

Revisiting “Post-AIDS”: Understanding Gay Community Responses to HIV Then and Now

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Abstract (343 words)

When the first author coined the term “post-AIDS” in 1996 and later that year presented a paper on it at the XI International AIDS Conference in Vancouver, the goal was to frame a growing division in the responses of Australia’s gay communities related to HIV serostatus and diverging priorities in prevention and in care and support for people living with HIV. At that time, some thought post-AIDS meant that AIDS was over. No, it did not. Others thought it meant an end to HIV as a “crisis. No, it did not. Later, some saw it as a precursor to recent slogans such as the “end of AIDS” and an “AIDS-free generation”. No, it was not. Finally, some applied the term to other groups affected by HIV. No, the term referred specifically to Australian gay communities but was quickly taken up in the U.S.A. Post-AIDS described a widening division between HIV-positive and HIV-negative gay men, starting in the early 1990s with discussions on what became known as “serosorting” (selecting sex partners of the same HIV status), discrimination in the choosing of same-status sex partners (sometimes framed in terms of HIV stigma) and, with the advent in 1996 of effective antiretroviral therapies, a renewed focus on treatment and away from HIV prevention. This division remained in play until the arrival of PEP (post-exposure prophylaxis) and PrEP (pre-exposure prophylaxis). Subsequently, when treatment improved to achieve an “undetectable” viral load, a new slogan arose, U=U (undetectable equals untransmissible), and HIV treatment itself is regarded as prevention (TasP). These changes have given treatment and prevention a common focus that remedicalizes HIV by placing all gay men under the scrutiny of the clinic. It is timely to re-assess post-AIDS to understand gay men’s relation to HIV and each other, its usefulness to other HIV-affected communities, and its relevance to effective vaccines, an HIV “Cure” and emerging treatment advances. This re-assessment takes place in a global context of nearly two million new HIV infections yearly and 40% of those infected still unable to access treatment. AIDS is definitely not over.

Introduction

When the first author of this chapter coined the term “post-AIDS” in 1995 (see Dowsett & McInnes, 1996a) and presented a paper on the idea to the XI International AIDS Conference in Vancouver in 1996 (Dowsett & McInnes, 1996b), the goal was to examine growing division in the responses of Australia’s gay communities to their continuing HIV epidemics. This idea was an attempt to re-read the everyday experience of the epidemic at a time when investigating the natural history of HIV infection preoccupied biomedical science. That growing division was configured partly by HIV serostatus but also by diverging priorities between HIV prevention and care and support for people living with HIV (PLHIV).

The Vancouver conference also saw the announcement of the first effective or highly active antiretroviral treatment (HAART, later ART) for HIV infection, which within a decade was to convert HIV infection from a terminal illness ending in AIDS to a chronic manageable condition, at least for those with access to good quality medical care and ART. This announcement is sometimes called the “Protease Moment”. The news of effective medications—at least in the short term—was momentous as it marked the beginning of a new phase of responding to the global epidemic, a phase characterized by the first real treatment successes, but also by divisions and conflicted positions on the dramatic turn in the epidemic that ART produced.

At the time those two papers on post-AIDS were presented, some commentators thought the term post-AIDS was intended to mean that the epidemic was over. This interpretation was buttressed by the arrival of ART. Importantly, the idea of post-AIDS did not and was never intended to mean an end to the epidemic. Indeed, the epidemic continues to this day. Others thought the term was calling an end to AIDS as a “crisis”. This too was incorrect, although

there was a gesture in the papers, drawing in part on the psychological work of Walt Odets (1995) on the situation facing HIV-negative gay men in the U.S.A. at that time, towards a need to rethink the singularity of the ongoing experience of those affected by the epidemic and, in particular, HIV-negative Australian gay men. It was no longer a crisis for all gay men, but it did not refer to an end to the crisis.

More recently, some have seen the term post-AIDS as a precursor to slogans such as the “end of AIDS” or an “AIDS-free generation”, which emerged early in the second decade of the new millennium. The term did not mean that, nor was it intended to contribute to the development of these kinds of slogans. These catchphrases derive from a dynamic in the global response to the epidemic that arose first with the establishment of the International AIDS Society (IAS) and the World Health Organization’s Global Programme on AIDS (WHO/GPA) in the late 1980s, which sought to encourage rapid governmental responses to the epidemic around the world, and later the Joint United Nations Programme on HIV and AIDS (UNAIDS) in the mid-1990s, which succeeded WHO/GPA and sought to coordinate the responses of various United Nations (UN) agencies and other global nongovernmental organizations. These agencies, positioned at the peak of the global response in terms of policy coordination and communication over the life of the epidemic have played an increasingly central role in shaping how we see, understand and, therefore, respond to the epidemic (Seckinelgin, 2017).

Finally, some commentators have applied the term post-AIDS to groups and populations affected by HIV other than gay men. The term originally referred very specifically to Australian gay communities. It is undoubtedly the case that the Australian gay communities’ responses to HIV were deeply influenced by those in the U.S.A. and, to a lesser extent, the U.K. There were, however, significant differences that emerged in the 1980s and continued to

do so well in the new millennium. Not the least of these was the early and rapid, federally coordinated, national response to the epidemic in Australia from 1984 onwards, something that did not occur as readily elsewhere. For example, little by way of a national response developed in the U.S.A. until very late in the second term of President Reagan, being finally encoded into a national strategy only decades later under the Obama administration.

That said, the term post-AIDS was quickly taken up and used in the U.S.A. after the first author met the late Eric Rofes, a prominent gay activist and leading HIV/AIDS educator from San Francisco, at the Vancouver conference. Rofes took up the term and reconfigured it to the situation facing U.S. gay communities in the second of his influential books – *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Cultures* (1998), which argued for an end to seeing the epidemic as a crisis and contributed much of that particular meaning to the term as a result.

What did post-AIDS really mean?

As originally employed in Australia, the term post-AIDS described a widening divide between HIV-positive and HIV-negative Australian gay men, starting in the early 1990s. It began from a discussion on what was happening within gay sexual cultures and could only have happened after the development of PLHIV as a distinct community of interest and circumstance in the late 1980s. A seminal moment in this development occurred at the 2nd Australian National AIDS Conference in Hobart, Tasmania, in 1988. Gay community activists attended this conference in large numbers and during the final plenary session, a call was made for people living with AIDS (the term then used) to come to the stage to be seen. Many people living with AIDS left the audience for the stage and thereby “came out”

publicly. Arms linked and to tremendous applause, they claimed a collective place in the center of the epidemic and national HIV politics.

This period is analyzed in the late Robert Ariss' posthumously published book *Against Death: The Practice of Living with AIDS* (1997). Ariss was a leading and founding member of the first PLHIV organization in Sydney—PLHWA, New South Wales [NSW]. He drafted its constitution and became its first convener. Ariss had a canny eye for the politics of the period, including the concatenation of HIV with longer-standing forms of gay activism that had developed since the early 1970s with the rise of gay liberation theory and politics and the “sexual revolution” inspired by it and second-wave feminism. During this period, PLHIV became a collectivity that constituted:

...a discursive systematization of the experience of HIV positivity into a strategic “anti-discipline.” This new identity, frail because built on the anticipation of death, drew on the established identity formations of gay identity and the “empowered patient”, the latter formulated within women’s groups and groups of the disabled”.
(Ariss, 1997: 135)

Gay communities and the politics of AIDS

The epidemic in Australia was and has always been largely confined to gay men, with relatively small numbers of infections among women, sex workers and people who inject drugs. As a result, the model for PLHIV politics derived much from gay community politics and the struggles for equality and social justice within them. While the epidemics in some high-income countries are different in the proportion of infected people who were and are men infected through sex with other men, the centrality of the contribution of gay activism in almost all high-income countries to shaping the politics of and responses to their epidemics is

incontrovertible. It is for this reason that we use the example of Australia to provide a context for the development of post-AIDS as a concept at that time.

Sex between men was still illegal in most of Australia when HIV struck, and anti-gay forces opposed any movement toward social equality for gay (and lesbian) people. While some progress had been achieved by the early 1990s, and the politics of gay civil rights were still active, they had dovetailed with HIV politics to the extent that, in the minds of many, HIV-positive people and gay men became synonymous. It is in this climate of progressive gains but continuing opposition that HIV politics and gay politics fused.

By the early 1990s, as the death rate from AIDS was heading towards its peak, and the politics of AIDS increasingly featured the voices of PLHIV, issues of discrimination added fuel to fire among HIV-positive gay men. Stigma and, to a lesser extent, discrimination were to develop into an important political framework that captured a wide range of HIV-related issues over the next 20 years, acting as a growing “hold-all” for struggles over treatments provision and access, approaches to HIV prevention, and legal responses to the epidemic (see Parker & Aggleton, 2003).

Cracks in the façade

This arena was ripe for re-framing issues that arose early in the epidemic. Such issues were reliant not just on external stimuli; they soon turned inward. One that became clear in the early 1990s among Australian gay men was that of sex partner selection and the discriminatory selection of HIV-negative partners by men who were also HIV-negative. To our knowledge, no social or behavioral research evidence confirmed that this was occurring on a wide scale, but anecdotal reports of partner selection practices were rife and caused

significant resentment among PLHIV who had already been subjected to mainstream anti-gay criticism of their sexuality based on their HIV serostatus. This was the first of emerging divisions among gay men related to their differing experiences of the epidemic.

One response to this issue of sex partner selection was to advocate for HIV-positive people to select only other HIV-positive partners—the discriminatory aspect of which went largely unnoticed. This kind of partner selection was eventually termed “serosorting“, and the practice was even advocated by some PLHIV activists as a form of infection control to prevent onward HIV transmission. In a study of the social impact of HIV/AIDS with Australian HIV-negative men, which the first author and Ariss conducted in Sydney and Adelaide in the early 1990s (and which gave birth to the term post-AIDS), the selection of partners of the same serostatus was seen as one acceptable strategy to remain uninfected. Furthermore, in Adelaide with its small epidemic, it was clear that a sense of crisis was hard to find. Most gay men there did not even know anyone infected and the representations of the devastating epidemic in Sydney (and the rest of the world for that matter) just did not resonate with local experience. It seemed that after 10 years of epidemic some HIV-negative men were no longer well-served by HIV prevention education programs that continued to represent AIDS as a crisis for everyone all the time.

By that time, related research had revealed further sophistication in gay men’s sexual responses to the epidemic. Social researchers in Sydney, to some alarm from their colleagues in the U.S.A., had published on what was termed “negotiated safely” in the sexual practices of Australian gay men (Kippax, Crawford et al., 1993). These findings confirmed those of an earlier study (Kippax, Connell et al., 1993) in which agreements on using condoms and other safe sex practices had been assessed. Negotiated safety referred to HIV-negative gay men in regular (or primary) relationships making clear agreements on safer sex with their similarly

HIV-negative partners, e.g. not using condoms inside the relationship, but restricting sex practices in various ways with other partners outside the relationship (condoms always, no anal sex etc.). HIV-positive men had already worked out that condoms were not needed in same HIV-status sex, so it was not a surprise to find the emergence of a parallel strategy among HIV-negative men. The surprise lay in the fact that HIV prevention education had only ever advocated using condoms every time for everyone and was still doing so. Gay men, irrespective of serostatus, had clearly moved on from any singular experience of the epidemic. As the first author commented in 1995 at the 2nd National Gay Educators Conference in Sydney:

Segregated partner choice is already happening; how...it is to be configured is up to us. We can decide to retain some outdated notion of blanket safe sex education. We can classify such choices as discriminatory, thus exacerbating an artificial divide based on serostatus which obscures our much greater commonalities. Or we can embrace the ingenuity involved in gay men's evolving sexual practice and re-incorporate it into our collectivity, into our safe sex culture. (Dowsett, 1995: 71)

What these discussions of gay sex revealed was a fissure in the, until then, unified experience of and response to the epidemic in Australian gay communities. There was still a crisis unfolding for HIV-positive people as treatments at that time, though growing in number, were still toxic, partial and sometimes ineffective. Those who were infected were still facing a foreshortened life and were often regarded as “diseased pariahs” (Long, 2000) in a still largely unsupportive and stigmatizing society. Yet, HIV-negative men, not only those who had known their status for quite a while and those who had very little direct experience with HIV-positive people, but also those who had lost many lovers, friends and family members, could no longer live lives on a knife's edge, even if infection might always be proximate—only one unsafe sex event away. This division in the sexual experiences and unfolding futures

of gay men, based on serostatus, could only widen—and it did so with the arrival of ART. It was the combination of these issues that post-AIDS as a concept sought to frame.

The “Protease Moment”

The arrival of ART added weight to these changes already in motion. Hitherto, most efforts internationally had focused on HIV prevention. That is not to say that the search for vaccines or treatment, or better clinical practice to forestall death were not priorities. However, the absence of effective treatment meant that classical biomedical responses took a back seat to HIV prevention, the latter supported by both significant epidemiological and social/behavioral research that had arisen to inform it.

What the protease moment did was change the balance between prevention, treatment and care to one in which treatment, and the possibilities of it, became a larger focus, thereby transforming the politics of AIDS globally. It created two clear but different priorities. For PLHIV, treatment and its politics, advocacy, science, effectiveness, cost, access and availability were to become the focus. For those not infected, these issues were also of major concern, but prevention remained the priority. As treatment changed, and its costs rose with every new treatment drug, the increasing allocation of public health resources toward treatments became another fissure. This first substantive success for HIV treatment began a new process of “re-biomedicalization” of the epidemic, which was to lead to a reconceptualisation of many aspects of the epidemic over the next 10 to 20 years, including but not restricted to the contribution of gay communities and PLHIV. Post-AIDS flagged a number of these issues and noted these fissures and the fracturing of any singular conception and experience of the epidemic in a linear sense, suggesting diverse and multiple strategies were needed instead.

Almost immediately after the protease moment, however, two things became clear. The first was that the then available drugs were not perfect. Despite great success in some cases, many drugs had serious side effects and were not suited to every individual. New drugs were developed between 1996 and 2006 by the global pharmaceutical industry with breathtaking speed to deal with this issue. The second issue was that the high cost of ART revealed significant problems of affordability (and profiteering) for HIV-positive people and public health systems (where these were supposed to provide or subsidize such drugs) playing into the unacceptable social inequalities that underpinned the epidemic. These inequalities were not just between wealthy and poorer citizens in any given country; global inequality between countries was exposed in starker terms that had been talked about for many years in international discourses of neoliberal-inflected international development. The demand for equal access to ART came to the fore at the XIII International AIDS Conference held in Durban, South Africa, in July 2000—the first time the conference had been held in the Global South. There, in another signal post-AIDS moment, activists from the Global South exposed not just inequality, but also the lack of access to ART and the privilege of Global North PLHIV already with access demanding better and cheaper drugs as their main agenda. It is possible to trace from this moment a rapid increase in the growing global treatment access movement that began not long after the protease moment occurred.

South Arica was to provide a graphic example of this kind of activism in its Treatment Action Campaign, which finally forced the post-apartheid government to provide ART as part of a constitutionally guaranteed right to health. Such activists and their allies in various agencies, e.g. UNAIDS, built a global treatment access and equity movement during this period that came to a head at the UN General Assembly Special Session on HIV/AIDS in 2001. From that moment, a massive scale-up of treatment was initiated throughout the 2000s, producing

various global health initiatives such as WHO's 3x5 (3 million HIV-positive people in treatment by 2005), the creation of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (a new global financing organization to fund the world's response to the epidemic), and new large-scale programs such as the U.S. Government's PEPFAR (President's Emergency Plan For AIDS Relief) initiative with its mammoth increase in funding.

However, while these extraordinary efforts recognized both the need for more affordable and effective drugs and began to address global inequalities in treatment access, the scale-up in activity also stimulated the re-biomedicalization of the epidemic, convincing many scientists, public health professionals and activists that a biomedical silver bullet would not only be effective but could also constitute the answer to HIV and AIDS. By 2010, this re-biomedicalization, driven by treatments development and activism, overtook prevention as the central strategy to slow and stop the epidemic. Attention soon turned to other “technologies” as the new buzzword for action. Condoms became a prevention technology, not just a safer sex adjunct; medical male circumcision was rolled out, mainly in sub-Saharan Africa, despite considerable skepticism and ongoing global criticism (Aggleton, 2007; Couch & Dowsett, 2007; Earp, 2015; Parker et al., 2015). Prevention education and community-based health promotion became the subject of “prevention science”, with an insistence that all prevention research adopt randomized control trial methodology, irrespective of population or context or whether the methodology was appropriate for the research questions being asked.

The next step in this process of re-biomedicalization came as disease prevention itself shifted from a broad-based public health approach to a narrower biomedical prevention framework, exemplified best in advocacy for the use of HIV treatments to prevent incident infections. The strategy was to deploy ART for HIV-positive people to reduce the onward transmission

of HIV to uninfected others, as a result of achieving viral suppression at individual and community levels (“treatment as prevention”, or TasP), and combine this with the use of ART for uninfected sexual partners of HIV-positive people to prevent their infection (“pre-exposure prophylaxis”, or PrEP). For this strategy even to be contemplated, a decisive discursive shift had to occur in the longstanding framing of the epidemic as an ongoing emergency and crisis. This was to arrive in the “end of AIDS” narrative, which soon came to dominate the fourth decade of the epidemic.

From the “Protease Moment” to the “end of AIDS”

By the late 2000s, with the perceived success of ART signaling the value of biomedical approaches to HIV prevention, and hot on the heels of significant advances in the scale-up of treatment access, the protease moment began to give way to a new era of optimism about the possibility of the imminent “end of AIDS”.

Globally, the seeds of what would later come to be the “end of AIDS” discourse were planted in a 2010 UNAIDS document that defined the agency’s strategic plan for the 2011-2016 period (UNAIDS, 2011). In something of a reversal of UNAIDS’s messaging to date, which had tended to stress the growing seriousness of the epidemic but begun to lose traction, this strategic plan focused on “getting to zero”, meaning the intentionally aspirational goals of achieving zero new infections, zero AIDS-related deaths, and zero discrimination. The strategy was formally articulated in the “Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS”, adopted by the UN General Assembly on 10th June 2011 (UN Resolution 65/277), committing to the goal of “getting to 50%” (on the road to zero) by 2015. As Michel Sidibé, then Director of UNAIDS, wrote in his preface to the media material for the launch of the 2001 World AIDS Day Report, issued on 1st December 2011:

Just a few years ago, talking about ending the AIDS epidemic in the near term seemed impossible, but science, political support and community responses are starting to deliver clear and tangible results. (UNAIDS, 2010: 5)

The Political Declaration adopted by the General Assembly committed the UN to a set of new targets with “with a focus on clear, time-bound goals designed to bring about the end of HIV and also improve human health across diverse communities” (UNAIDS, 2010: 5). To reach these targets, the Declaration also argued that the world would need to “step on the accelerator” and adopt “a new framework for AIDS investments, focused on high-impact, high-value strategies” that had been mapped out by UNAIDS.

This new approach was rolled out for prime-time publicity in the media frenzy surrounding the XIX International AIDS Conference in Washington D.C. in 2012. This was the first conference to be held in the U.S.A. since 1990. Counting on significant involvement of the U.S. administration, and with former U.S. President Clinton and the former First Lady, by this time U.S. Secretary of State, Hillary Clinton in attendance, the conference announced an end to mother-to-child transmission in the District of Columbia (hence, the claim of an “AIDS-free generation”). The announcement was accompanied by a show of optimism from the biomedical research establishment with the launch of the International AIDS Society’s “Toward an HIV Cure” initiative (Deeks & Barré-Sinoussi, 2012).

On the heels of the 2012 international conference, with the government of the U.S.A. and its PEPFAR project on board, and the international scientific community, as well as the pharmaceutical industry as willing partners, came the development of the UNAIDS “Fast Track Strategy” (UNAIDS, 2014a, 2014b). Now the goal was to become “90-90-90” (90% of people with HIV diagnosed, 90% of diagnosed people on treatment, and 90% of treated people with fully suppressed viral load) by 2020. This strategy was formally launched, again

with an elaborate media campaign, in a 2014 UNAIDS document that explicitly articulated the goal of ending AIDS by 2030 (UNAIDS, 2014c). The new goal was first announced at the XX International AIDS Conference held in Melbourne in 2014, where the emerging “success story” was heralded by the global scientific community and increasingly amplified in the mainstream media (The Economist, 2014). In October 2014, the “Fast-Track Strategy” was published as “an ambitious treatment target to help end the AIDS epidemic” (UNAIDS, 2014c). On 1st December 2014, it became the focus for World AIDS Day media coverage, with the “90-90-90” targets for 2020 marketed as a necessary step to be able to end the epidemic in 2030 on schedule to achieve the UN’s Sustainable Development Goals, in which the epidemic received a specific mention (Kenworthy et al., 2018a).

As soon as the Fast Track Strategy was issued, most major donor agencies began to endorse it, and key players such as PEPFAR, the Global Fund and UNICEF (the United Nations Children's Fund) issued statements that articulated the “end of AIDS in 2030” as the global AIDS movement’s overarching goal (The Office of the U.S. Global AIDS Coordinator 2014; The Global Fund 2014; UNICEF 2015). By 2015, private donor buy-in was increasingly evident, noted in statements by well-known figures such as Sir Elton John and his husband David Furnish for the Elton John AIDS Foundation (Furnish, 2015; The Guardian, 2015). Civil society organizations were also encouraged to rally around the slogan through U.N.-sponsored events such as large civil society organizations meetings that UNAIDS organized in Bangkok in 2015, which aimed to mobilize support for the “90-90-90 by 2020” and the “end of AIDS by 2030” goals (Equal Eyes, 2015; amFAR, 2015).

In the echo chamber of both the international development industry and the mainstream media of the digital age, the speed and ubiquity with which this policy goal was embraced began to make it seem something of a fait accompli (Kenworthy et al., 2018a, 2018b).

Indeed, it came almost as an anti-climax when, in June of 2016, the UN General Assembly held a High-Level Meeting on Ending AIDS and officially adopted the new “Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030” (UNAIDS, 2016). Just a month later, the Declaration had been endorsed by the scientific and policy communities of the international AIDS movement in both the scientific sessions and the media briefings at the XXI International Conference on AIDS held for the second time in Durban, South Africa, in 2016.

It is important to stress just how different this “end of AIDS” narrative was from the post-AIDS understandings of increasing separation and division described earlier in this chapter. While the concept of post-AIDS was strongly informed by grassroots, community-initiated responses to the epidemic, in contrast, the “end of AIDS” story was a top-down, deliberate manipulation of the epidemic narrative in the face of clear evidence that all was not well in the epidemic. Paradoxically, the international AIDS conferences that were used to herald the “end of AIDS” narrative provided the very same platform for literally hundreds of scientific papers and plenary presentations that made it clear how deeply problematic the “end of AIDS” story was when confronted with the reality of the epidemic for affected individuals and communities. As just two examples, we might point to Filipino, HIV-positive, gay man, Laurindo Garcia’s final plenary address to the same 2012 conference on the still-pervasive discrimination experienced by gay and other men who have sex with men, and incoming IAS President and Nobel Prize winner Françoise Barré-Sinoussi’s plenary challenge to all with its list of “unacceptable” things still occurring in the global response. Both contrasted sharply with former U.S. President Clinton’s “Energizing Call to Action” in closing that conference.

Looking beyond the sloganeering of administrators and bureaucrats and listening to those most affected by the epidemic, what was soon evident was a rapid multiplication of relations

to the epidemic in the form of greater inequalities in access and outcomes, old epidemics reviving (among gay and other men who have sex in Brazil or Thailand, for example), small epidemics exploding (among men who have sex with men and people who inject drugs in the Philippines), deteriorating social responses (such as the passing of anti-gay laws in Nigeria and Uganda, the continuing criminalization of HIV transmission, sex work legalization), and vastly different, poorly articulated legal and governmental frameworks in abundance revealed by the Global Commission on HIV and the Law report (2012) *Risks, Rights and Health* and the WHO report (2015) *Sexual Health, Human Rights and the Law*. The epidemic was increasingly multi-faceted, occurring in many parallel versions rarely in step. At the very same time, there was clear evidence of a heterogeneous post-AIDS-like multiplicity being discursively homogenized (as an “end of AIDS”) in a manner that insulted the intellect of and marginalized those most affected.

In one way, this discursive maneuvering amounted to serious misuse of science, contributing to and covering up the progressive fracturing of affected communities. A reification of scientific expertise not only reproduced Paulo Freire’s (1970) “banking theory” of pedagogy—in which experts deposit supposedly true information (the epidemic is ending) into the deficit accounts of the objects of their knowledge who were assumed to know nothing—but actually intensified the stigma experienced by, and its effects on, those directly affected by the epidemic. Inadvertently or not, the “end of AIDS” narrative further fractured affected communities (so-called “key populations”), reinforcing HIV-positive and HIV-negative divisions and creating numerous other social categories (Truvada “whores”, PrEP “refusers”, circumcision “denialists”, and so on), now seen as traitors to the epidemic. These new post-AIDS effects contributed to the conflation (and misreading) of prejudice, hate, vitriol, injustice and other forms of oppression as a singular “stigma”, while at the same time combatting stigma and discrimination has increasingly fallen beneath policy priorities and

outcome indicators, now reduced to biomedical markers of success such as “90-90-90”.

Taken together, all this made any coherent community-conceived and initiated response to HIV much more difficult, perversely promulgating the conceit that the “end of AIDS” would be possible only through the enlightened leadership of global administrators and bureaucrats who would take the necessary steps paternalistically to ensure that no one would be “left behind”.

Crucially, unlike this contemporary vision of an “end of AIDS”, the post-AIDS analysis originally emerged precisely from the context of (gay) communities’ responses to the epidemic, and never suggested that the epidemic was close to ending. Rather, it sought to understand and interpret the fracturing and fragmenting of an epidemic as it impacted upon the changing experiences of those affected by it. The “end of AIDS” story, in contrast, was invented and articulated first and foremost from the top down by administrators and bureaucrats. It posited a kind of biomedical Potemkin Village—a fantasy world that almost completely ignored the grim reality on the ground, largely disconnected from experience grassroots experience and invented in conferences and board rooms. As just one example, 30 years on from the protease moment, only 62% of PLHIV globally currently have access to HIV treatment (UNAIDS, 2019), and a significant percentage of those who do have access to medication in low and middle-income countries only have access to first- and second-generation medications with significantly greater side effects. An “end to AIDS”? Well no, these events typify the division and fracturing that first characterized post-AIDS that is with us still in 2020.

The period between 2001 and 2010 also saw a significant shift of power from affected communities to large global institutions and an increasing sidelining of the social response to the epidemic. Until the protease moment, the prevention of HIV infection had been largely a community-initiated activity underpinned by health education and promotion principles and social and community research. As ART improved, the process of re-biomedicalization was accompanied by a “scientization” of the social aspects of the global responses. The notion of “prevention technologies” shifted the focus of prevention (and the funding streams) away from the socially created and subculturally derived responses to HIV that had so successfully managed the epidemic in the earlier years. For example, the invention of safer sex by gay men in the early 1980s was based on gay men’s understanding of sexual practices and relationships well before HIV had been isolated and identified as the cause of AIDS. Likewise, later strategies of negotiated safety and serosorting had their origins, not in public health and prevention science, but in the creative responses of affected individuals and communities—again, gay men—as did the safer drug use practices among people who inject drugs that eventually led to widespread syringe and needle programs and the safer sex and drug use strategies adopted by sex workers with their clients early in the epidemic.

For affected communities worldwide, this marginalization and progressive loss of control were masked by the urgency of a solution to AIDS and formed a trap of their own making. Since the epidemic had begun, community-based prevention programs and care and support for HIV-positive people had adopted culturally appropriate language and imagery. Prevention education materials often featured colloquial phrases, slang terms and attractive images to promote safer sex—in essence, slogans in their own right, e.g. “You’ll never forget the feeling of safe sex”, “Condoms are cheaper than AIDS”, “AIDS: prevention is the only cure”, and ones related to supporting PLHIV such as “Hate the disease, but not the diseased!” and “Silence = Death”. Collectively, these programs and resources amounted to an extraordinary

catalogue of cultural creativity over 38 years, and international AIDS conferences have long celebrated and promoted this ingenuity in the global villages, filled with activists and community-based organizations still doing grassroots prevention and supporting PLHIV, which accompany the scientific program.

However, this use of catchy phrases and colloquial terms was easily colonized as re-biomedicalization proceeded. In a bizarre twist, the slogans developed by international agencies began to attract affected communities' support. For example, worldwide treatment supply problems became a conference theme 'Access for all'. Its companions—"Breaking the silence"; "Time to deliver"; "Knowledge and commitment for action"; "Turning the tide together"; "Access equity rights now"; "Breaking barriers, building bridges" and "No one left behind"—quickly followed, each ever more glib and each reducing complex and intractable economic, political and social issues, and inequalities to the clever use of the English language. There are numerous other examples, but the point is that affected communities were co-opted into the process, as these goals, phrases and slogans increasingly informed the priorities and cultures of community-based action. The "end of AIDS" was just another moment in this successive co-option, despite the fact the end of the epidemic was nowhere in sight even in those countries where HIV incidence rates were dropping.

Even re-biomedicalization itself had become a victim of this sloganeering. The success that ART achieved in controlling HIV infection in those in treatment and reducing viral load to undetectable levels provided grounds for a new slogan: "U=U" (undetectable viral load equals untransmissible HIV) now heavily promoted by affected community activists. The science behind this assertion is very strong. However, there are caveats in viral load assessment (e.g. treatment effectiveness and adherence, medication supply and access, drug resistance, sex partner susceptibility to infection, e.g. having STI lesions, patient

misunderstandings of viral load status, and so on). As just one example, a recent report from three U.S. cities (Atlanta, Boston and Chicago) found that, while 72.5% of 314 HIV-positive gay and bisexual men accurately reported their viral load, 7.5% thought their viral load was detectable when it was suppressed, and 20% said their viral load was undetectable but tests indicated this was not the case (Stephenson et al., 2020). The current science tells us that undetectable is very likely to be untransmissible, but as scientific paradigms evolve so does the “truth” or facticity of scientific certainty. The virus mutates; treatments can become less effective over time; ART does not work equally well in everyone; health systems change; global funding for treatment is never certain and rarely grows despite the need. While the use of ART not just to keep HIV-positive people healthy, but also to prevent onward transmission of HIV (the underlying premise behind “U=U”) is a major step forward in prevention, it remains dependent on potentially confounding social and contextual factors. Yet, like the “end of AIDS”, these discursive maneuvers now drive affected community action as if they were incontrovertible truths.

The second issue underpinning post-AIDS had been “discrimination” based on HIV serostatus. This issue, framed by the notion of “stigma”, was to provide a platform for a second major arena of leadership by PLHIV and affected communities. We noted earlier the origins of the politics of stigma and discrimination in 1970-80s gay liberation activism and its centrality to PLHIV identity formation. From the late 1990s onwards, the agenda in this politics expanded to include an array of issues drawing on human rights, legislative changes to decriminalise sexual activity of various sorts and protect other minorities, health service provision and access, race/ethnicity and socioeconomic status, education and employment issues, and many more (AVERT, 2020). As a “hold-all” term, HIV stigma has travelled a fair distance from stigma’s original meaning as defined by Goffman (1963). While providing a successful rallying cry and focusing attention on an increasingly wide range of issues, there

must be doubt that all that is regarded as occurring under its banner is, indeed, stigma and/or discrimination. It is distinctly possible that these terms mask more complex underlying social processes that prevent the global response to HIV from addressing the real structural and political drivers of the epidemic.

Just two examples of these drivers may suffice: the extraordinary profiteering of multinational pharmaceutical companies that underpins ongoing problems in ART access and supply; and the profound effects of neoliberal economic policies at international and national levels that are exacerbating poverty and marginalization, driving mass migration, the disenfranchisement of millions of people, and placing the planet in peril for the many to guarantee the profit of the few. The increasing vulnerability of huge numbers of people provides a near-perfect ecology for disease development and HIV infection is one of these. Indeed, as UNAIDS (2020, online) admits: “The pace of progress in reducing new HIV infections, increasing access to treatment and ending AIDS-related deaths is slowing down”. Put quite simply, the “end of AIDS” is nowhere in sight.

Earlier in the epidemic, responses to some of these issues began to be framed as human rights, especially via the “right to health”, as a way of registering the structural forces driving the HIV epidemic yet almost invisible in the dominant biomedical framing through which the epidemic was largely conceived. Human rights issues have become increasingly prominent over the last 30 years. Issues such as women’s vulnerability and the illegal status of sex between men are just two examples. The WHO report (2015) on *Sexual Health, Human Rights and the Law* is just one of many more recent attempts to position human rights as central in the global response. This is a signal achievement of HIV in transforming global health. Hitherto, there had never been any attempt during the twentieth century to frame malaria or tuberculosis (or other medical conditions) in this way until their coming together

with HIV/AIDS with the advent of the Global Fund. That said, one important concern is that efforts to tackle stigma and discrimination during the first two decades of the epidemic were largely driven by affected communities fighting for themselves (derived initially from gay liberation politics as we noted earlier), whereas current discourse on these issues is increasingly disconnected from reality on the ground and practical actions that address its root causes. The work of research scientists and institutions endlessly measuring and monitoring “stigma” and the production of ever more complex expert documents such as the WHO report mentioned above provide but two examples of this process. As a result, human rights and stigma have become other slogans just like an “end of AIDS”, a kind of “must-have” tag line always to be mentioned, or at the least nodded to, but very few real or effective programs or policies have been developed specifically to combat these issues on the ground.

This gulf between the expert discourse and the real experience of the HIV epidemic marks a new aspect to the post-AIDS epidemic, which is no longer just a dispersal and fracturing of focus or diverging futures among those most affected. Notions such as having “partnership” with affected communities as government policy, or the Greater Involvement of PLHIV (the GIPA Principle), and other phrases in many and varied forms have become smokescreens. Together, they mask the actions of a neoliberal cartel of UN agencies, international NGOs and development aid organizations, huge philanthropic foundations such as the Gates Foundation, and the global pharmaceutical industry seeking to manage both the epidemic and its narrative for themselves. We noted earlier that only 62%, or 24.5 million (range: 21.6 million–25.5 million), of HIV-positive people, were accessing ART as of June 2019. While the rates of new infection and deaths from AIDS-related conditions have dramatically declined since the worst days of the epidemic, in 2018 1.7 million (range: 1.4 million–2.3 million) people became newly infected with HIV and 770,000 (range: 570,000–1.1 million)

PLHIV died from AIDS-related illnesses (UNAIDS, 2019). This is not the “end on AIDS” by any stretch of the imagination. Such is the current governmentality of the epidemic.

Finally, the irony for gay men, whose activism has been so central to understanding and framing the epidemic, is that the crowning achievement of this governmentality and its entourage of administrators, the ascendancy of re-biomedicalization, and the marginalization and co-option of affected communities, has been to insert gay men’s sexuality firmly back into and under the surveillance of the “clinic” (Dowsett, 2017). By this, we mean that, with the advent of TasP for HIV-negative or untested men, and affected community advocacy for “90-90-90” and TasP for HIV-positive men, all gay and other homosexually active men find themselves and their sexual activities firmly back under the scrutiny of biomedicine, reliant on ART provision by physicians’ prescriptions, dependent on public health subsidies (where they exist) for supply, access and affordability, and subject to public debate as to why diminishing government resources for HIV and other pressing health issues should be spent to facilitate sex between men. One hundred and fifty years of the pathologization of homosexuality resisted and fought so successfully by the gay liberation movements of the world in the late twentieth century have, indeed, come full circle. In a paradoxically post-AIDS fashion, we are now all patients again!

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