Pence, Putin, Mbeki and Their HIV/AIDS-Related Crimes Against Humanity: Call for Social Justice and Behavioral Science Advocacy

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Abstract Indiana, a large rural state in the Midwestern United States, suffered the worst North American HIV outbreak among injection drug users in years. The Indiana state government under former Governor and current US Vice President Mike Pence fueled the HIV outbreak by prohibiting needle/syringe exchange and failed to take substantive action once the outbreak was identified. This failure in public health policy parallels the HIV epidemics driven by oppressive drug laws in current day Russia and is reminiscent of the anti-science AIDS denialism of 1999–2007 South Africa. The argument that Russian President Putin and former South African President Mbeki should be held accountable for their AIDS policies as crimes against humanity can be extended to Vice President Pence. Social and behavioral scientists have a responsibility to inform the public of HIV prevention realities and to advocate for evidence-based public health policies to prevent future outbreaks of HIV infection.

In late 2014, the Indiana Department of Health identified an HIV outbreak in the southeastern part of the state [1]. The observed rapid transmission of HIV in Indiana occurred as a result of sharing scarce injection equipment in the context of a growing opiate addiction crisis in rural Indiana [2]. Studies have demonstrated that a large number of syringe sharing partners in this socially dense network accelerated HIV transmission [3]. There were apparent warning signs early-on, including increases in opiate-related hospitalizations, overdoses, and deaths, and an

emerging hepatitis-c virus epidemic. Local health authorities sounded alarms to the state government, but with syringe access and exchange restricted by state law, there were few available interventions. Archaic prohibitions placed on syringe-exchange in the face of this HIV outbreak unnecessarily tied the hands of public health officials. Along with oppressive policies that were instituted as part of the so-called “war on drugs”, stigmas around HIV/AIDS and drug treatment are also to blame for keeping in place obsolete restrictions on syringe-exchange. Now deeply ingrained in the social psyche, stigmatization and prejudices against people who inject drugs can foster inaction even during a crisis such as the one in Indiana. The social forces of stigma, ignorance, and fear created political barriers to HIV prevention that were more intractable in Indiana than was the virus itself.

By April 2015, the Indiana outbreak had reached 190 confirmed cases of persons living with HIV in rural Scott County. Prior to the 2014–2016 outbreak, Scott County did not have a baseline HIV prevalence. Tragically, the estimated HIV prevalence in Scott County is now 5%. Scott County’s HIV outbreak occurred in a context of historically low spending on public health services [4]. Other recent Indiana outbreaks of infectious diseases were similarly met with poorly resourced responses that foreshadowed the HIV crisis, including outbreaks of syphilis [5] and tuberculosis [6]. Underfunded HIV testing services translated to poor coverage and virtually no rural surveillance, causing delay in detecting and stemming early cases [7].

While Indiana faces a serious opiate crisis, the state’s HIV outbreak is attributable to a lack of access to inexpensive, sterile syringes more so than drug abuse itself. Neighboring states with similar or worse opiate epidemics have not yet experienced HIV outbreaks. As shown in

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Table 1 HIV infections attributed to injection drug use and changes in opiate overdose deaths in Indiana and selected comparison states

State/City	Year ^a	New injection-related HIV infections	% Change in opiate overdose deaths 2014–2015 ^b
Indiana	2015	175	7.1
Iowa	2014	6	17.0
Kentucky	2015	2	21.1
Ohio	2014	15	21.5
Michigan	2014	16	13.3
Maine	2015	5	26.2
North Dakota	2014	5	36.5
New York City ^c	2015	16	20.4
Chicago ^c	2014	30	7.6

^a Sourced from the most recent year available from state and city HIV surveillance reports

^b Available from CDC <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

^c City data for HIV infections and state data for overdose deaths

Table 1, during the Indiana outbreak, the state suffered more HIV infections than occurred in all neighboring states plus New York City and Chicago combined. Furthermore, rural New England is experiencing increased deaths from opiate-related overdoses on a far greater magnitude than Indiana, yet New England as a region has not experienced accompanying HIV outbreaks.

In astounding contrast to anywhere else in North America, Indiana looks alarmingly more like what we are witnessing in Russia. The injection drug use HIV epidemics of Eastern Europe have been raging for nearly three decades and Russia's HIV epidemic far surpasses neighboring countries [8]. Nevertheless, the Russian government's stigmatization of HIV, oppressive drug policies, restrictions on needle-exchange, and failure to legalize drug treatment have fostered what is now one of the world's fastest growing HIV epidemics [9]. An estimated 1.2 to 1.4 million people in Russia are living with HIV, and 100,000 new HIV infections were reported in 2015. At this point in the history of AIDS, when incident infections in the injection-related HIV epicenters are nearing zero, HIV epidemics that continue to grow among people who inject are the result of failed public policies that deny prevention science and ignore the effectiveness of interventions [10].

It is common knowledge that HIV infections are averted by expanding drug treatment and providing sterile syringes. Syringe exchange programs are effective in preventing the spread of HIV, have no known unintended consequences, and are highly cost-effective [11]. *AIDS and Behavior* has published more than 1000 articles concerning the prevention of injection-related HIV infections, with nearly 300 studies that evaluated the impact of syringe exchange programs and policies. These studies along with countless others show that syringe exchange programs not only slow

HIV infections, they have the potential to stop injection-related HIV transmission altogether. Expanded drug treatment, access to sterile syringes, HIV testing, risk-reduction counseling, and a broad array of services bundled as harm reduction programs have controlled HIV infections in some communities hardest hit by HIV in the world. In New York City, for example, the rate of HIV incidence declined more than 18% per year between 2001 and 2015 [12]. Dramatic declines in HIV infections are occurring in other cities with expanded harm reduction programs, including Vancouver with 80% fewer infections in 2014 than 2005 [13]. The science could not be clearer: syringe exchange programs prevent HIV and other viral infections without any risk for proliferation of drug use, increases in criminal activity, or community hazards from discarded syringes/needles [14–16]. Nevertheless, unfounded fears, stigmas, prejudices, and ignorance remain the basis for discriminatory practices and policies that account for local surges in injection-related HIV infections.

Denying Evidence in Public Health Policy is an Attack on Citizens

At the societal level the long-term consequences of misguided public policies from years past continue to fuel some of the world's most devastating HIV epidemics. In South Africa, the presidency of Thabo Mbeki stands as a worst case scenario for when health policies ignore scientific knowledge and deny reality. Mbeki infamously used pseudoscience and AIDS denialism to justify his decisions to withhold HIV prevention and refuse the scale-up of antiretroviral therapies. Mbeki claimed that there was, in the year 2000, still a debate among scientists as to what

was causing AIDS. He questioned whether HIV even existed and claimed that antiretroviral therapies are toxic poisons propagated by a conspiracy against Africa [17, 18]. Chigwedere et al. [19] showed that from 1999 to 2007 more than 330,000 South Africans senselessly died and more than 35,000 babies were born with HIV as a direct result of Mbeki's failure to implement basic HIV-related services. These policies ended when AIDS activists, who included social and behavioral scientists, ultimately forced Mbeki out of office. Only after AIDS denialism was replaced with evidence-based public health policies did South Africa invest in HIV prevention services, scale-up antiretroviral therapies, and dramatically decrease the rate of HIV infections. South Africa is now experiencing a slowed HIV epidemic and is on a path toward eliminating mother-to-child HIV transmission.

Similar to the devastation in South Africa, the Indiana HIV outbreak could have been averted with a proactive approach to harm reduction and HIV prevention [2]. However, the state government's lack of response to the crisis was based on political expediency and a strange confabulation of syringe access with anti-drug policy. Reminiscent of Thabo Mbeki's denialism, former Governor of Indiana and current Vice President of the United States Mike Pence infamously stated "I do not support needle exchange as an anti-drug policy, but this is a public health emergency" [20]. Needle exchange, of course, has no known impact as an 'anti-drug policy'. However, needle exchange is a proven effective public health intervention. The official account of Governor Pence's response is found in the Indiana State Department of Health's *Syringe Exchange Program Guidance for Local Health Departments* [21]. The report reads:

In response to the outbreak, the Governor issued Executive Order 15-05, declaring a public health emergency in Scott County and allowing Scott County to request an SEP as part of a broad disease control and prevention plan for a period of 30 days. Scott County officials completed this request and opened the first legal SEP in the state of Indiana on April 4, 2015. The Executive Order was renewed in mid-April and SEA 461 passed both houses later that month. Under the new law, the Scott County Health Department requested the continuation of their SEP and the Indiana State Health Commissioner approved it for a period of one year. There are no federal or state funds available to support the development, implementation, and/or evaluation of syringe access programs (p. 3).

The law allowed for local officials and concerned communities to declare a public health emergency and request permission to establish a syringe exchange for one

year, requiring annual renewal. Allowing communities to request permission to establish a temporary unfunded program should not be confused with supporting prevention services. This policy change was essentially empty as it came with "no federal or state funds", leaving communities on their own in the midst of a crisis.

In this issue of *AIDS and Behavior*, Meyerson et al. [22] report an evaluation of 24 Indiana counties that went through the process of trying to establish syringe exchange programs under the new and unfunded Indiana law. They found that local health officials were eager to establish syringe exchange programs. Despite their efforts, these dedicated health officials and concerned citizens experienced multiple obstacles including poorly defined terms and ambiguities in the law, and scarce resources. Structural barriers to implementing syringe exchange in Indiana did not change. Meyerson et al. document how agencies shared information, strategies, and resources to manage these challenges and ultimately received permission to start needle exchange programs that have the potential to end the crisis. Unfortunately, because state funding remains unavailable the programs have relied on private donations that required months to secure [23], all the while HIV continued to spread.

Willfully Allowing HIV to Spread among Citizens is a Crime Against Humanity

South African AIDS activist Nathan Geffen [24] demonstrated that the devastating impact of AIDS denialism in South Africa during the Mbeki years meets the standard as a crime against humanity. As set forth by the Rome Statute [25], a crime against humanity is "Any of the following acts when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack... inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health." Geffen and others [26] argued that Mbeki's AIDS policies fell square under the definition of a crime against humanity and that he and his Health Minister should be held accountable. The same case can be made against Russia's President Putin. As stated in the UNAIDS 2014 Gap Report [27],

In the Russian Federation, where the official policy is against providing opioid substitution therapy services for people who inject drugs, the HIV prevalence among people who inject drugs is estimated to be between 18% and 31%. In contrast, in countries in western and central Europe, where coverage of services such as needle and syringe programmes and opioid substitution therapy is high, the numbers of

people becoming newly infected with HIV are low (p. 21).

Despite the fact that infections in Indiana's HIV outbreak are not nearly the scale of Mbeki's South Africa or Putin's Russia, HIV infections in Pence's Indiana were nonetheless preventable and no less tragic. In all three cases, the long-term consequences of withholding lifesaving measures have caused great ongoing suffering and injury to body. All three public health tragedies are a clear result of systematic failure to aide civil populations. While Mbeki has not been held accountable, he is no longer a threat to the people of South Africa. Vice President Pence and President Putin have also not yet been held accountable for the harms caused by their failures to act, and even worse their prohibitions that keep others from acting. And while there has been extensive news coverage of Vice President Pence's continued and varied assault on LGBT communities including denial of marriage equality, removal of protections against discrimination, and support for conversion therapy (another violation of human rights also shared with President Putin, see [28]), we are not aware of the US national press ever asking candidate Pence during the 2016 presidential campaign about his role in his state's HIV outbreak.

Given Vice President Pence's history of denying effective public health approaches, we must remain highly vigilant in demanding the implementation of evidence-based HIV prevention policies to prevent the further spread of HIV. We must be keenly aware of the extent to which political climates and ideologies (as evidenced by Indiana, Russia, and South Africa) can do immense damage to progress made in the HIV prevention and treatment landscape. We need to work against the illusion that elected civil servants have *alternative facts* for implementing public health prevention policies. In Pence's case, he chose stagnation on the basis of moral superiority, while thousands of his constituents senselessly risked exposure to HIV.

AIDS policies grounded in the denial of scientific and medical facts are acts against the public interest and may very well be crimes against humanity. From a social justice perspective, HIV/AIDS social/behavioral scientists have a responsibility to bring evidence forward to improve public and political discourse. We must more effectively package our findings in a way that enters into the public consciousness. Our research should be especially useful to activists in their efforts to influence policy. As a scientific outlet, *AIDS and Behavior* shares this responsibility. Articles published in the journal have been important in past policy initiatives [29–33]. Continued progress in controlling HIV requires us to become scientist-activists and hold ourselves accountable for demanding evidence-based public health policies.

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