those in media and in positions of power should be less aghast and should start asking more incisive questions. Some apt questions for Bill James back in 2009 would have been: Why was it important for you to clarify DJ Leake’s sexuality during the meeting? Why did you whisper the question to Commissioner Leake rather than speak into your microphone? Why did you choose the term “homo?”

14 Hayes 98, CEHP

15 [https://aidsvu.org/map/#{"city":"charlotte","datatype":"prevalence","maptype":"city","overall":"selected","ratescases":"rates","zipcode":"selected"}](https://aidsvu.org/map/#{)

16 m.wbtv.com/story/11684780/contentious-exchange-at-county-meeting.

17 mecknc.gov

18 <https://www.hivplusmag.com/stigma/2017/11/22/why-charlotte-hiv-capitol-north-carolina>

19 <https://goqnotes.com/41252/homophobic-racist-commissioner-bill-james-running-for-reelection-seven-worst-moments/>

20 <http://www.charlotteobserver.com/opinion/letters-to-the-editor/article94449867.html>

21 <http://www.charlotteobserver.com/opinion/letters-to-the-editor/article94449867.html>

