Child's Play: Insight into the Similarities and Differences Between COVID-19 and HIV/AIDS in the LBGTQ+ Community

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As of May 1, 2020 over 700,000 people have lost their lives to HIV/AIDS, and over 576,000 to COVID-19. Both pandemics have had detrimental impacts on the lives of Americans, reshaping the US economy, culture, and society (CDC 2020). It is difficult to not compare the current pandemic to the most recent major pandemic of HIV/AIDS, yet research is lacking. Four decades into the HIV pandemic, there has been an evolution in regard to social and behavioral responses to infectious disease in the world. Responses to the two pandemics have varied on intrapersonal, interpersonal, communal, and global levels. I will be observing the differences and similarities in responses to both pandemics in one of the most marginalized populations, the LGBTQ+ community. AIDS in the US became a public health crisis around 1982; by 2016, 1.1 million Americans were diagnosed with HIV/AIDS (Yongli 2016). COVID-19 overwhelmed American health care systems and public health strategies have heavily relied on social and behavioral change strategies to slow transmission (Eaton 2020). Similarly, efforts to stop HIV/AIDS transmission were predominantly dependent on local non-profits and grassroots movements as the disease was stigmatized and victims of the disease were demonized. Prior to the COVID-19 pandemic there were already major healthcare and financial disparities between LGBTQ+ populations with 23% reporting lack of health care coverage (Krause 2021), and further research supporting discrimination towards the LGBQ+ community in healthcare. In this paper, I ask how the responses to infectious diseases differ between the HIV/AIDS epidemic, and COVID-19 in LGBTQ+ communities. I argue that the LGBTQ+ community in the US has experienced similarities between both pandemics through the neo-liberal health approaches with the US governmennt placing responsibility for safety and health on communities most directly affected by HIV/AIDS and COVID-19. Due to a lack of research on this topic, I am starting with federal level research to provide preliminary understandings of the comparison between the two pandemics.

Background

While limited attention has been paid to the human immunodeficiency virus (HIV) in the United States in recent decades, it is a disease that has been forgotten by the general public but many members of the LGBTQ+ and black communities regard HIV an American genocide (Guinan 1993). In 1981, a rare lung infection called Pneumocystis carinii pneumonia (PCP) was reported in five young gay man in Los Angeles, CA. In 1982 the CDC first acknowledged the term AIDS (Acquired Immunodeficiency Syndrome). By the end of 1983 there were reported 3,064 American deaths due to the identified AIDS syndrome. The end of the 1980's saw the understanding of HIV as the virus that leads to AIDS. The HIV pandemic has disproportionately impacted the LGBTQ+ community since the beginning. While gay and bisexual men only make up 2% of the US population, they accounted for 68% percent of new HIV infections in 2015 (Fact Sheet 2019). SARS-CoV-2 virus was first reported in Wuhan, China in December 2019. This infectious disease spread rapidly around the world and became the most prevalent pandemic of the last century, changing the modus operandi of all parts of society (Shah 2020).

Towards the beginning of the pandemic as US hospitals were being overwhelmed with bodies and patients, researchers Dr. Eaton and Dr. Kalichaman gathered lessons that should be learned from the HIV/AIDS pandemic. Eaton and Kalichaman's research reported social dimension to the HIV/AIDS pandemic and recommendations for the US healthcare system, including a public health approach of social and behavioral changes to help halt transmission. The first level of individual-level behavior changes they show has historically been the most difficult to implement. Social media and political leadership created an atmosphere of distrust and conspiracy-driven messages early in the pandemic, which is quite similar to the distrust during the HIV/AIDS pandemic. Prior research supports that multi-level community intervention yields better results and more sustainable ways to combat transmission rates than the single-level efforts used for HIV prevention. This research establishes the contributions that HIV prevention and treatment research has found to the mitigation of COVID-19. My research builds on this and reflects on the COVID-19 pandemic over a year later to find what lessons may or may not have been learned.

Quantitative research conducted on the LGBTQ+ community shows cause of concern for how this population may potentially be further harmed by structural violence during the COVID-19 pandemic. Structural violence is the concept of a form of violence wherein some social structure or institution harms certain groups of people more than others who live in the same political and economic system (Farmer 2005). For example as of August 2020, 30.2% of LGBTQ+ Americans have lost their jobs and not been rehired (Krause 2020). As of 2018, 17% of LGBTQ+ adults were not covered by health insurance compared to just 8% of the general public. These disparities are even greater in LGBQ adults of color with 23% reporting no health care coverage. As COVID-19 hits communities, certain communities are at higher risk due to intersecting identities in the US healthcare system like gender identity, socioeconomic status, race, and sexuality. The LGBTQ+ community not only faces more barriers to receiving health treatment and insurance coverage, but carry the social stigma associated with AIDS. Sociologist, Kimerely Kline addresses "undocuqueer" people—LGBTQ+ im/migrants who have intersecting identities that leave them vulnerable to unemployment, health care discrimination, and exclusion from financial relief offered from Coronavirus Aid, Relief, and Economic Security Act (2020). These preliminary implications of the possible inequalities that LGBTQ+ people will face illustrate the need for research to fill the gaps in the study of how COVID-19 is affecting this community, and structural violence from the HIV pandemic may be affecting them in the current one.

It is important to understand the neoliberal healthcare system at play in the US because it shapes how policy, regulations, and medical practices are formed and implemented. The three principles of neoliberalism are individualism, free market through privatization, and decentralization (McGregor 2001). The root of this approach is the assumption that human beings favor themselves and are responsible for their own actions. This eliminates community and public good. For example, the social stigma surrounding HIV/AIDS through the late 1900's was that if an individual was infected it was their fault (Zarei 2015). This is a large part of what caused delays in funding, research, and health policy which will be further investigated. During the COVID-19 pandemic, the 'burden' of protection was left to individuals to defend which was widely seen in confrontations between anti-maskers and essential workers. Moreover, neoliberalism ensures sustained economic growth by deregulating (or lack of regulating) and privatizing public and state owned-entities (McGregor 2001). Many hospitals, important treatments like EpiPens, and other life-saving parts of the US healthcare system are privately owned. Private hospitals were able to refuse treating HIV/AIDS patients, resulting in lack of access and minimum health support for the LGBTQ+ population due to lack of regulation. The final part of neo-liberalism is decentralization by transferring power to provincial, state, or regional governments. COVID-19 exemplifies this as the Trump administration implemented little policy or support for states. States were left in bidding wars with each other and against the federal government for Personal Protection Equipment (Feiner 2021). Neo-liberalism holds the economic market above consumers and public healthcare.

There is a strong base of research documenting the experiences of the LGBTQ+ community during the HIV/AIDS pandemic as a result of systemic violence. My research helps to fill the void with connections across the decades between the two largest pandemics in the last century by uniquely observing the experiences of COVID-19 through the LGBTQ+ lens. The most predominant part of my research that will contribute to the understanding of the American healthcare system, and response is the connection made by the community that has lived through both and been deeply affected by both pandemics.

Research Strategy

This paper will first take a qualitative approach to analyzing the similarities and difference between the COVID-19 and HIV/AIDS pandemic in the queer community. The research I will be comparing predominantly comes from New York City and San Francisco since these two cities have some of the largest queer communities in the US, and best recorded information on queer specific impacts and legislation. I will observe educational programs, legislation, and bio-power at play in the United States. I am choosing to rely on qualitative information like policy and journal articles as I am trying to build on research that has already been conducted. The purpose of my research is to draw parallels and important comparisons between these two deadly pandemics to better understand the lasting impacts on the queer community. While I would recommend future research focus more on specific case studies, this is preliminary research that lends itself to a more national scale, with national observations and trends being where smaller trends and potential research can be found.

The second part of this research entailed interviews with members of the LGBTQ+ community, and front-line healthcare workers who worked during both pandemics. These interviews were conducted with ten individuals from different parts of the United States. Interviewees were asked a series of six open-ended questions to understand their lives, communities, and experiences during both pandemics. Interviewees were predominantly people of color with identities ranging from gay, lesbian, intersex, polyamorous, queer, bisexual, pansexual, and trans. Healthcare workers interviewed do not belong to the LGBTQ+ community. The ages of interviewees range from 52 to 77 years old. In order to prioritize archive-building, my research shifted focus from the medical similarities and differences of these two pandemics or personal experiences contracting either infectious disease, and towards observing the social, political and economic relationship between the two by using the lived experiences of LGBTQ+ members, and analysis.

My results are organized into four distinct categories: education and misinformation, policy, treatment and testing, and interview findings. Comments and stories from interviews are mixed into the three first categories, but especially focused on in the fourth section. Because interviews came from such diverse backgrounds there are a lot of suggestions found in further research as well as similarities observed across their shared experiences of being a part of or helping the LGBTQ+ community.

Findings

1. Education & Misinformation

There are very strong parallels between the two pandemics when it comes to misinformation. During the 1980-1990s there was heightened scrutiny from both the LGBTQ+ community and the general public about HIV research, and well documented lines of thought that were conspiracy driven, often rooted in homophobes, and anti-government rhetoric. This misinformation and lack of information ended up being quite deadly, and is estimated to have killed 330,000 individuals, and 35,000 infants were born with HIV as a result of this conspiracy-driven public health programming. Participant 3, a gay white man living in San Francisco, who spent most of the HIV pandemic in New York explained "They left us alone, to figure out how to navigate something that was kill us. The misinformation was rampant, and we were piecing together a puzzle that we didn't even have the right pieces for." It is too early to know the true determinants of misinformation during COVID-19, but preliminary research from the American Journal of Tropical Medicine and Hygiene already estimated there have been at least 5,800 people who died due to coronavirus-misinformation.

As saddening as both cases are, and the number of lives that have been lost to lack of education and misinformation, I argue that the two cases are not as comparable as they seem at first. COVID-19 misinformation has been driven by an infodemic. Infomedics are caused by an abundance of information, driven by social media, internet access, rumors, and conspiracy theories (Islam 2020). Research found that the majority of misinformation was rumors (about 86%), and these rumors were predominantly focused on infection prevention like eating garlic, keeping throat moist, or spraying chlorine (Islam 2020). In contrast, the HIV/AIDS pandemic saw a height of denialism, that was rooted in racism, homophobia and sexism, and largely ignored for the first decade that it spread across the United States. This will be further expanded upon in the policy section. Both diseases have seen stigmatization, but at different levels. Both pandemics see the establishments of in-groups and outgroups, with a devaluing of out-group members which perpetuates misinformation and leads to the death of specific populations (Link & Phelan, 2001).

Many Americans have spent the last 12 months feeling unsure of what information is right or wrong, and the best way to navigate COVID-19. This contrasted the interviews with both healthcare workers and LBGTQ+ people who strongly expressed just how little information there was available during the 1980's. Participant 3 explains "The government didn't want to help us, doctors didn't want to help us. We tried our best to help each other, but even then it was the uneducated trying to educate the uneducated." Healthcare workers agreed with this sentiment. Although the COVID-19 pandemic has seen misinformation run rampant through many forms of public correspondence, public announcements by government leaders and medical officials have recognized the disease quite openly. While COVID-19 response and education was delayed by about 1-2 months, the education and awareness for the queer community was delayed by several years (Lawrence 2020). Lacking resources and education stem from stigma surrounding the virus. While stigma centers different groups, it is very present and has killed people in each pandemic. COVID-19 has seen the stigmatization of healthcare workers, patients who survived COVID-19, and Asian Americans. There were a recorded 200 incidents of COVID-19 related attacks before the third month of lock-down (April 2020) (Bagcchi 2020). Participant 9, a black lesbian woman in San Francisco explained "I'm watching what happened during the HIV/AIDS pandemic all over again. They spent decades demonizing us, and now they are demonizing Asian Americans. They always need to have someone to blame." Interviewees acknowledge that the COVID-19 pandemic was easier for them in regard to stigma because they were not the 'out-group' of this pandemic. Still, some participants explained that witnessing the violence against healthcare workers, previous patients, and Asian Americans has been triggering for large parts of the queer community. Miseducation of both pandemics must be acknowledged, as well as their similarities and differences because the stigmatization of both pandemics looked different but are rooted in similar justifications of discrimination.

2. Policy

The road to action for HIV/AIDs was long, spanning across a decade of intense activism, and hundreds of thousands of deaths. In June of 1981, the CDC published its first report on the new disease, but the political climate of the country prevented proactive federal response. Kennedy had just been elected president, and cut funding to the National Institute of Health and the CDC. During this time, grassroots movements were programs actively working to prevent infection and spread information. Organizations like the New York City's Gay Men's Health Crisis, the Los Angeles Gay and Lesbian Center, and Denver's Gay Lesbian Community Center task force are just a couple of hundreds of nongovernmental organizations that led the charge to curtail infection rates amount gay men within the first three years of the pandemic (Yongle 2017). It is important to note that community-based AIDS service providers like the Gay Men's Health Crisis in New York City were founded and taking action within a year of the CDC acknowledgement of the virus. (AIDS Gov 2016). In 1983 activists succeeded in designating AIDS as a disability under Medicare, but most AIDS patients died before being able to receive benefits due to long government wait times. It wasn't until 1985 when President Reagan publicly acknowledged the existence of AIDS; during this four-year gap reported cases exceeded 18,000 (Renseberger 1985), but experts argue that these numbers are gross underestimates. During my interviews, healthcare workers and LGBTQ+ people alike all echoed the same sentiments that numbers of deaths due to HIV/AIDS were hidden due to the stigma around them. Participant 3 recalled "As I would walk home from work, I would stop and sit with people as they died on the side of the road. They knew they were dying because of AIDS, and I knew it too. But I know it was reported that way, if their deaths were even reported at all."

Participant 6, a previous head of public health at UC Berkeley, acknowledged at that time doctors would often attribute the cause of death to a symptom of AIDS rather than the infectious disease itself. At the end of 1987, the US government finally took steps to raise awareness of AIDS. This came over a year after major industrialized countries (Tasleem 2007). While the path to treatment progressed, the gap for low-income people to be able to use developed treatments became more obvious. For the 20 years between the government-sponsored AIDS awareness campaign launch, and the passing of the Patient Protection and Affordable Care Act there was a major policy vacuum that left treatments being developed unaffordable. Even testing that was developed was unaffordable to many. In 1988, Congress outlawed the federal funding of needle exchange programs, which had been well documented to be a core prevention strategy that was used by other countries like the UK, Netherlands, and Australia (Tasleem 2009). Through the 1990's there was more awareness and some funding of HIV/AIDS prevention programs but never as much as requisitioned. The Bush presidency saw a continued ignorance of the pandemic as numbers continued to grow, but HIV/AIDS funding was cut even more.

While there is no federal legislation directly taking rights away from the LGBTQ+ community today, the policy vacuum that exists is just as harmful and results from the historic discriminations against the LGBTQ+ community (Kline). For example, there is a lack of federal employment protection from being fired due to sexual orientation, making the LGBTQ+ population more susceptible for employment loss. The LGBTQ+ community is at an elevated risk for depression and substance abuse. Participant 5, a non-binary, gay, black person residing in Florida spoke to me about the queer addict community. The participant spoke about the massive amounts of suicide they witnessed in their community at the beginning of lockdown, as their friends who were addicts lost their support systems, jobs, and housing leaving them with nothing but the streets and drugs. It is extremely difficult to measure how detrimental the impacts of policy vacuums are, but as demonstrated by this participant's personal accounts, their influence can be observed where previous policy vacuums existed.

Government policy addressing COVID-19 was quicker than the response to HIV/AIDS but saw similar trends of lack of federal oversight. This policy included mask mandates, stimulus bills, and other regulations or financial stimulus. Within the first six months of the COVID-19 pandemic, travel bans, mask mandates, and school and day-care closures were implemented (Cheng 2020). There was heavy reliance on social policy that already existed like the Supplemental Nutrition Assistance Program, housing support, and unemployment. Outside of pre-established federal programs, it is alarming to experts how little federal oversight there was during the last year of the Trump presidency. This is a surprisingly similar trend to the 1980's and 1990's when states were in charge of funding their own HIV prevention and education programs. The United States has only had two major pandemics in the last 100 years, and in both instances the federal government took a concerning amount of time to step in and implement federal policy. This supports the understanding of the US healthcare system being a neo-liberal institution, addressing pandemics in an individualistic manner until numbers are serious enough for funding and action to be required. As established in the previous paragraph, when the federal government fails to take action, the policy vacuums that exist leave marginalized communities like the LGBTQ+, black, indigenous, immigrant communities at higher risk of a variety of health and economic factors. Every non-white LGBTQ+ participant interviewed acknowledged this acknowledged the aforementioned qualities of a neo-liberal healthcare system that had personally failed them and, more broadly, their communities. This contrasted healthcare workers, who had seen the fallout of the HIV pandemic but hadn't experienced the discrimination and individualism necessary for survival in the same way the LGBTQ+ community had.

3. Treatment & Testing

3.1 Treatment Development

The vaccine rollout for COVID-19 has broken records. The AstraZeneca and Oxford vaccine was released to the United Kingdom under a year from the World Health Organization declaration of COVID-19 as a global pandemic on March 11, 2020. Within the year there was an estimated 22.5 billion dollars poured into vaccine development and production in the United States by the government, and this is rivaled by the billions of private donations made (Allen et. al 2020). It is arguably too soon to assess if the vaccine rollout has been successful in terms of equitability, and the rates in which vulnerable populations have received the vaccine, but the rapid response rate is undeniable. While the investments in HIV prevention and treatment research outweighed any infectious disease in history until COVID-19, the journey to achieving that milestone illuminated the inequalities in health care research (Eaton 2020). Most notable is the amount of money allocated to the development of treatment and testing for the virus. Governmental funding of Aids research didn't hit the billion milestone until 1993, about 12 years and underestimated 500,000 deaths later (AIDS Gov).

The highly active antiretroviral therapy (HAART), the most effective and notable treatment wasn't approved and made available to the public until 1997. Unfortunately, AIDS treatments quickly skyrocketed in prices, becoming almost unaffordable the population most in need of the treatments which were low-income queer individuals (Eaton 2020). HIV/AIDS treatments were clearly not a priority in government and this affected treatment development and rollout. Even 30 years later an estimated one third of Americans living with HIV can't afford the treatment (Childress 2012). The inequality is overwhelming when comparing these two case studies. It is hard to argue that COVID-19 treatment and vaccine development would have received the same amount of support if there were not people part of non-marginalized communities like Tom Hanks, the president of the United States, senators and diplomats that weren't directly affected by the disease.

3. 2 Testing

Testing is another element of these two pandemics that highlights their disparities. COVID-19 same day testing was developed within the first 8 months of the COVID-19 pandemic and officially approved by the FDA by November 2020 (Marshall 2020). Even before it's approval this testing was being used by celebrities, universities and other high-profile situations to expedite results. As for HIV/AIDS, it wasn't until May 27, 1992 that the FDA licensed and approved a rapid HIV diagnostic test kit which gave same day test results. I was unable to find research specifically what early HIV/AIDS testing looked like but learned more in the interviews I conducted. Three participants talked about how bad the testing was specifically in poorer queer communities of New York City and San Francisco. Participant 7, who identifies as a bisexual, intersex, pansexual woman, discussed how testing would take 2-3 weeks to find out results:

> "It was effective or accessible for us to actually get tested. We knew we were supposed to, by you go in and get tested, and were expected to stay celibate for the weeks it took

> you to find out your status. When you went to get tested with someone, that was a sign that you were more committed to each other because it was such a long process. I rarely had time to get tested working all my jobs, and even if I did by the time I received my results I had already had sexual encounters with other people and the test results were useless."

While this participant's anecdote comes from a small set of individual responses, and is not concrete enough to draw a well-supported conclusion, the evidence implies that accessible testing was developed quicker and implemented better during COVID-19 than the AIDS pandemic.

4. Preparation and other Findings

An interesting trend that appeared across nine out of ten interviews was the preparedness of people who were directly impacted by HIV/Aids to the COVID-19 pandemic. Participant 5 explained to me "I started wearing a mask, bringing hand sanitizers with me, and wiping things down when I first heard about the disease in February." She was not alone in this sentiment, and across the board interviewees showed this extreme preparedness to COVID-19 like wearing masks before federally mandated, already being stocked up on items like toilet paper, hand sanitizer and food. Some people always had these items in stock, and some purposefully went out and stocked up on these items ahead of the rush. Five of the participants acknowledged that this was directly because of their experiences, Participant 4 for instance mentioned: "I know not to expect anyone to take care of me, so I take care of my family and my community. I wasn't surprised that it took so long for there to be state or federal mandates, I expected it."

Other participants who were prepared before the general public like health care workers didn't make the connection that this was because of their previous experiences with HIV/AIDs, but research shows high rates of diagnosed and undiagnosed post-traumatic stress disorder among people in adulthood who are living with HIV/AIDS have much higher rates of PTSD than the general population. Occupational exposure to trauma for medical workers has been proven to have lasting impacts on health care workers as well, and this was evident in the emotional interviews (Grossman 2006). The healthcare workers I interviewed were all brought to tears relieving and talking about their experience working during the 1980's in hospitals, rehab centers, and homes specifically for people dying from AIDS. They shed tears as they recalled stories of seeing the pervasive racism, homophobia, transphobia, classism, and other policies that criminalized the populations that they were working with. Although this finding requires further research, I argue that people who had lived through and been affected by HIV were more prepared for the poor response of the government. They were prepared in a physical way, taking care of themselves and their community before the general population realized how bad the situation was going to get, but they were prepared emotionally as well. Participant 1 a nonbinary black queer person said "Covid-19 is child’s play [in comparison to HIV/AIDS]… the people deeply affected by COVID-19 have not experienced intense trauma, or mistreatment in their lives yet."

This comment, which inspired the title of this paper, was echoed by every member of the queer community I interviewed except for one cis, gay, white man. This anomaly was quite interesting because he falls into the most privileged group in the LGBTQ+ community. It is important to note that the queer community is not a monolith, but there was overwhelming agreement that HIV/Aids was worse than COVID-19 for the queer community. The interviewees were more mentally prepared because they had no expectations from the government. They had already lived through a period in history when they hadn't been cared about and had been demonized when their community was most in need so COVID-19 was not the wake call for them as it was for many other more privileged parts of the community who had experienced this directly yet.

Another trend that emerged from survey data was the preparedness in the LGBTQ+ community with language to navigate COVID-19. The majority of interviewees expressed that their communities already knew how to remain safe and communicate about their status (whether they were sick or not) because that language had been ingrained in the community for decades. One participant pointed out:

> "The general population hasn't learned how to communicate well like we have had to. Because we only have either other, we have had to learn how to communicate honestly. Of course there are always bad apples in the bunch, but my community and I didn't have to try and get over the speed bump of stigmatizing people who had COVID-19 like it looked like a lot of others did."

Another interviewee, who was a healthcare worker in the first home for people dying of AIDS in the US remembered "I was amazed how I was treated once I had COVID-19. I felt like people avoided me just like I had seen people avoid patients sick with HIV/AIDS in the 1980's."

Interviews were critical to this study, in particular because of the overwhelming lack of recorded stories from queer people on the topic. The people that I interviewed pointed out flaws in the system that are evident, but that there is almost little to no research on. For example the section above about COVID-19 safety precautions only being written for the 'nuclear family,' and only designed for heterosexual, and traditional families that aren't community oriented. While I delved deeper into this finding with literature and theory, this was originally brought to my attention by Participant 7. She experienced the limitations and difficulties with adhering to the COVID-19 guidelines in her community where people have multiple partners and children are raised by the community, in contrast to suburban families that can stay self-isolated in one home. Participant 1 also brought to my attention the concern of COVID-19 transmission in poor communities in New York city by rats. Although the CDC ordered a stay-at-home order which was heavily enforced in New York City, numbers in poor neighborhoods stayed high. The majority of this is contributed to poorer communities being unable to stay home from work, which is a strong argument, but fails to account for the two-week period when the entire city was in lockdown and cases still increased exponentially (CDC 2020). While this is speculation, Participant 1 spoke about the rats that run from apartment to apartment in project housing in New York city where they live. The CDC reports that animals can and do spread SARS-COV-2 to humans, but further research is needed to understand if this is significant. This hasn't been prioritized though, when over 50% of public housing reports rodent problems, which would be millions of people who may have been exposed to COVID-19 even when they were following CDC guidelines because of unavoidable interactions with animals proven to be able to transmit COVID-19 (Neltner). Participant 3 spoke to me about the queer addict community that was deeply affected by the solution at the beginning of COVID-19, where they lost nine friends to suicide and not the pandemic. The addiction community lost access to their support systems, to their mentors and sponsors, and were encouraged to not go to the hospital. Drug rehab centers were forced to operate at 50% capacity (Bruce 2020). LGBTQ+ folks make up a disproportionately larger amount of the addict community and they were left with fewer treatment options as victims of the other potential deadly disease of addiction.

Conclusion

After conducting these interviews and analyzing the similarities and differences of the LGBTQ+ experience during the HIV and COVID-19 pandemics I discovered finding in our main categories: Education, policy, treatment, and preparation. Both pandemics experienced misinformation, with the LGBTQ+ population being blamed and demonized for the AIDS crisis primarily. Subjects overall recognized the formation of in and out groups in American society, and expressed solidarity with Asian Americans who have been the blunt of this stigma during COVID-19. Before the development of the COVID-19 vaccine both pandemics saw a neo-liberal approach to combating the spread of the diseases, and decentralized policy. LGBTQ+ populations were highly ignored and unprotected by the federal government until more than seven years after the beginning of the pandemic. Subjects emphasized the lack of protection in government for them during the AIDS crisis, and how this has carried over into COVID-19. Legislation, and regulations did not prioritize or take into consideration people who lived 'non-traditional' lives outside of the new liberal nuclear family structure. Federal programs have been alarmingly poor at financial support response for at risk populations. Treatments and testing was prioritized during COVID-19, and evidence strongly supports that this is because more of the majority population was directly affected by the pandemic. Members of the LGBTQ+ community that had lived through the HIV pandemic seemed more prepared and aware of personal steps they needed to take to keep themselves protected from experience of being a marginalized group. These trauma informed responses should be further investigated. The queer community seems to have had better language and more open communication during COVID-19 from their previous experience talking about disease status, and community communition from the previous pandemic as well.

The focus on the LGBTQ+ experience during both pandemics is not meant to ignore other vulnerable populations in the US, but rather serves to underscore the importance of continued attention to the social and political factors that affected the outcomes of the two pandemics from the perspective of this vulnerable population. Healthcare systems, and responses are only as strong as how the most vulnerable populations are treated, and the lesson that can be learned from the LGBTQ+ experience can lead to not just a more equitable future for this population, but better preparedness on the government's behalf for all populations. Further research on the effects of both pandemics on the LGBTQ+ community is necessary. I recommend expanding survey information and interviewing a larger number of older members of the queer community to gain better insight into unexpected trends. More qualitative data is needed and can be collected once more COVID-19 data has been released. The healthcare system has historically been discriminatory against the LGBTQ+ community, and the ways this may present itself in deaths, diagnoses, and who received treatment may show ways in which the US healthcare system has fixed or exacerbated these social inequalities. Frontline worker information is useful, but I would recommend researchers continuing this investigation to make sure to not center voices of frontline healthcare workers. The stark contrast between members of the LGBTQ+ community finding the HIV/AIDS pandemic to be worse than COVID-19 compared to the healthcare workers suggests that even medical workers cannot speak to the lived experience of a population that was as abandoned during the HIV/AIDS pandemic as accurately.

This research presents many possible ways forward. I make recommendations throughout the paper of areas where gaps exist in literature, like the development of HIV testing, how low-income housing affected the spread of COVID-19 through rodents, and the effects of COVID-19 closures on the addict community. The LGBTQ+ community is vast, and far from a monolith. My research is scratching the surface of the comparisons between HIV/AIDS and COVID-19. This paper suggested that there were important similarities and differences to note between the HIV/AIDS pandemic and COVID-19 in the marginalized LGBTQ+ population. Findings show that across individual, state, and federal levels many similar mistakes were made between the two pandemics in regards to policy and the spread of misinformation. The LGBTQ+ population is still suffering from inequalities in the healthcare system perpetuated by policy gaps and lack of protection, compounded on from the height of the HIV/AIDS pandemic. Research implies that the LGBTQ+ population was more prepared for COVID-19 primarily motivated by personal understanding of the structural violence that they face. Science shows that a future pandemic is inevitable, and the lessons that could be learned from studying the LGBTQ+ population which has survived the worst the last two largest pandemics have had to offer can hold keys to saving lives and stopping discrimination in the future.

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