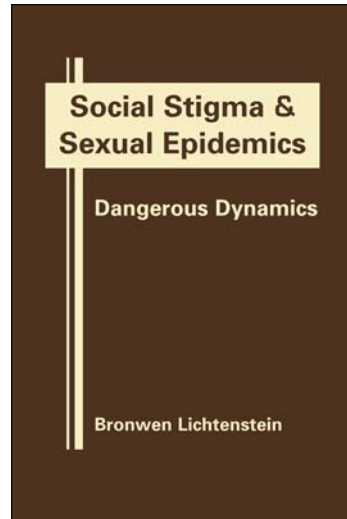


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Social Stigma and Sexual Epidemics: Dangerous Dynamics

Bronwen Lichtenstein

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Contents

<i>Acknowledgments</i>	<i>ix</i>
1 Bowled Over by the Grim Reaper	1
2 Sexually Transmitted Infections and Social Structures	25
3 Colonizing Stigma	41
4 Undercutting Prevention	57
5 Blaming Victims	83
6 Blurring Religion and Medical Care	115
7 Theoretical Implications and Practical Actions	139
<i>Bibliography</i>	<i>159</i>
<i>Index</i>	<i>179</i>
<i>About the Book</i>	<i>193</i>

1

Bowled Over by the Grim Reaper

The genesis of this book began when I first became aware of the HIV epidemic in Australia in the mid-1980s. At the time, I was living in a religious community that was largely sequestered from the outside world. Few people in my community owned a radio or television, but nothing could stem the “guess who?” rumors that were generated after the first cases of HIV/AIDS were widely and ominously announced in the Australian media. Someone we knew had been infected by a prostitute (speculation, to be sure, but the rumor shed light on a shady practice that tacitly allowed religious men to visit sex workers outside the community). In a parallel event, a public service announcement aired on Australian television to warn the public about an epidemiologic apocalypse that threatened our shores. In dark tones, the male voice-over told us that we were all at risk of dying of a plague that had swept the United States and arrived in Sydney by way of the gay community. The TV spot featured a Grim Reaper who bowled a ball down an alley, scoring a strike on the men, women, and children who were positioned like skittles at the end of the lane. The Australian public was suddenly aware that this was no ordinary epidemic, and the means by which people heard about HIV risk were, according to Debra Lupton (1994), designed to shock them out of their complacency. The announcement achieved its goal. Twenty years later, everyone who saw the advertisement still remembers the Grim Reaper campaign and the terror it struck into the hearts of the Australian public. Little did I realize that the campaign that had so terrified me would also be the springboard for a career in the Sociology of Acquired Immune Deficiency Syndrome (AIDS), also known as the Human Immunodeficiency Virus (HIV).

In the Beginning, There was Eve

An early victim of HIV in Australia was a little girl named Eve van Grafhorst who contracted HIV from a blood transfusion she received as a neonate. In many ways, Eve's story is similar to that of Ryan White, a US teenager with hemophilia who was vilified in his hometown and barred from school after local citizens discovered that he had contracted HIV from a blood transfusion. Like Eve, he was valorized by the media and became the symbol for the need for compassionate HIV care after he died. After Eve enrolled in a New South Wales primary school, outraged parents forced her expulsion out of fear that she would infect their children. The family then fled to sanctuary in New Zealand, where I followed her story after I returned to New Zealand (my country of birth). When considering a topic for postgraduate study, I decided to focus on social responses to HIV/AIDS in the local context. By this time, Eve was a media darling, with organizations and the public pledging money to her cause, and the New Zealand media documenting her daily life through photographs, stories, and updates. Even Princess Diana of Wales sent well wishes in recognition of Eve's special status as a child victim of a new and frightening epidemic. Eve was a symbol of innocence, compassion, and the fair-mindedness of New Zealanders, even if her celebrity hid a less palatable fact: that she (and her family) perceived herself to be the victim of adult immorality.

Eve's name became part of the subtitle of my dissertation after I realized how many Eves had gone before her: the biblical Eve, who was mythically portrayed as a sexual temptress in the Garden of Eden and whose sin was forever borne by women through painful childbirth; the syphilitic Eve, who was blamed for infecting "innocent" men in the Middle Ages of Europe and cast outside city walls; the African Eve, who was hypersexualized and then accused of infecting black men, as well as the white race through the forces of colonization; and, eventually, the Eve-like men who were identified as feminized vectors of HIV and vilified for reckless sexuality after HIV/AIDS emerged in the United States. Everywhere I turned, the discourse of Eve framed public responses to sexuality and disease according to race, gender, and social power. The difference between Eve van Grafhorst and the other Eves was that she was an archetypal innocent, a young blond girl from a middle-class family whom the media dubbed "Angel Eve" even before her death in 1993. This framing of a new epidemic in terms of good and evil was powerfully symbolic prior to the biological mechanisms of HIV/AIDS being fully understood or before treatments could be

developed for a virus that was widely perceived to be more social than biological in origin.

Thus began my journey into the history of social responses to what I will refer to in this book as “the sexual epidemics.” In this context, the term “sexual” distinguishes between infections such as syphilis that occur in venereal and non-venereal forms in certain parts of the world (e.g., Australia and South Africa). During the course of the research, I could not ignore the fact that history was repeating itself. In particular, I discovered that the stigma associated with the HIV epidemic mirrored the stigma in other sexual epidemics, most notably for syphilis. It was as if the same stigma had simply leapfrogged from one epidemic to another. Even the stigma surrounding nonsexual epidemics such as yellow fever or cholera was eerily similar, with the usual culprits—foreigners, prostitutes, Gypsies, immigrants, Jews, criminals, the “retarded,” and the so-called “putrid poor”—accused of being vectors of disease and made to suffer the consequences, which included being stoned or thrown down village wells. The history of plagues is replete with examples of how certain groups of people were blamed for spreading disease. These typologies were remarkably consistent unless epidemic disease appeared to strike blameless innocents such as the white, middle-class US children who were struck down by poliomyelitis (Sontag 1989).

Origin Theories

We need to locate the origin of a disease, since its source, always distant from ourselves in the fantasy land of our fears, gives us assurance that we are not at fault, that we have been invaded from without, that we have been polluted by some external agent (Gilman 1988:262).

Epidemics are often so unexpected or deadly that people, even physicians and others we expect help from in times of medical catastrophe, seek to distance themselves from putative sources of contagion. Social distancing and other expressions of fear in terms of typecasting, name-calling, blaming, or exile, are typical reactions to such threats as people seek to avoid being afflicted. Even in the AIDS era, wrote Watney (1989:47), “Deaths in the houses have prompted survivors to flee in the belief that the buildings themselves are in some way responsible for the illness.”

Origin theories, which are often proposed in order to identify and control the latest plague, have an important role in setting the stage for

stigma. Prior to the Industrial Revolution, epidemics were thought to come from “bad air” (miasma theory), especially among the poor; or, in the case of leprosy or the sexual epidemics, were evidence of God’s wrath for sexual licentiousness. During the nineteenth century, germ theory trumped miasma theory as a causal explanation for contagion, and the search was on for the external source of epidemics that appeared to sudden and catastrophic effect. The terms “oriental plague” (bubonic plague), “Asian flu,” “French disease” (syphilis), “Jewish disease” (typhus), or “Irish Catholic disease” (cholera) bespoke of blameworthy people or places. This trend prompted Susan Sontag (1989) to write that plagues were no longer “sent” in biblical terms but that people were “visited” by plagues from other places, although one could also argue that professional fulminators, as she describes them, promote the idea that plagues are sent by God. It seemed that so-called normals were always attributing blame to the “other”—defined as social outcasts, immigrants, or foreigners—and that the search for origins was an inevitable part of the stigma trajectory.

Stigma Goes by Ship: the Trade Route Theory

A central premise of this book is that stigma resurfaces in each epidemic through cautionary tales, institutional practices, and cultural stereotypes about social undesirables. Stigma also travels the high seas: in the old days, fear and blame followed the spread of exotic disease from port to port, while, in the modern era, immigrants, animal husbandry, or air travel are blamed. These events or attitudes are often accompanied by efforts to control the threat of contagion, sometimes through quarantine or fumigation and at other times by travel bans. Even in modern times, such bans are legion. For example, before 2010, in a futile effort to prevent transmission in a globalized economy, HIV-infected people were barred from traveling to the United States. But then and now, the sourcing of epidemic disease has been a critical step in the epidemiologic search for foreign culprits. In his exposition of the cholera epidemic in nineteenth-century Paris, François Delaporte (1989) described how French health officials sought to identify trade routes to control exotic diseases “[whose] major breeding grounds lay in the Americas, from which yellow fever had come, in India, the birthplace of cholera and the plague, and in the Mediterranean, which maintained close relations with Africa and which was vulnerable to diseases from all over the world” (192). The Black Death of fourteenth-century Europe, according to modern scientists who managed to hunt down its origins by investigating the genetic structure of live plague in various

locations, originated in China and was transported in shipments along the Silk Road (Haensch et al. 2010). In similar fashion, public health responses to HIV/AIDS echoed nineteenth-century efforts to locate and control a foreign pathogen, even though HIV is not airborne; that is, not contagious. The long latency period for HIV meant that traditional methods of control such as fumigation, travel bans, or quarantine were ineffective, but they did placate the public who wanted something done to protect them from disease.

From the beginning, HIV was assumed to be foreign, with African origins later being confirmed by US scientists. This sourcing provided a fertile backdrop for the stigma of otherness that accompanied the spread of HIV disease around the globe. Simon Watney (1989:47) fulminated that “The situation in ‘Africa’ is offered as a premonitory image of ‘our’ future in Europe and the United States, as planes fly out carrying away ‘the seeds’ of infection, to be planted on foreign soil.” In the United States, HIV was associated with social deviance, as evident in “the gay plague,” “Gay Related Immune deficiency [GRID],” and even “an epidemic of the four H’s” (i.e., homosexuals, heroin addicts, hookers, and Haitians) as coined by the Centers for Disease Control in the 1980s. But this does not detract from its essential foreignness, particularly its origins in Africa as “the dark continent” from which alien diseases were said to emerge (Treichler 1999:101). True to the trade route theory, the former French colony of Haiti was the putative portal for HIV to enter the United States, probably through sex tourism in the 1970s. Gilbert et al. (2007) discovered the African connection through genetic subtyping that traced the US strain of HIV-B to Haiti and then to Zaire through Haitian professionals who worked there prior to a wave of nationalism that drove them out in the 1960s.

The thematicity of foreignness in plagues and epidemics, including HIV/AIDS, has largely been documented in Eurocentric or US-centric terms. In reviewing public health responses to the cholera epidemics in Europe—mostly involving the quarantine of districts, travelers, and ships—it is clear that contagion is inevitably regarded as an external threat because the disease replicates itself by colonizing animal or human hosts. More often than not, the threat cannot be seen, smelled, felt or sensed until it is too late. Fear is a natural response to this type of invasion, especially for epidemics that are both widespread and deadly. The emergence of plague typically evinces moral panics, quarantine, a scramble for remedies, and attempts to flee from the imagined source. Historians note that prior to the nineteenth century, physicians were notorious for heading to the hills when dangerous epidemics struck. Although governments in the late Middle Ages often responded to

plagues by sealing off towns and cities, it is noteworthy, in terms of theory development for this book, that quarantine was largely abandoned after the Industrial Revolution changed the mapping of disease. Simply put, “diseases spread along trade routes [and] seaports . . . were like revolving turntables that received incoming disease from one part of the world and rerouted it to another” (Delaporte, 1989: 192-193).

The history of stigma took a similar turn. Just as exotic diseases had entered Europe from foreign places, so too had so-called European diseases such as measles, the common cold, and influenza colonized faraway people and places. The effects of this pathogenic onslaught on native populations in Africa, Canada, the United States, Australasia, Asia-Pacific, and the Caribbean are well documented sequelae of colonization. However, the spread of syphilis and gonorrhea to native populations, the “color” of stigma that emerged from this invasion, and the legacy of colonization in social and public health responses to HIV/AIDS are less familiar territory.

This book will develop a theory of colonizing stigma, both as an historical construct and as a structural phenomenon involving intersections of race, gender, and class in the sexual epidemics. The theory has two components that I will develop in case studies from around the globe. The first component, “colonizing stigma,” will be used to describe how ideas about sexual disease have persisted throughout history to discriminate, vilify, and punish, sometimes until death. The second component, “colonized stigma,” refers to how European colonization in the nineteenth century created race-gender stereotypes and institutional practices that discriminate against the colonized in the name of control of sexually transmitted infections (STIs). The theory is a new approach to stigma that will be developed according to C. Wright Mills’ “sociological imagination” as the analytical framework for this book.

Methods of Inquiry

My methods of inquiry were more accidental than intentional. At first, there was simply a question that kept popping into my head while I was teaching a class on the sociology of HIV/AIDS in Alabama. It was a deceptively simple question, but also a very meaningful one: Why had the HIV epidemic become so endemic among African Americans in the US South? I had heard all the usual explanations about individual-level factors involving high-risk behavior, meso-level factors such as the gender-ratio imbalance, prisonization, and sexual concurrency, and even macro-level factors involving the moral geography of the South, but

none of it was satisfactory from a sociological point of view. What is worse, these explanations often seemed judgmental and made it difficult to teach the topic to mixed-race classes of undergraduate students. If I were teaching the students that the South, as their home, was the locus of the HIV epidemic, then I needed something better to offer in terms of reasons why, once again, the South was being impugned for having the worst health problems in the nation. These well documented problems include major killers such as obesity, heart disease, stroke, diabetes, and cancer (US Centers for Disease Control and Prevention [CDC] 2007); mental health conditions such as depression (Reinberg 2010); and the social ills of teenage pregnancy, illicit drug use, and infant mortality (Annie E. Casey Foundation 2010).

In order to answer the question, I began to do what Linda Tuhiwai Smith (1999) calls “researching backwards” through the history of the US South. Because HIV/AIDS is essentially an epidemic of stigma, I decided to examine sociohistorical texts about the stigma pathways to sexual disease in the United States. This task was like peeling an onion—removing layer after layer until I had gathered enough clues as to why, when, and how sexual disease followed the patterns of social organization in the South. At this point, the question then became: How does HIV risk in the Deep South relate to the sociology of place? After all, as François Delaporte (1989) so emphatically stated about cholera in nineteenth-century Paris: “Disease does not exist. It is therefore illusory to think that one can ‘develop beliefs’ about it or ‘respond’ to it. What does exist is not disease, but practices.” Of course, everyone knows that pathogens seek to colonize, sicken, and kill, but the point he was making was that epidemic disease is not a random event, and that social organization lays the groundwork for or fuels its contagion. The South had patterns of social organization that were racially and socially distinctive from the rest of the United States. Intuitively, I felt that the history of difference had a bearing on epidemiologic outcomes for HIV/AIDS.

It soon became evident that the sociological journey I had embarked on would take me back to slavery as an economic activity that linked the United States to the British Empire in the colonial era. It would even take me further afield as I delved into the linkages between colonization and the sexual epidemics. At the height of its powers, the British Empire held dominion over thirty-five countries across the globe. Other European powers such as France, Germany, Spain, and Portugal had far-flung colonies; Islamic countries colonized parts of Africa; the United States colonized parts of the Pacific (Guam and Hawaii) and the Caribbean (Cuba and Haiti); and China colonized Tibet. Prior to the

modern era, the Celts were invaded by the Romans. The original inhabitants of New Zealand, the Moriori, were colonized by Maori and pursued to the edges of the Pacific. Colonization still occurs in border disputes, invasions, and through less obvious means in what Tuhiwai Smith (1999:59) calls “colonization of the mind” through assimilation and cultural transmission of the ideas and practices of a dominant culture. In other words, history is about colonization as much as about any human activity. It was through the history of colonization that I would be able to document stigma pathways in the sexual epidemics, including those in the US South.

I decided to travel to the United Kingdom to study the British Empire at its source. Great Britain, as it was known during the sixty-three-year reign of Queen Victoria, who presided over the expansion of the colonial enterprise, was home to the largest and most influential empire of the modern era. In terms of medicine and public health, the empire was well-documented, and all of these documents were available in the English language. The University of Southampton, where I was located during this time, provided access to university libraries and was within easy reach of archival sources in repositories and hospital collections in London. One cultural anthropological gem that I found in a bookshop in Wales was *Education of Primitive People*, a treatise about the Bura tribe of Nigeria that took my breath away with its missionizing zeal to interpret (and correct) tribal mores and practices. Tuhiwai Smith (1999:42) called this type of cultural-anthropological project “research through imperial eyes”—in other words, as a means by which Western rules and values were imposed on colonized peoples. With sources like this—and there are many—it was not difficult to make connections between colonization, stigma, and the sexual epidemics.

As I broadened the scope of the book from the United States to Britain and then further outward to Africa, the Caribbean, and the Antipodes, I draw more extensively on materials from online sources and from scholarly books and reports. Sources for the book also consisted of my own body of work on the sociology of sexual disease that I had accumulated over two decades. This work included my dissertation, published articles, a wealth of interview and survey data, and an organizational analysis of responses to HIV/AIDS in New Zealand. In other words, the methods I used for this book follow the pattern of my career in the sociology of HIV/AIDS. I synthesized published materials to make a case for theory on colonizing stigma, traveled across the globe to interview, photograph, record, and collect and analyze materials from all manner of sources, and then sat down to organize and interpret these materials into a scholarly book while on

sabbatical leave at the University of Southampton. What emerged from this process is an exposition of how sexual stigma became a tool of colonization that was enacted through policies and practices for STI control that persisted into the twenty-first century, promulgated ideas about social status in the sexual epidemics, and ultimately provided answers to the question I wanted to answer about how, and by what means, the South became the locus of HIV/AIDS in the United States.

Stigma Theory

This book will follow the tradition of Mills (1959), who coined the term sociological imagination to describe a process of enlightened self-awareness in which one's personal troubles can be fully understood in terms of the conditions that produced them. In Mills' view, the ability to perceive personal troubles in this way, which he termed "quality of mind," provides people with the proper tools to overcome the false consciousness of individual misfortune and helps them to change their circumstances through social activism and/or by enacting social change. The sociological imagination requires taking three elements of the "social"—that is, history, biography, and the social structure—in order to develop this broader perspective of society and one's place within it. No book on stigma in the sexual epidemics would be complete without such an analysis. I will begin here by addressing each component with examples of how these elements are useful for understanding the intersecting roles of race, gender, and social status in the sexual epidemics, and to explain why I refer to stigma as a colonizing force.

1. History: the Case of Nadja Benaissa

Mills (1959:8) recommended taking history into account in order to "transcend [the] local environments of the individual and the limited range of his [sic] life." This recommendation is certainly useful for addressing the long and dishonorable history of stigma in the sexual epidemics. An example of how history affects one's biography and the social structure bears telling here in order to illustrate how stigmatizing frames from prior epidemics provide a conceptual template for HIV/AIDS as the latest plague. The consequences of this history have been profound, and scholars of the sexual epidemics are under no illusion about how lives are blighted, damaged, and even cut short because of attitudes and beliefs about infections that afflict so many people in nations across the globe. This intensity of beliefs is puzzling and often tragic.

The history I refer to here begins with the case of Nadja Benaissa, a twenty-eight-year old musical artist from Germany. The band she belongs to, No Angels, is credited with being the most successful women's band in Europe, having won many awards for its pop musical style. Benaissa's success seemed assured until 2009 when German police stormed a solo concert she was about to give, arrested her, and charged her with grievous bodily harm for allegedly infecting a male sexual partner with HIV. She was also charged with nondisclosure and for having unprotected sex with two men who did not contract the virus (BBC News 2010). A British newspaper, *The Independent*, claimed that Benaissa learned she was HIV-infected when she was seventeen years old and pregnant. Benaissa's explanation for nondisclosure was that publicity about her HIV status would affect the band's hard-won success, a stigma response that is recognized by HIV prevention specialists everywhere. What is noteworthy about this story — apart from a celebrity figure being on trial and conviction for nondisclosure earning up to ten years in a German prison—is how *The Independent* felt compelled to identify Benaissa's pre-HIV past as a “drug addict,” although alcohol and marijuana as her drugs of choice are not risk factors as defined by the US Centers for Disease Control and Prevention (CDC), and she no longer used marijuana or drank alcohol after her diagnosis. Even more tellingly, *The Independent* referred to her Roma (Gypsy) ancestry, and the photos that accompanied each story showed her as dark and voluptuous as she performed with great abandon. So there we had it: Benaissa was a stereotype, another Eve in the annals of women's history.

There are two strands to this story concerning intersections between race, gender, and social status in the sexual epidemics. The first is the reference to Benaissa's Roma ethnicity; she is also part Moroccan and has been described as black. It is at this point that history becomes important in the racial subtext of Benaissa's trial for infecting a sexual partner. It is well known that Roma have been blamed throughout Europe and the Baltic states for many social problems, ranging from pathological criminality to racial degeneracy. My own experience of this blame motif occurred during a recent visit to the Vilnius AIDS Centre where I was told that HIV infections in Lithuania had increased dramatically among people who injected drugs (IDU) and that the traffickers were Roma who made a living in selling heroin from Afghanistan—an example of the trade route theory. Official statistics confirmed the surge in IDU-related cases, which accounted for 72 percent of Lithuania's total for HIV/AIDS in 2009 (UNAIDS 2010). Although I could not substantiate the claim that Roma had fueled the

HIV epidemic in Lithuania, except to note that this is a powerful claim for such a tiny minority and that HIV rates in Lithuania are very low, it was clear that the denigration of Roma was unselfconsciously expressed in both public and private spheres. The Roma theory was challenged in *Science* (2010), in which substantial doubt was raised about the claim that Roma had spread HIV by picking up used syringes from the street, refilling them, and then reselling the product to consumers. In the public sphere, attributions of criminality are often articulated by local politicians who pander to their constituencies with populist rhetoric, but the news media express these views as well. One study of the Lithuanian press found that “The Roma minority receives the cruelest stereotypical representations of all ethnic minorities in Lithuania. Virtually all stories related to the Roma were systematically associated with crime, drugs, violence, and asocial behavior . . . which consolidated the image of gypsy/criminals in the Lithuanian mass consciousness” (Sükösd and Bajomi-Lázár 2003:220). At this point, if Benaissa were considering the confluence of stereotypes that characterized her in media reports, at her trial she might point to ethnicity as the master status in her tainted biography and wonder at the forces of exclusion that have constructed Roma as scapegoats on an historical basis.

The second strand in Benaissa’s story is that of criminalizing HIV-infected people. A ten-year sentence might seem excessive for nondisclosure but not long enough for commentators in the blogosphere, who vilified her and wished her dead. There are a host of reasons why people do not disclose, including fear of violence, but in Benaissa’s case, a doctor had advised her that she was unlikely to infect anyone and, of course, she feared the publicity. As much as we would like to think that justice is being served in this case, the law of *mens rea* is that one must be of “guilty mind” in order to be found guilty of a crime. A legal scholar might therefore wonder why the word “intent” has been written out of this particular crime and its punishment. But laws are passed by politicians who are elected by constituents, and the moral panic surrounding HIV/AIDS in the 1980s was so fierce that it gave rise to cautionary tales about vengeful AIDS carriers, much in the spirit of World War II posters that warned soldiers about being tempted by syphilis-ridden vamps, prostitutes, and even fresh-faced girls next door. This mythmaking about AIDS carriers was followed by reactive legislation and, in some jurisdictions, the criminalization of nondisclosure. In later years, challenges to the legislation (at least, in the United States) were successfully thwarted by prosecutors, in part by resurrecting the “revenge theory” to justify keeping these laws in place. The myth of the vengeful AIDS carrier is arguably the most powerful

and enduring in the HIV epidemic, and it is no accident that Benaissa's biography was immediately reduced to the vengeful Eve in the blogosphere.

Perhaps the most famous urban myth concerning HIV/AIDS is about an infected woman called "AIDS Mary" who had unprotected sex with unsuspecting men and then scrawled "Welcome to the World of AIDS" on bathroom mirrors as she left their apartments, hotel rooms, or homes the next morning. This cultural trope of the 1980s was so powerful that students in my sociology of HIV/AIDS course invariably refer to the vengeful AIDS carrier as a reason to criminalize HIV transmission, and little would convince them otherwise. But this type of mythmaking could perhaps be as old as the iconography of Mary herself, although in this case she is the symbol of death rather than fecundity and motherhood. In the nineteenth century, an Irish immigrant cook was dubbed Typhoid Mary after being accused of willfully infecting people with typhus in New York. Since then, the terms Typhoid Mary or AIDS Mary have been used to describe a variety of malicious actions by people who cause harm to others, including those who "willfully" spread computer viruses by opening e-mail attachments without checking the source (Reed, 2010). In other words, this trope became colonizing on several fronts, not only because it stigmatized people as vectors of deadly disease but because the term "Typhoid Mary" and its equivalents spread to actions that are tagged as both malevolent and female, as if such actions were a modern form of witchcraft.

Benaissa therefore had the misfortune of being diagnosed with a disease that is historically so loaded with stigma that criminalization seems both reasonable and just. If she had understood the role of history in her case—and perhaps her attorney did, although she was convicted on all counts—she might have been empowered to challenge the law that makes nondisclosure a crime for HIV-infected people but generally not for others with life-threatening infections that are also sexually transmissible. Infections in this category include hepatitis B and C, and, for that matter, methicillin-resistant staphylococcus aureus, or MRSA, which can be acquired through skin contact. Criminalization for nondisclosure is also less likely if HIV transmission occurs during needle sharing rather than sex. I am not suggesting that infected people who inject drugs should be prosecuted for nondisclosure or that people with all types of infectious diseases should be prosecuted, but I am pointing out inconsistencies in the law. AIDS activists certainly adopted Benaissa's case in order to challenge the broader outcomes of criminalization, such as a widespread fear of HIV testing. In this

equation, fear of prosecution leads to reluctance to be tested: ergo, more people will become infected because knowing one's diagnosis and taking antiretroviral drugs (ARVs) on a regular basis greatly reduces infectiousness (Donnell et al. 2010). Activists have also challenged outdated assumptions in the law, such as the belief that HIV is a death sentence rather than a chronic condition with a near-normal life expectancy if people take ARVs on a regular basis. The take-home message is that Benaissa's professional life is probably over: She has been colonized by an historical stigma that conflates race, gender, sexuality, and disease with willful culpability. This stigma, which has been written into law, seems just as powerful today as it did when HIV/AIDS was an almost certain death sentence in the 1980s.

2. Biography: When Private Trouble Is a Public Issue

Biography is Mills' second component in promoting an understanding of how society works and the role of the individual within society. Biography can mean one of two things. First, it refers to the identity of individuals in a particular place, region, or country in terms of their social behavior. This characterization provides clues as to what the society looks like more broadly. Second, biography refers to developing self-awareness of how personal problems might be indicative of larger social issues in society. Mills wished to teach social scientists and people within their sphere of influence about how to develop a sociological imagination so that connections could readily be made between someone's personal troubles, such as unemployment or discrimination, and the broader social conditions that created these problems, such as outsourcing or class competition. According to Mills, the ability to translate personal troubles into public issues would improve self-awareness, individual reason, and the quality of democratic society.

In the course of examining one's personal problems, self-awareness must be present. And here is the rub. When it comes to sexual epidemics, it is difficult for people with STIs to consider the broader social structure in order to identify discriminatory institutions or practices, thereby providing a rationale to engage in reasoned action or even collectivism in the name of stigma reduction. STIs are strictly a private affair— secrets that dare not speak their name. For most people, being infected is considered an error of judgment or evidence of betrayal of the most intimate kind. It is difficult to consider STIs as anything other than a personal matter. But consider this quote from Infed.Org (2010):

For much of the time governments tend to cloak or to present such public issues as private troubles: it is the fault of individuals that they cannot find work, rather than an outcome of structural or political arrangements. Furthermore, given the orientation of social workers and educators, when working with individuals or groups, it is all too easy to end up working with people around the immediate issue or trouble. In C. Wright Mills' (1967: 534) words they can "slip past structure to focus on isolated situations" and consider problems "as problems of individuals". We can confuse personal troubles with public issues.

In public sensibilities, STIs are always framed as "problems of individuals." To my knowledge, no one has written articles or books, or proposed a theory, that would transform the personal trouble of having a STI diagnosis into community action for social change. The suggestion would seem laughable. An exemplary exception, of course, is HIV/AIDS, for reasons (and outcomes) that I will discuss later. Thus, to be self-aware in terms of one's biography of STI is to feel victimized, dirty, and ashamed, and to keep the diagnosis a secret. People will blame you and will certainly keep their distance. Who would consider broadening social awareness of such a private matter in order to identify public issues that are located in history and social structure? It is better to "pass" and try to forget it. But that is what I am asking the reader to do in order to broaden social awareness, and I will provide the basis for such reformulation in this book.

The task of going from biography to the larger social issue of stigma in what Eng and Butler (1997) have termed "the hidden epidemic" begins by defining the scope of the problem through public health data for STIs. This step is necessary in order to consider the third component, social structure, which is represented by social facts such as STI prevalence. Taking the United States as an example, public health reports indicate just how common these infections are across the nation and how the almost fifty infections are considered to be sexually transmitted. The numbers vary, but some estimates suggest that lifetime prevalence of STIs stands at one in every two people at some point in their life (Itsyoursexlife.Com 2011), with trichomoniasis, chlamydia, and gonorrhea being the most common (CDC 2009a). The lifetime prevalence of incurable STIs (e.g., human papillomavirus [HPV], genital herpes, hepatitis B, and HIV/AIDS) is around one in every four people in the United States (CDC 2009a). Even more startling are STI rates among teenagers: A 2003-2004 government health study of a large sample of teen girls indicated that one-fourth of the girls had at least one STI, the incidence among sexually active girls was 40 percent, and the most common infections were HPV and chlamydia (Reinberg, 2008). In

2007, the CDC estimated that 19 million new infections occur each year in the United States among all age groups—a significant increase over the approximately 15 million per year reported in 2000. Many infections are asymptomatic, so the true number of STIs is undoubtedly higher. The millions of diagnosed and undiagnosed infections each year suggest that the sexual epidemics are hardly a minor issue involving a few individuals who can be labeled promiscuous, but rather indicate an extremely common set of conditions. These “private troubles” are sometimes minor in terms of health outcomes, but several others have serious health consequences: cervical cancer in the case of HPV; endometriosis, autoimmune disease, ectopic pregnancy, or infertility in the case of chlamydia; stillbirth, arterial disease, or even death in the case of Stage III tertiary syphilis; cancer, liver failure, and death in the case of hepatitis B; multiple illness and death in the case of HIV/AIDS, and the list goes on, including for nasty conditions that most people are unaware are related to STIs.

To add to this broad array of infections and symptoms is another problem: resistance to antibiotics for infections that were once highly treatable. Antibiotic resistance has raised concerns among health experts about prevention and control (CDC 2009a), especially since the 2011 discovery of a strain of gonorrhea that is resistant to extended-spectrum cephalosporin, the last-line treatment for *Neisseria gonorrhoeae* (Ohnishi et al. 2011). Gonorrhea has the potential for widespread harm because it is the second most commonly reported notifiable disease in the United States and can lead to ectopic pregnancy and pelvic inflammatory disease for women, premature birth, and arthritis and infertility in both men and women (CDC 2009a). In this case, the sexual epidemics appear to qualify as a fully fledged social crisis. And yet, beyond the health professions, few people perceive the sexual epidemics to be worthy of note, let alone urgent attention. Even HIV/AIDS has been relegated to the social or geographic margins—that is, either in terms of third world nations or home-grown social deviants. Statements such as “One in every four teenage girls has a sexually transmitted disease” are unlikely to provoke much outrage since the infections could be viewed as easily treatable or a rite of passage rather than a life-changing event, or as happening to someone else rather than to one’s own son or daughter. The saying “The Personal Is Political” has never been applied to the plight of the millions of people who are the face of the non-HIV sexual epidemics in the United States.

3. *Social Structure: A Case of Racial Redux*

The term “social structure” is often interpreted to mean bricks-and-mortar institutions such as schools and colleges or public health departments, or social institutions such as religion and marriage. This institutional order is the skeletal structure of society. In the sexual epidemics, both types of social institutions play a pivotal role in how history and biography intersect to produce stigma through tradition, policy, and the law. In the United States, the institutional role in the production of stigma was enacted variously through compulsory premarital testing for syphilis, contact tracing for notifiable STIs, and the location of STI clinics in predominantly minority neighborhoods. Religious institutions are an obvious example of institutional machinery for stigma production in the sexual epidemics, if only because biblical teachings are a moral guidepost for millions of Americans who are likely to frame responses to the sexual epidemics accordingly. In these settings, STIs are typically presented as a morality tale. It should not come as a surprise to learn that religious teachings often advocate abstinence before marriage, contest the efficacy of condom use for STI/HIV prevention, and, in some cases, lead to the expulsion of church members who are known to be infected with HIV/AIDS (Lichtenstein 2003). These are powerful messages about what it means to be diagnosed with STIs.

Religion often behaves in paradoxical ways. For example, some churches send emissaries to countries in sub-Saharan Africa to minister to HIV-infected people, especially women and orphans, but also to entire communities—a charitable act that is often at odds with their activities at home. It is telling that this outreach increased exponentially after faith-based organizations received federal funding in 2003 from the George W. Bush administration for HIV-service delivery to Africa (Bradley-Springer 2010). In terms of raising awareness of the role that institutions play in reproducing stigma, what should an HIV-infected person make of the apparent contradiction in churches that provide HIV outreach to Africa and practice social exclusion at home—both in response to a sexual epidemic? A Millsian analysis would probably be a cynical one: consider the proselytizing history of the Christian church in Africa and then consider the excluded person’s role as an outsider in the local church’s moral order. If saving souls is church business, then the Africa connection is part of a colonizing enterprise; stigmatizing tropes will be promulgated through this expansion, and social exclusion will be evidence that stigma is a useful control mechanism for marking morality. There is also the suggestion that meeting local needs is less

compelling than international work being funded by donor agencies or the federal government.

If this interpretation is correct, then the exclusion/inclusion paradox would help to explain why health officials in the United States who enlist church leaders for help in educating their congregants about safer sex often fail in their task. The take-home message is that cultural transmission of ideas about sexual or social deviance through the stigmatized body is all powerful, that the church is an efficient transmitter of these ideas, and that the social structure is being reproduced through institutionally sanctioned stigma that colonizes one's own body as well as bodies in other nations. As I explain in Chapter 6, the comingling of HIV-service delivery and religious services in Africa is not value free: ample evidence reveals how ideology has trumped science through funding criteria that effectively ban family planning and condom distribution (Evertz 2010). Despite the highly public act of charitable giving for HIV/AIDS, the destigmatizing of non-HIV STIs or even HIV is highly unlikely in these circumstances, primarily because the stigma is an ideology that is exported as an American ideal.

Thus, the role of social structure is nowhere more evident than in the politicization of funding for the sexual epidemics. Taking the case of funding for HIV/AIDS further, community activists in the United States have looked askance at the wealth of taxpayer funds being sent to countries in sub-Saharan Africa for the President's 2003 Emergency Plan for AIDS Relief (PEPFAR) and the inpouring of private money from the Melinda and Bill Gates Foundation in subsequent years. No one would begrudge donating money to impoverished HIV-infected people who lack access to ARV medicines as well as the basic necessities of life. But consider the federal funding for HIV care in the United States as guaranteed by the Ryan White Care Act of 1990 and its amendments. In the early years of the epidemic, most of this funding was allocated to the HIV epicenters such as San Francisco and New York where gay men were becoming infected at alarming rates. In the intervening years, the locus of the epidemic shifted to African Americans in the regional South. Funding allocations did not follow this shift in epidemiology until 2006 and even then failed to keep pace with a rapidly growing problem that was variously described as "catastrophic" and "systematic" as well as "similar to the epidemic in less wealthy nations than to other areas of the U.S." (Southern AIDS Coalition [SAC] 2008:7). The politicization of funding pitched the urban North against the rural South as AIDS workers scrambled for funds from a parsimonious federal pot in a zero-sum game. In the meantime, the

scaled-up funding to Africa was both highly visible and widely praised as the best legacy of the Bush administration (Bradley-Springer 2010). In effect, the HIV epidemic in the rural South had become the awkward stepchild of US funding formulae, a signifier of structural inequities on home soil and, ultimately, a reminder of how matters of race still divided America.

For an African American on a waiting list for ARV medications or dying of HIV disease, as is the case for more than 36,000 Southern blacks since 2002 (SAC 2008), the irony of this situation might seem all too familiar. Racism is acknowledged in statements such as: “Studies have shown that blacks receive a lower quality of care even in our best medical facilities” (SAC 2008:11) and was certainly on display at a public meeting I attended in Alabama when black members of the audience pleaded with mainly white officials to allocate funding for ARV medications. Recessionary pressures had resulted in loss of funding for drug treatment programs, and clients, who were mostly African American, were afraid they would die. They were right to be fearful. CDC surveillance statistics indicate that African Americans are more likely to die from HIV/AIDS than any other racial group else in the United States, with most of these deaths occurring in the South.

Finally, it comes down to this: The face of HIV/AIDS in the US South is undeniably black. In Alabama, for example, 72 percent of new HIV cases were recorded among African Americans in 2009 (Alabama Department of Public Health 2010), even though blacks comprise only 26 percent of the state’s population. This racial patterning of the sexual epidemics occurs across the region as a whole. In fact, the mapping of HIV cases mirrors the social demographics of nineteenth-century plantation society, when most African Americans lived in Black Belt states that spanned a swath of counties from Texas to Virginia. A Millsian interpretation of the juncture between biography, history, and social structure in this instance would suggest that racial stigma played a crucial role in health disparities, funding priorities, and a political structure that favors the economic interests of the white elite (*Birmingham News* 2002). SAC (2008:11) made connections between stigma, HIV incidence, and the “resource-poor and compromised health care systems which are characteristic of many Southern states.” If maps of slavery, poverty, and STI/HIV rates were superimposed on each other, the startling convergence between slavery, poverty, and STI/ HIV rates in the United States would be apparent. Furthermore, the correspondence between slavery and HIV/AIDS would be more compelling than for poverty and non-HIV STIs, which afflict broader swaths of the US population. If there were any doubt about the existence

of a “black epidemic” along socio-structural lines, these doubts should be dispelled by the dark clusters that correspond so precisely with historical patterns of slavery in the Black Belt states, as they are known to Southerners.

To summarize, the three cases presented here illustrate the role of history, biography, and social structure in reproducing stigma. First, Nadja Benaissa became the archetypal Eve in which historical discourses about race, gender, and sexual identity were reproduced through the social power of the media and the legal power of the German social structure. Benaissa’s case is evidence that history should never be underestimated in its capacity to shape present day outcomes. Second, the idea of using biography to develop self-awareness about non-HIV STIs beyond the individual milieu is a difficult concept for STIs as a social issue, because these infections are paradoxically both unmentionable and mundane. In this case, colonizing stigma occurs in the willful silence surrounding common, treatable infections that can have lasting outcomes if not caught early or that could be prevented if stigma was not a barrier to knowledge about sexual health. People are vaguely aware of STIs being a social problem, but because most sufferers no longer display the telltale signs of Kaposi’s sarcoma lesions of AIDS or the suppurating sores of syphilis (in which case the response would be more visceral and perhaps more funded), the problem is hidden in the recesses of our private worlds, and the stereotyping continues its historical journey. Third, I introduced the topic of social structure by describing the partnership between the US government and faith-based organizations for HIV care in Africa and by comparing this response to lack of similar programs in the regional South, the epicenter of the nation’s HIV epidemic. Because the past is institutionalized through policy and practice, this example speaks volumes about how racial history has shaped US institutions for public health. Taken together, the three examples suggest that the sociological enterprise should always be mindful of the role of history, not just as a quaint or fondly remembered past but as a colonizing force in everyday social relations and certainly in the reproduction of stigma.

Outline

Throughout the book, I will explore the meaning of colonization in the sexual epidemics as a set of ideas that “colonize” in terms of what people hear about, come to believe, and act in relation to STIs. I will also explore the role of colonizing forces in the more traditional sense of conquering land and people. This colonization is a process by which

ideas and practices spread through trade routes, invading armies, slavery, and settler colonies; have been perpetuated by the laws and institutions of the conqueror; and have come to be accepted as normal in the way STIs are framed and acted upon in everyday life. Colonization is deeply implicated in the intersections between race, gender, and social power in the sexual epidemics and in the epidemiology of disease. Why are some people more at risk of sexual disease than others? The history of colonization can help to provide answers.

The present chapter, Chapter 1, began to develop the idea of colonizing stigma in the sexual epidemics and outlined the theory of Mills (1959), who coined the term sociological imagination to help people make sense of their social world. By arguing that one's problems are likely to be experienced by many other people and that these problems collectively could comprise a public issue, Mills proposed viewing one's biography as a product of history and the social structure as represented by institutions in society. The chapter took three components of Mills' sociological imagination—biography, history, and social structure—to demonstrate how stigma in the sexual epidemics individualizes blame, is a multilayered product of discourse from centuries past, and prevents the lived experience or personal trouble of an STI diagnosis from being translated into broader awareness of a public issue, even when such infections affect the health and longevity of majority populations at home and abroad.

Chapter 2 reviews stigma theories from sociology with particular relevance to the sexual epidemics. While briefly describing the work of classical theorists who identified some elements of stigmatizing constructs in their analyses of society, I focus mainly on the work of Erving Goffman as the foundational theorist for analyses of social stigma. It is a truism to say that anyone who writes about stigma and the sexual epidemics always refers to Goffman's work—I am unaware of any scholar who does not mention him in passing or in detail—but this chapter will suggest that his interactionist theory can be extended to the concept of colonizing stigma. As opposed to Mills' public action theory, Goffman's micro-level theory on stigma was more bidirectional than historical, as evident in terms such as audience-actor and social-psychological, but this chapter will demonstrate the role of history in reproducing stigma in everyday life. The latter part of this chapter addresses new developments in stigma theory during the HIV epidemic, particularly the role of sociologists in contextualizing blame for HIV risk. Finally, I provide a rationale for considering the idea that colonizing stigma is a valid construct through which to explain the exemplary nature of sexual stigma.

In Chapter 3, I explain the concept of colonizing stigma more fully by describing two fundamental ways in which stigma can be colonizing. The first is through the cultural ideas and practices of invading forces who propagandize the risk of disease in relation to race, gender, and social power. The second is through popular ideas about the sexual epidemics, which are driven by epidemiology, the media, and urban myths, or through preexisting discourse about race, gender, and social class. The chapter provides examples of these colonizing stigmas by referencing how, in a triumph of racist propaganda over reality, Maori women were blamed for the spread of syphilis in New Zealand, African women were similarly blamed and then targeted by Western science, and how the Eve identity, as it applies to all women, was colonized by a discourse of blame for spreading disease. I also describe how, as a social construct, “gender” itself is colonizing, with notions of male power being the locus for gender inequalities in the sexual epidemics, both historically and in modern times. The gendering of the sexual epidemics is problematical for several reasons, including the widespread belief that women are more likely to infect men than vice versa—the Eve stigma at work. The second half of this chapter is a case study of HIV/AIDS in Haiti as an example of the effects of colonizing stigma on the other side of the world. However, in contrast to Africa as a region in which women were uniformly blamed for being vectors, I describe how the troubled history of Haiti generated considerable sympathy in the donor community. This response led to an influx of funding for targeted interventions that helped stem HIV rates prior to the destructive earthquake of January 12, 2010.

Chapter 4 consists of a case study of colonizing stigma at work. Here, I focus on Alabama, a state with a troubled history in terms of stigma and sexual disease. Alabama is useful for theory building on several counts. First, it has the dubious distinction of being home to the Tuskegee syphilis study in which 399 impoverished African American men were studied without receiving available treatment from 1932 to 1972, sometimes until they died. Prior to this event, African Americans experienced Jim Crow laws of segregation and the perils of slavery that existed for several hundred years until ending in 1865. I trace the organizational response to HIV/AIDS in Alabama through these historical events for a Millsian analysis of how the biography of African Americans is seated in institutional practices and racialized history that engenders HIV risk in the sexual epidemics. Second, I propose an origin theory of syphilis that undercuts everyday assumptions about the social drivers of sexual diseases that predisposed African Americans to HIV risk. In so doing, I use the two strands of colonizing theory to

demonstrate how the global slave trade promoted the spread of sexual epidemics in the colonial era and how this process inverted blame for infections from the colonizers to slave populations. I then describe how the intersecting stigmas of race, gender, and social class were harmful for sexual health among African Americans. These outcomes promoted social disparities that were extremely persistent over time and that gave rise to ideas such as “AIDS is a genocidal plot to kill blacks.”

For Chapter 5, I return to New Zealand for contrasting cases on colonizing stigma, the syphilis epidemics, and institutional responses to HIV risk. While blame paradigms singled out Maori for blame, the absence of a slave history produced remarkably different outcomes for HIV prevention compared to the US South. The purpose of this chapter is to compare the two cases in order to demonstrate how stigma evolves according to how societies develop over time. In the US case, the drive for economic development in an earlier colonial era led to slavery, segregation, and a stigmatizing legacy of sexual diseases among African Americans. In the New Zealand case, the colonizers’ desire to build a better Britain free of the social ills of the old world led to a cultural ethos of social progressivism with positive outcomes for HIV prevention.

Chapter 6 addresses, in three sections, the tragedy of HIV in sub-Saharan Africa. In the first section, I describe the colonial legacy of sexual stigma by charting the history of Christian missionary work in relation to the syphilis epidemic. In particular, I interrogate the twin roles of British missionaries in “civilizing” indigenous people through moral education and in providing medical care to people who were believed to be in need of Western intervention. I then analyze Western appraisals of HIV risk in Africa and note how these models were fundamentally flawed in framing the “African problem,” especially for women who became stigmatized through this process. This section is followed by a discussion of biological discoveries on the origins of HIV, which deemphasized sexual promiscuity as a causal factor. Finally, I note how US aid programs in Africa fueled HIV-related stigma by blurring religion and medical care. Foreign influences not only replicated the colonizing practices of the British Empire by proselytizing in the name of HIV care, but this approach had dire outcomes in Uganda where the death penalty was proposed for gay men. The chapter ends with an explanation of why black Africans do not view these moralizing influences as neocolonialism but rather as a true expression of African values.

Chapter 7 concludes by discussing how colonizing stigma is enacted through policies, laws, and social institutions in the United States. The

chapter will draw on my own research in the southern United States on stigma as a barrier to STI care and extend the material in Chapter 4 to describe postwar history in prevention and treatment of the sexual epidemics in the United States. I describe how Britain's model for STI care was adopted as part of sweeping reforms for public health care in the Great Depression of the 1930s and how this visionary plan unraveled as time went on. In the latter half of the chapter, I describe the lived experience of people who seek STI care at public clinics, and a gender analysis of how stigma is used as weapon against both men and women in African American communities. I end with two scenarios that are currently unfolding in the annals of colonizing stigma and with suggestions of how the theory developed in this book can provide insights into future pathways for stigma in the US.