

Some notes on learning from AIDS activism for our responses to the Coronavirus (COVID-19) pandemic

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While living through the current Coronavirus/COVID-19 crisis I am struck by the connections between the AIDS crisis (which is also not over) and this health crisis. These connections are not often being made or remembered in the commentaries and analysis I have seen. At the same time there are also major differences between these two different health crises including mode of transmission, impact on people's bodies and health and to some extent who is most affected. I was actively involved in AIDS organizing and activism in the 1980s and 1990s and have also been involved in documenting some of these histories. In this initial sketch I try to draw out some of what can be learned from the history of AIDS organizing and activism for the current pandemic. I know this is partial and limited but I feel an urgency to get it out there. Please feel free to add to it or critique it. It is intended to get discussion going.

Contents

- ['Expendable populations' \(...\)](#)
- [Social solidarity/responsibili](#)
- [Health care for all! - health](#)
- [Transferring Resources to the](#)
- [Problems with distancing \(...\)](#)
- [Opposing the dissolving \(...\)](#)

Referring to AIDS organizing and activism I refer firstly (but not only) to the treatment based (but always much broader) direct action informed activism associated with various AIDS Coalition to Unleash Power (ACT UP) groups that existed across the USA, in 'Canada,' and around the globe (some of which still exist) or groups like AIDS ACTION NOW! (AAN!) based in Toronto. These groups with the themes of "Silence=Death, Action=Life" focused on fighting to get access for people living with AIDS/HIV to treatments to fight the infections that were actually killing people. They put the needs of people most affected by AIDS at the centre of the social response. I am also referring to the first wave of the setting up of community based groups in the early 1980s (and later) that supported people living with AIDS/HIV, developed education and fought against discrimination when governments were leaving people to die. It was these community initiatives growing out of gay and lesbian, and to some extent the feminist and progressive health movements, that provided support for people affected by AIDS in the face of state inaction and indifference from the elites of the medical profession. These forms of activism extended and saved people's lives.

Like all health emergencies the AIDS crisis was/is a condensation of many social relations - including sexuality, race, gender, class, poverty, underdevelopment, colonialism and neocolonialism,

ability, drug use, sex work, the power of pharmaceutical corporations, the character of the medical profession, problems with public health and so much more. It is always important to ask which 'public' is being defended and whose 'health' is being protected? For the AIDS crisis to be fully addressed all of these relations had to be engaged with.

The current pandemic includes all of this and more but in a context where neoliberal capitalist relations have gone much further in their destruction of health care, social assistance and the social wage, and the generation of precarious wage labour in many countries. The power of multinational pharmaceutical corporations over our lives has intensified.

More specifically, there are a number of connections needing to be made:

‘Expendable populations’ and fighting discrimination and stigmatization.

In the early years of the AIDS crisis there was little official and state response since it was seen as only affecting 'expendable populations' — gay men/men who have sex with men, drug users, Haitians and other people of colour (including the racist construction of 'African AIDS') and sex workers. These were the groups identified as the "high risk groups" and this term was lifted out of epidemiological discourse to organize social discrimination and stigmatization against these groups. These people were thought by moral conservative (and often neoliberal) governments as 'expendable' and therefore years of social and health care response were lost in the fight against AIDS. Instead the 'general population' (coded as white, middle class and heterosexual) was defended against the 'vectors' and 'reservoirs' of infection. Early AIDS organizing fought against this by refocusing on the risk activities that anyone could engage in and by affirming the importance of the lives and needs of people living with AIDS/HIV and the communities most affected by AIDS. AIDS activism fought against discrimination and racist responses to AIDS. It also took up the concerns of those who were being ignored in the social response to AIDS, including the needs of women and people of colour. AIDS activists argued for the needs of those most directly affected to be at the centre of the social response and not only the needs of the non-infected.

In the current pandemic there has been the social organization of discrimination, racism, and stigmatization against people from China, Korea and other Asian countries, including continuing references by Trump and others to the 'Chinese' virus (or for some the 'Asian' virus). In a slightly more localized fashion this has also been mobilized against people from Iran — in the middle eastern context in particular. This early focus on the pandemic as only affecting 'other' people (and only viewing these 'other' people as the 'threat') led to weeks of delay in developing a response in many state and official circles.

But there are also ways in which those most vulnerable to the coronavirus — older people and those living with compromised or weakened immune systems - including people with cancer, HIV infection, diabetes, heart conditions, and forms of disability — are seen as also being 'expendable.' This was especially clear in the first responses of Boris Johnson and the UK government with their mobilization of 'herd immunity,' or, what some people conjuring up pseudo-eugenic aspirations referred to as the 'culling' of the population. The elderly were viewed as 'non-productive' (in relation to capitalist production), or by some as a 'drain' on social resources — in contrast to Indigenous traditions where elders are seen as having wisdom and are treated with great respect- and those with immune-compromised bodies, including those with cancer and HIV, often those living with disabilities were also viewed by these people as 'expendable.'

With the articulation of 'washing your hands' as part of the preventative measures this means that all those who cannot access clean water (like many on First Nation reserves in 'Canada') also

become 'expendable.' With the official advice of 'social distance' and 'social isolation' as the way to prevent transmission this also makes all those who do not have the material basis to do this becoming 'expendable.' It is now clear to me that the term 'social distancing' participates in dissolving the social and since we need to maintain and build the social in the context of this pandemic we need to use terms like spatial or physical distancing instead. Those who cannot participate in these distancing and isolation practices include the poor and homeless (who are often racialized), and those in institutions (including nursing homes) and prisons, as well as those who cannot miss waged work when they are sick given the massive growth of precarious labour and the lack of paid sick days and social support given the ripping apart of the social wage by neoliberal capital. The class and racialized dimensions of this become very clear. Finally the closing of borders serves to place the lives of refugees, migrants and those without status in very difficult situations. These are mostly people of colour.

All these approaches prioritize the lives of those least at 'risk' of death from the coronavirus — the younger, the 'healthy,' the non-disabled, those with healthy immune systems, and the wealthy over everyone else. It is their health that was being protected, They became the 'public' to be defended from those who could potentially die from COVID-19. Calls for attention to the specific needs of Indigenous nations and communities, homeless people in the shelter systems, the need for all workers to have paid sick leave and relief from evictions and mortgages and to be able to refuse unsafe work, the need for adequate social supports. and for the needs of refugees and migrant workers to be addressed are ways to actively cut across this. This must be taken up as central to social responses to the pandemic.

Social solidarity/responsibility - from safe practices to 'spatial or physical distancing.'

When people including Michael Callen (an early AIDS activist living with AIDS) began to figure out that whatever was causing AIDS (this was before HIV was identified) was transmitted through specific sexual acts and blood to blood contact this led to the development of safe sex and later safe practice guidelines for injection drug use and other practices that meant there was no transfer of bodily fluids or blood to blood contact. These practices were effective in lowering HIV transmission. This was not an individualist response but was instead based on a sense of group social and collective responsibility and meant that people with support were able to alter their social practices for the benefit of their communities. It was not easy for people to alter their practices so this was based on a great deal of popular education and community support. Much of this was based on the assumption that everyone was infected so it broke down the barriers between those infected and those not. Regarding drug use it became central to harm reduction practices. It became part of a community ethics. In relation to safe sex it was also based on the eroticization of safe sex and practising safe sex as fun. This is how safe sex campaigns worked. Safe sex was the erotic and social way to do it for everyone.

In the current pandemic this takes a different form but also one that has to be social and collective in character if it is to work. Spatial or physical distancing - combined with hand washing, use of gloves and coughing/sneezing into one's sleeve etc — is now what is socially necessary and responsible to lower the infection and death rates. This is also based on the need for all of us to continue engaging in the vital work of social reproduction (including increasing caring labour) even in more distanced and isolated ways. It is this labour of everyday/everynight social reproduction — much of which is not waged and often associated with women (both cis and trans) in the prevailing gender division of labour — that creates the very possibilities for our survival. We need to change our social practices and this requires social support and solidarity, especially to protect those most

at risk of death from COVID-19. This means opposing the selfish individualism often displayed in response to a health crisis bred in capitalist societies.

Like with safe practices this collective response requires popular education and social support. While governments and officials can encourage this much of the impetus for this must come from below and we need to provide mass support for doing this. There are some inspirations for this in the early support groups for people living with AIDS/HIV, the buddy systems, and more in early grass roots responses to the AIDS crisis. Networks of mutual aid and social solidarity to support people are being formed in many locations (there is a list of some resources below) in the current pandemic and these need to be facilitated and given resources. Without violating spatial or physical distancing we need to provide support and solidarity for people. For those who have to engage in isolation practices we also need to provide as much support and care as we can. These initiatives will be crucial in determining whether we can slow the infection and death rate. The next few months will be crucial on a global scale.

Health care for all! - health from above to from below.

Central to AIDS activism was health care for all. In the USA ACT UP groups engaged in important campaigns for universal access to health-care. In the 'Canadian' context and other countries with more of a 'welfare state' there was more access to health care but still major problems (no Pharmacare, very expensive treatments, no coverage for dental care etc). Since the 1980s and 1990s things have largely got worse with major attacks by neoliberal capital and state agencies on access to and the quality of health care and a growing privatizing of health care. Existing health infrastructures have been weakened and torn apart. As Mike Davis points out in the context of the current pandemic:

“capitalist globalization now appears to be biologically unsustainable in the absence of a truly international public health infrastructure. But such an infrastructure will never exist until peoples' movements break the power of Big Pharma and for-profit health care.”

Here Davis raises major concerns about the need for our survival to shift the character of health care away from capitalist profit rates and the domination of big Pharma. If we are going to be successful in addressing this pandemic it requires major transformations in health care and social policy. This needs to be based on universal free access to quality health care, and free access to testing, treatments and vaccines when they becomes available — and the spending of major social resources on developing treatments and vaccines. Informed by feminist health organizing and AIDS activism this also needs to be a health from below where people get to take more control over their bodies and health in a rupture with capitalist health care and the power of the pharmaceutical corporations. This requires a major shift from health from above to a health from below. Michel Foucault, a French theorist, wrote about the development of 'biopolitics' where forms of social power mobilized bodies and the population as a resource for ruling forms of power starting in the 19th century. ACT UP type politics began to articulate what can be called a 'biopolitics' from below which is what we will need to address and build on in ending this pandemic.

Transferring Resources to the 'Global South'

In the AIDS crisis AIDS activists called in the Montreal Manifesto (issued by ACT UP NYC and AIDS ACTION NOW! at the World AIDS conference in Montreal in 1989) for a major transfer of wealth and resources to people in the global south if the ravages of AIDS were going to be successfully fought.

This was based on an understanding of how the underdevelopment of much of the global south was based on the transfer of wealth and resources through colonialism and imperialism to 'overdevelopment' in the global north. If people were going to be successful in combating AIDS they needed more wealth and resources and these needed to come from the more wealthy countries in the 'global north.' While these campaigns had only a limited impact they pointed in a very important direction.

In the current pandemic the situation is a bit different and even though China faced the first attacks of this virus they and Cuba are now the only countries in the world who seem to have the skills and resources to help people in Iran, Italy, Iraq, Venezuela, Nicaragua and other countries. We can actually see how neoliberal capitalism and its tearing apart of social programs and the social relations of health have weakened the ability of countries like the USA and many countries in Europe to be able to respond to this pandemic. At the same time forms of colonialism and neo-colonialism and imperialism still cause major forms of 'underdevelopment' in major parts of the 'global south' and the transfer of resources, wealth and expertise there are urgently needed.

An important part of this now is also to end the sanctions against Iran and Venezuela that are making it far more difficult for these societies to respond to this pandemic. The sanctions against Cuba actually make it more difficult for other countries to be able to use the medical experience that Cuba has gained. These sanctions must be ended. The Israeli state in its restriction of what can enter Gaza and the occupied territories is also making it more difficult for Palestinians to survive this pandemic. The Israeli state must let aid and assistance in and not leave Palestinians to die.

Problems with distancing and isolation.

There are problems with the solutions proposed to stop the spread of the coronavirus. While absolutely necessary 'social distancing' (what needs to be called spatial or physical distancing) and 'social isolation' (what needs to be called spatial or physical isolation) can be taken up in a very individualist way. Those with lots of material resources are able to accomplish this far easier than others and there are major racialized class implications. These measures also can facilitate isolation and depression and exacerbate mental health problems in people who need everyday social contact. 'Social isolation' with abusive partners can intensify problems of domestic abuse and violence against women and we must develop ways to respond to this. We need to also see that there is a lot of work/activity involved in 'distancing' and 'isolation' and this needs to be recognized and supported. We need to provide as much social support and solidarity for this 'distancing' and make it clear this is a needed and necessary social and collective response. In this sense we need to see it as the opposite of an individualist response but view it as our social and community responsibility. We need to consistently check in on people via telephone, email, facetime and other social media. We need to make sure people are able to get their groceries and whatever else they need. We need social solidarity and mutual aid and need to facilitate networks that can accomplish this. The scenes from Italy, Lebanon and other places of people singing to, and with, each other from their balconies are an inspiring example of what is very possible and badly needed. We need to constantly remind ourselves that we all engaged in collective practices of survival and find joy, play and pleasure wherever and whenever we can in doing this.

Opposing the dissolving of our social struggles and movements and resisting the social organization of forgetting - Returning to the streets when we can.

From above they are using 'social distancing' and the ban on public gatherings in the streets to

attempt to dissolve our public struggles and movements. In the AIDS crisis we resisted their attempts to have us so overwhelmed with grief that we could not continue our collective struggles. We resisted this through the political mobilization of anger, rage and grief including with the development of 'political funerals.' But in the AIDS crisis we were still able to express publicly our social and collective response and our power from below in direct actions. In this pandemic we can no longer do this.

Those in power are attempting to use this pandemic to dissolve our social struggles and to further their class and racial interests. The wave of declaration of states of emergency, while necessary in very important ways, can also give state agencies powers they can use against us collectively and individually. We need to remember how quarantine legislation was used against the communities of people most affected by the AIDS crisis in the 1980s and 1990s.

This demobilization of struggle is very clear regarding the Wet'suwet'en struggle for sovereignty and against pipelines and 'man camps,' in the major teachers struggles in Ontario, and perhaps most clearly in the halting of mobilization against the neoliberal pension reform and in the continuing Yellow Vest struggles in France. We need to keep these struggles going, even if using new tactics. For instance, this year's Israeli Apartheid Week (a pro-Palestinian global week of education and action) has had to cancel and postpone many events and this week is being kept alive via social media. The Wet'suwet'en struggle continues via telephone and social media and popular education in a more dispersed fashion.

We need these struggles to be kept alive in the various ways that we can, and also use this pandemic period to do as much popular education on these and other struggles as we can. This means using social media as a terrain of struggle, while at the same time recognizing its limitations including that not everyone has access to it — and how measures like the closing of libraries will further limit access to it. We need to use the internet and social media as much as possible as a terrain for remembering and for critical social analysis. We must not allow them to make us forget about the struggles we were engaged in before this pandemic hit nor what we will learn from surviving it about the need to get rid of neoliberal capitalism and for radical social transformation. When the situation again allows for it we must return to the streets and large public assemblies to continue, intensify and to link together our struggles for justice and dignity with the added wisdom of what we will have learned from surviving this crisis.

Gary Kinsman

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Panagiotis Sotiris, "Is a Democratic Biopolitics Possible," *The Bullet*, March 14, 2020, at: <https://socialistproject.ca/2020/03/is-a-democratic-biopolitics-possible/#more>

Resources for Mutual AID.

Montreal COVID-19 Mutual Aid Mobilization

<https://secure.ijvcanada.org/sites/all/modules/civicrm/extern/url.php?u=706&qid=129437>

CareMongering Toronto

<https://secure.ijvcanada.org/sites/all/modules/civicrm/extern/url.php?u=707&qid=129437>

Vancouver COVID-19 Coming Together

<https://www.facebook.com/groups/841903382944884/>

CareMongering Hamilton

<https://secure.ijvcanada.org/sites/all/modules/civicrm/extern/url.php?u=709&qid=129437>

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P.S.

- Radical noise. March 18, 2020:

<http://radicalnoise.ca/2020/03/18/some-notes-on-learning-from-aids-activism-for-our-responses-to-the-coronavirus-covid-19-pandemic/>

- Gary Kinsman was one of the first three employees of the AIDS Committee of Toronto, a member of AIDS ACTION NOW!, the Newfoundland AIDS Association, the Valley AIDS Concern Group in Nova Scotia, and now the AIDS Activist History Project (<https://aidsactivisthistory.ca/>). He is also the author of *The Regulation of Desire*, and co-author of *The Canadian War on Queers*. His website is: <https://radicalnoise.ca/>