Remarks by Ricky Price, PhD.

Hello, and thanks to the community and campus organizers for hosting this and inviting me to talk. My name is Ricky Price and I'm a visiting assistant professor of Political Science here at HWS. My work is in the history of HIV/AIDS policy and activism. What I do is I look at federal science institutions, like the CDC and the NIH, and try to understand the way health policy is created, and how it's transformed. We talk a lot about institutional and systemic racism, and so for me as a scholar of American institutions, I seek to look at what sort of practices, rules, interpretations, memos, reports, etc. reproduce health care inequalities.

What I've found in my research on HIV/AIDS is that institutional practices, that we can observe, that we can locate, that we can measure, led to the shepherding of HIV/AIDS into poor, Black and Brown communities. That the specific containments strategy to control HIV/AIDS, absent of a vaccine or cure, ensured through public health policy that only the poorest, only those with the least access to health care, those with the most interaction with the prison systems, the communities with the least investment in education and health services

would not be able to afford or get access to the preventive and treatment therapies that now make living with HIV a chronic rather than a terminal illness. So, from this perspective, it's quite obvious why HIV seemingly migrated from white affluent gay urban communities to the rural south, where 50% of queer Black and Latinx men are likely to become HIV positive, where Black women without access to health care represent the American epicenter of the ongoing HIV/AIDS crisis—and where HIV/AIDS is one of leading causes of death for women globally of reproductive age—14-44 according to the WHO.

HIV and COVID-19 are very different viruses. Biologically, socially, and politically. But What I want to talk about today is the way that these disparities in the HIV/AIDS crisis—created through the development of policy, by people working inside these public health institutions, and in the halls of congress, represents the model for treatment and care that we're now using to combat COVID. It is individualized—your identity matters in an epidemic. Individual therapies produced for profit are the motivating force behind finding a vaccine or a cure. And criminalization will be increasingly used to organize "healthy" bodies from "risky" bodies.

One stark difference between the politics of HIV and COVID is that within the first weeks of the crisis it has been openly documented and reported that Black and Brown and indigenous communities are bearing a disproportionate amount of the illness and death. It took the CDC 6 years into the HIV/AIDS crisis to breakdown infections and deaths by race. In the late 1980s and early 1990s you saw the racial disparity of deaths grow wider as anti-retroviral therapies began development. By 1996 when ART therapy was officially on the market, AIDS continued to develop in communities that lack access to affordable health care. So—in this crisis there is less ability to gaslight—we know Black and Brown and working class communities across the country face the brunt of the crisis—just like Black and Brown communities do with HIV/AIDs, and diabetes, and cancer, and infant and mother mortality rates, and on and on and on.

How you understand this disparity—how you make sense of why this difference exists, and seem to only get worse with every reform—undergirds—is the literal backbone of your politics. One could see this disparity and understand that the lives of Black and Brown and working-class people are shortened by the organization of our bodies in different environments and within different systems. When we look at the data it is communities that lack health care, living in toxic neighborhoods, who work the riskiest jobs without the support of a robust

welfare state who have their life chances shortened the most. Here in Geneva it's Wards 5 &6, who live in a food desert. Who live in the fallout from the toxic waste of the foundry, which the city of Geneva hid for 30 years. Until a movement from the community used direct action and social protest to get the remediation plan. From this perspective it is the political organization of our bodies that creates health disparities, not race.

Or you might interpret these sets of facts differently. As Ohio Senator Steve Huffman did early this week on June 10th. Seeing this racialized disparity in COVID-19 cases Senator Huffman asked in a hearing,

> "We know it's twice as often, correct? Could it just be that African Americans — the colored population — do not wash their hands as well as other groups? Or wear a mask? Or do not socially distance themselves? Could that just be maybe the explanation of why there's a higher incidence?"

Senator Huffman's is also a Doctor. Dr. Huffman is also racist. This is common. He has been since fired from his day job for this statement, and there has been outrage in the community and online---but most of it comes in the form of shock that a medical doctor would interpret racialized health disparity in terms of personal behavior and identity. But that is precisely what I found in my research on HIV to be the main priorities of health care policy: you are responsible for your health in contemporary America—even to the point of criminalization.

This is also called biological determinism—an ideology that scaffolds racist actions and beliefs—that genes are destiny. Indeed, our obsession over the past 50 years with genetics as the key to our health and identity often verges towards eugenics, as sociologist Troy Duster pointed out in the 1990s with his classic book critiquing scientific practices from a critical race perspective, "Backdoor to Eugenics." Or Dorothy Robert's book *Fatal Invention*, or Harriet Washington's book *Medical Apartheid*. In my own research I try to uncover the practices of people embedded within institutions that reflect and reproduce social inequalities. How they point resources towards some communities and away from others. How they help some communities matter and how they help to un-matter communities they don't see and they don't hear.

For example, in the 1980s the CDC was primarily focused on testing and investigating the spread of HIV in gay communities. They were ignoring the communities of drug users and sex workers who were outside their surveillance capabilities and harder to isolate for institutional studies. So, for over a decade, to paraphrase an ACT-UP slogan, "Women didn't get AIDS they just died from it." The case definition of AIDS was narrowly tailored to the types of infections that men got when their immunes systems were fully compromised. It took data from community health workers, like Dr. Joyce Wallace taking a van around NYC and

testing sex-workers for HIV, finding ¼ of all sex workers in the city has the virus years before the CDC even considered women at serious risk for the HIV. It took a coalition of social movement activists and lawyers to sue the CDC to eventually force the CDC to include things like, cervical cancer, in the case definition of AIDS. The difference meant disability, housing, and employments benefits. It is these practices that I'm talking about that un-matter certain lives over others.

COVID-19 shows the way in which our health care systems un-matter Black lives. This is the material effect of the systems of labor, health, and criminal justice, on marginalized communities. And so one of the political discourses that is transforming before our eyes—is tied deeply to these protests—Part of the change we are seeing is the breakdown of the idea of biological determinism- That you are merely playing out a genetic program you or society have no control over. That poverty, imprisonment, and the police department are natural and necessary.

So rather than using the passive formation that "COVID disproportionally affects" Black and Brown communities, or higher rates of poverty or criminalization—we might better describe the situation as a consequence of our politics. We have created policy and politics that shorten the life spans of Black and Brown

communities. It is not a natural thing, but, rather, a product of human agency. COVID is exposing what political ideas are based in pure fiction—and that is one reason why the protestors are having such success in gaining reforms across the nation. This is the hopeful opening transformation offers us. AIDS activists forced medical institutions to take their communities seriously. Through protest, community health research, and media campaigns institutions like the CDC and NIH were forced to change their priorities to include marginalized people in research, testing, and policy. This is true here in Geneva with what the young people have been organizing for weeks now, this can also be true on campus as we start to reimagine campus amidst this crisis. How can we use this as an opportunity to tear down some of these institutional practices that reflect and reproduce the social inequalities that shorten some lives and lengthen others?