Brenda Tyrrell //

A notion that has been carelessly tossed around since COVID-19 emerged last spring is that it is 'the worst pandemic in the last century.' Is it, though? Those making this declaration are most likely thinking of the 1918 Influenza Pandemic, when one-third of the world's population was infected by the H1N1 virus, and the resultant 50 million worldwide deaths (675,000 in the US). If we look at recent COVID-19 statistics, we learn that there are 67 million current cases worldwide, 43.1 million recovered cases, and 1.54 million deaths. In the US, which has the highest number of deaths (282K as of 11/25/20), there are 14.8 million active cases. While the impact of these viruses is undeniable, it seems easy to forget that COVID-19 is not the only game in town. 75.7 million people worldwide have been infected with HIV and 32.7 million people have died from AIDS-related illnesses since the pandemic started in 1981. Currently, 38 million people worldwide are living with HIV—1.2 million of those in the US—even scarier, 14% of these cases are not aware that they carry the virus, thus potentially and unintentionally spreading the virus. Even more devastatingly, these faceless numbers connected with both HIV and COVID-19 reveal both pandemics' ability to stigmatize, racialize, and essentialize certain populations.

Fear reverberates loudly when we talk about not only COVID-19, but also HIV. In her recent article, Dr. Gladys Palacio Velarde reminisces about the emergence of the HIV and AIDS pandemic, saying, "I remember gowning and masking, as if I was going to the moon. I remember the fear in people's faces—the patients, nurses, doctors and students—all facing many unknowns." As a former nursing assistant and nurse, I myself remember not only observing this fear, but also experiencing it. I was sixteen years old and working as a nursing assistant during the earliest years of the crisis. Initially, there was little knowledge on the spread of the virus or how to decrease the spread, but I (we) soon became aware that the days of gloveless resident cares were over. More significantly, the residents resented these new safeguards, feeling targeted, and repeatedly felt the need to assure us that they did not have 'the AIDS.'

The stigmatization is real. While filling out my first nursing job application (in 1994), one question shocked me: 'Check here if you will find taking care of a patient with AIDS ethically or morally challenging.' I left it blank, thinking 'of course I wouldn't, what nurse (or other medical professional) would?' However, when I took care of my first patient with full-blown AIDS, I was terrified. Questions and doubts in the science flooded my mind as I prepared to enter their room for the first time. The fear is genuine, and the stakes are high, though: in my eighteen-plus years of nursing, I had two needle sticks—one was a needle slip, one was because the sharps container was

not emptied by the previous shift. Both times, I underwent about nine months of testing (each), as well as postponing any plans I had for starting a family, before I was considered virus-free.

One might wonder how COVID-19 affects those who experience HIV. There are at least three ways; first, and most urgently, the effects of lockdowns. Lockdowns, or sheltering in place, results in several outcomes, including a slow-down or complete stoppage of receiving ART (anti-retroviral therapy) medication and the monitoring of treatment and prevention due to difficulty in travel or an individual (and realistic) fear of going out to the doctor. A second way is the shifting of health care resources from HIV treatment, prevention, and research to COVID-19 research, treatment, and vaccine. Vaccine research is especially important to note here: the 1918 Influenza Pandemic abated on its own in late 1919, and there is currently a massive (and, at times, problematic) effort to develop a vaccine for COVID-19. Significantly, though, nearly forty years have passed since the advent of HIV, and a vaccine has yet to be developed. (To be clear, PrEP is not a vaccine; it is a preventative measure.) What's at stake here? According to the International AIDS Society (IAS) 'modelling to assess the impact of a total interruption of six months of ART across Africa, an estimated 500,000 additional lives would be lost to HIV-related causes.'

Let me just say that again: **500,000 lives.**

Which leads to the third way COVID-19 affects those who experience HIV: based on the ongoing and renewed stigmatization, racialization, and essentialism of those experiencing HIV and AIDS, these lives might be considered sacrificable by some; after all, Black and other marginalized individuals are already 'disproportionately affected' by not only HIV, but also reported higher death rates due to COVID-19 than for the total population. There is hope, however. Much can be learned from the early and continuing struggles faced by those experiencing HIV when we consider the shared social justice issues of both pandemics. Those interested in stopping the stigmatization, racialization, and essentialism associated with both pandemics might consider how public health, communities, and affected populations banded together in the early days of HIV and learn valuable strategies to combat structural racism, sexism, and ableism. Then, perhaps, COVID-19 can be a team player.

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