

Campaigns of Autoimmunity: Public Health Responses to AIDS and COVID-19

Amanda M. Caleb

Geisinger Commonwealth School of Medicine
acaleb@geisinger.edu

Abstract

This article uses the concept of autoimmunity as a framework to examine how public health, designed to help protect the entirety of a population (and therefore act as an immune system), turns to an autoimmune response during pandemic flare-ups. In this context, public health campaigns seek an overactive and overrepresented focus on historically marginalized and at-risk populations, resulting in a targeting that places both the self of the body politic and the non-self of the targeted population at risk for infection. The persistency of autoimmunity as public health is evident in the America Responds to AIDS campaign of the 1980s and 1990s and Ohio's Together Ohio and More than a Mask campaigns in response to the COVID-19 pandemic. Using these examples, the article examines the paradox of distinguishing and blurring the self and non-self by emphasizing collective risk and collective action and overrepresenting Blackness, demonstrating a latent autoimmunity of prejudice that informs public health messaging and its reception.

Keywords

Public health campaigns; America Responds to AIDS; Together Ohio; otherness; racial prejudice

In autoimmunity, one gets so viciously close to the mirror of otherness that no room is left for reflection.

—David A. Napier, *The Age of Immunology: Conceiving a Future in an Alienating World*.

Caleb, Amanda M. 2024. "Campaigns of Autoimmunity: Public Health Responses to AIDS and COVID-19." *Catalyst: Feminism, Theory, Technoscience* 10 (1): 1–20.

<http://www.catalystjournal.org> | ISSN: 2380-3312

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Autoimmune Responses of the Body Politic

The rise of immunology in the nineteenth century led to a redefining of immunity from solely a granted legal protection or exemption to a biological descriptor of the body's ability to fight infection. At the 1866 International Sanitary Conference, delegates described natural immunity to cholera within a socioeconomic context of quarantine avoidance: "This immunity, as a general rule, when closely regarded, can be linked to good hygienic conditions existing in these localities, or to notable improvements which have operated there for a while. The relative immunity answers to those who are too inclined to commend the safety of nations against cholera exclusively to quarantine measures" (E. Cohen 2017, 32). Historically, epidemiologists and other public health officials linked biological immunity to politico-legal immunity; as simplified by Ed Cohen, "If a nation was deemed 'relative[ly] immune' (in a biological sense) from cholera, then it could remain entirely immune (in a legal sense) from quarantine" (2017, 32). Implied within this biopolitical concept of immunity are structural inequities, tied to socioeconomic and environmental factors: "natural" immunity to cholera includes access to clean water and hygiene education.

This description of immunity from 1866 is integral to the language and practice of public health. For instance, herd immunity is a biological defense against disease transmission within a population, but it relies on high percentages of existing individual immunity—achieved through infection or vaccination. Embedded within herd immunity is the politico-legal issue of immunity as granted protection, seen in access to and education about vaccinations provided by the government. More problematic is the implied ability to survive a disease: in practice, herd immunity has no interest in those who die from a disease, which can ultimately impact the allocation of resources and access to life-saving treatments. Sweden's initial approach to the COVID-19 pandemic was focused on achieving herd immunity without enacting government shutdowns—a modern-day version of the 1866 description of the response to cholera—but in doing so, negatively impacted the care of those most susceptible to severe disease and death (Vogel 2020).

Such an approach accords with the meaning of immunity, which shares the root *munus* with *community* but whose prefixes create opposition: "If *communitas* is what links its members together in a reciprocal commitment to donate, *immunitas*, on the contrary, is what unloads from this load and exonerates from this onus [*onere*]" (Esposito 2012, 2). In the context of a body politic, this view of immunity justifies a nation-first (or nation-only) approach to combating disease, privileging the immunity of a single nation over a global community. However, as Roberto Esposito (2012) notes, "what protects the body—whether individual, social or political—is what at the same time prevent its development," and as evident during the COVID-19 pandemic—or any pandemic—a nation-first approach naively ignores the realities of globalization.

Such external barriers, however, can prove to be greater threats to the self, as evident in the autoimmune response in which the system that is meant to protect becomes intolerant of itself and attacks a part of the body (or body politic) now viewed as foreign. Ed Cohen (2017, 29) describes autoimmunity as the collapse of distinction between self and not-self (or non-self) that results in the body viewing the self as both, leading to an intolerance of self. Jacques Derrida describes autoimmunity as “the autoinfection of all autoaffection. It is not some particular thing that is affected in autoimmunity but the self, the *ipse*, the *autos*, that finds itself infected” (2005, 109). In Derrida’s definition of autoimmunity, self-experience, or how the body thinks about itself, ultimately leads to a created perception of infection within the self: to protect against that singularly perceived infection is to attack the body itself.

Juxtaposing Cohen’s and Derrida’s constructions of autoimmunity reveals the ways in which the overconcentration on self can lead to (or perpetuate) otherness that is grounded in intolerance. Within the context of epidemiological flare-ups—pandemics—it is that very intolerance of self that triggers an autoimmune response of the body politic that seeks to attack the perceived cause of infection while ultimately harming itself. In relying on a philosophical autoimmunity when responding to pandemics, the search for a nationalized immunity (by way of prevention) is represented rhetorically by an autoaffection that *is* autoinfection, an overactive response to and an attack of a racialized other who is part of the national body. The metaphoric national body’s immune response against itself is an act that is harmful to a collective health of a nation through the targeting of one population through overrepresentation (leading to blame) and creating a false immunity for the other.

Applying this framework of autoimmunity to public health campaigns in the United States, I begin with the AIDS pandemic, which aligns with an increased interest in immunology and autoimmunology: even as the field worked to combat a foreign virus, it actively discriminated against its own body politic (Porter 1997, 589). I situate this first flare-up within a context of a metaphoric autoimmune disease of US public health and pandemics, marked not by new disease but by new flare-ups of the same disease: responses to the COVID-19 pandemic. Both flare-ups are designated by their overactive response and reaction to Black communities as sites of disease transmission that become the target of an autoimmune response. In viewing pandemic responses through the lens of autoimmunity, we can confront the “logical but also a bio-logical impropriety” (E. Cohen 2017, 29) of public health during a crisis: the targeting of minoritized populations that reinforces a latent autoimmunity of prejudice.

Autoimmunity and HIV/AIDS: America Responds to AIDS

As is well documented, the US response to the emerging AIDS epidemic in the 1980s was slow, stymied by politics and social stigma.¹ The initial labeling of AIDS as the “gay plague” minimized the impact of the disease on the nation and the world, downgrading it to something affecting a historically marginalized population with fewer rights than heterosexual Americans—in other words, outside the body politic. The turning point was twofold: the public death of President Reagan’s close friend Rock Hudson from AIDS and the increasing incidence of AIDS outside gay communities, specific among hemophiliacs. Reagan’s naming it a “top priority” and the congressional allocation of \$190 million for AIDS research in 1985 resulted in the “everyone is at risk” focus of AIDS prevention campaigns (Carney 2021, 336).

This inclusive approach was embodied in the America Responds to AIDS (ARTA) campaign sponsored by the Centers for Disease Control and Prevention (CDC) from 1987 to 1996 and included pamphlets mailed to all households and television and print public service announcements (PSA). The CDC envisioned the campaign as targeting “a wide range of audiences variously defined by identity or behavior, from heterosexual single mothers, to teenagers of all races, to young adult African Americans, to people who lived in rural areas” (Tuohy 2013). ARTA targeted local and national distribution, resulting in materials being seen by both the communities depicted in the images and those outside those communities, creating the conditions for an autoimmune attack (Woods, Davis, and Westover 1991, 618). Notably absent from early campaign materials was gay representation: in 1987 Congress “explicitly banned the use of federal funds for AIDS prevention and education campaigns that ‘[promoted] or [encouraged], directly or indirectly, homosexual activities’” (Geiling 2013).

Congressional restrictions on federal funds meant that the CDC essentially rendered the gay community invisible in the early days of ARTA: they were grossly underrepresented (or not represented at all) in the materials, leading to criticisms of “diluting the message” about AIDS (Carney 2021, 336) and “not meeting the needs of high risk-audiences, [specifically] gay men, by not providing sexually explicit behavioral messages” (Rowitz 2009, 316). In other words, everyone could get AIDS, but such messaging ignored the variable relative risk for certain populations. The messaging that everyone could get AIDS was a political paradox, or, more aptly, an autoimmunity. Such messaging positioned a hyped threat of the disease for the entire nation against the reality of disease transmission through bodily fluids, meaning that not everyone was at the same level of risk, and in fact most individuals were not at risk of contracting HIV. However, the autoaffective perception of risk to the body politic indicated a need to protect it from internal yet othered threats, and that protection came through the discrimination of those perceived to create the risk for themselves and everyone else.

While ARTA marginalized gay communities in its PSAs, it overrepresented Blackness. From 1981 to 1987 the percentage of Black, non-Hispanic persons with AIDS was 25.5 percent, less than half that of the prevalence for white, non-Hispanic persons (59.7 percent) (CDC 2001, 431) and more than double the Black population percentage of 12.2 percent in 1987 (US Department of Commerce 1988, 3). This percentage of Black, non-Hispanic persons with AIDS rose to 31.2 percent from 1988 to 1992, while that of white, non-Hispanic persons dropped by more than nine percentage points (CDC 2001, 431). These numbers indicate an increasingly disproportionate impact of AIDS on Black communities, one that the CDC saw as warranting community-specific PSAs. ARTA quickly became the autoimmune response to AIDS through its overrepresentation of racialized models, signaling a much greater surge—and therefore threat—of AIDS within that community: 80 percent of CDC communication about HIV/AIDS featured models who were people of color, of which 70 percent were Black models, equating to 56.4 percent of all communication (El Hazzouri and Hamilton 2019, 372). This overrepresentation of nearly double that of disease prevalence—and more than fourfold the Black population—invokes the overactive immune response of targeting normal cells within the body. In other words, while this approach achieved the goal of targeting a community, the overrepresenting of that community created a perception of infection risk for the entire body politic caused by a specific population within it.

Public health campaigns aligned two major HIV transmission routes—unprotected sexual intercourse and injecting drug use—with Black communities, representing a longer history of discrimination that were intertwined into autoimmune intolerance during the pandemic. In 1987, Dr. John O. Brown, president of the National Medical Association, warned about blaming AIDS on Black folk: “whenever they talk about sexually transmitted diseases this country has a tendency to blame everything on Blacks” (“NMA Leader” 1987, 53). The Black community faced stereotypes of being oversexualized and harbingers of disease for centuries before the AIDS pandemic: in the early twentieth century, US Public Health Service physicians described the Black community as “a notoriously syphilis-soaked race” (Washington 2008, 160). The prevalence of drug dealers within largely minority (and, in the 1980s and ’90s, specifically Black) communities influenced perceptions of drug use by Black communities; yet research from the 1990 indicates that of the 66.5 million Americans who identified as having ever used drugs, only 10.8 percent of these were Black, non-Hispanic (Burston, Jones, and Roberson-Saunders 1995, 22). What was disproportionate to the Black community was the drug arrest rate: by 1990 Black folk represented 41.2 percent of all drug arrests in the United States, nearly four times the rate of Black drug users (US Federal Bureau of Investigation 1997, 282). Racial intolerance fueled such false representations of promiscuity and drug use by Black individuals that

public health campaigns used to support messaging about AIDS transmission within that community.

PSAs produced by ARTA and overrepresentations of Black communities distorted this risk of HIV transmission primarily through depictions of irresponsible drug use, often combined with unsafe sexual practices. This is not to say these links to HIV transmission are completely absent in PSAs targeting other populations or to the general public but rather that the messaging to and about Black communities attacked behaviors and attitudes based not on fact but prejudice. A 1989 ARTA poster (Figure 1) depicts two Black individuals seated on an urban stoop coupled with the tagline: “Getting High Doesn’t Cause AIDS. It Just Lets It Happen” (CDC 1989). The implied lack of agency regarding drug use—allowing AIDS to happen—signals disease transmission rather than prevention. Notably, there is no messaging related to drug cessation or AIDS treatment, and the PSA blankets all drug use, not just injectable drugs, implying a moral and health judgment of any drug use, regardless of the reality of HIV transmission.

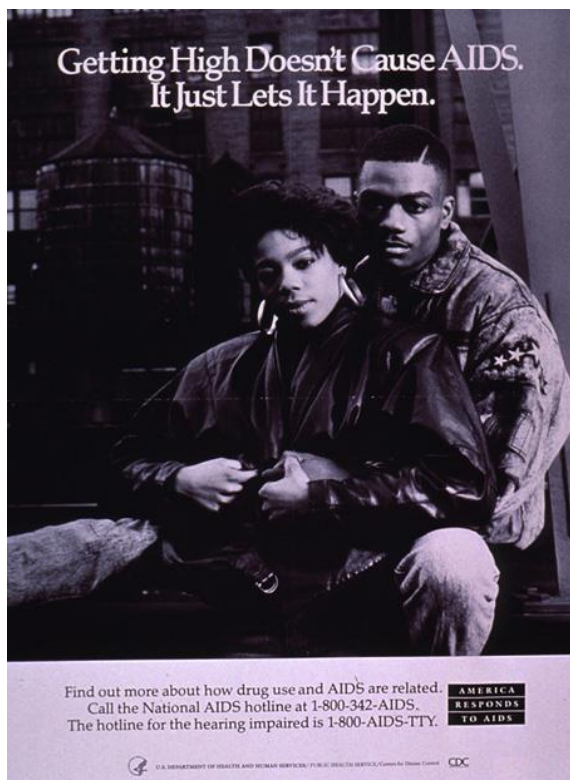


Figure 1. “Getting High Doesn’t Cause AIDS: It Just Lets It Happen.” Poster from America Responds to AIDS campaign, 1989.

Alt text: America Responds to AIDS poster showing two Black models embracing with the tagline “Getting High Doesn’t Cause AIDS. It Just Lets it Happen.”

This moral judgment is echoed in a second ARTA poster (Figure 2) featuring a Black woman that depicts a lack of education as the cause of her and her baby

contracting AIDS. Leaning over a crib, the guilt-riddled mother shares her AIDS story: "Last year my man died. Now they tell me it was AIDS. At the time I didn't know anything about AIDS. Then I had my baby and found out about it the hard way. My baby has it, I have it and all because my man was shooting up drugs and sharing needles. Had I known better, I would have made him use condoms, and if that didn't work I'd have stopped being with him. But now..." (CDC 1988a). The connection between her lack of education and the transmission of AIDS to her baby implies the mother's "irresponsible refusal of knowledge was her baby's death sentence" (Scott 2003, 174). The advertisement ends with the mother's plea to the viewer: "Please don't let this happen to you. You find out about AIDS" (1988a). The implication here is twofold: the Black mother's (ir)responsibility for her own AIDS education and the Black woman's (ir)responsibility for having a baby with AIDS, a nod to the stereotype of the sexualized Black woman. Absent is any effort to address reducing drug use or reducing structural barriers to education and care. The PSA evokes the politicized intolerance of the so-called welfare queen (C. Cohen 2009, 143): a Black woman who *chooses* to remain ignorant about AIDS and who is now without a partner and with an AIDS diagnosis for herself and her baby, risking the body politic both health and wealth.

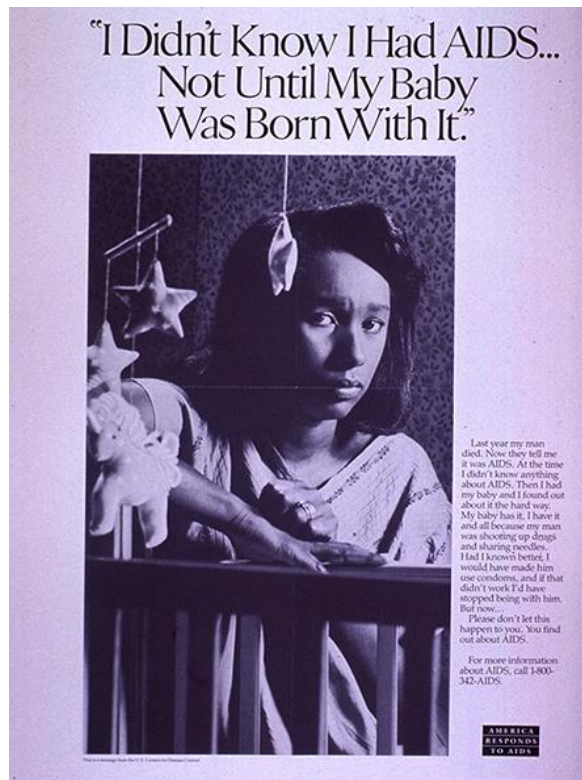


Figure 2. "I Didn't Know I Had AIDS. Not Until My Baby Was Born With It." Poster from America Responds to AIDS campaign, 1988.

Alt text: America Responds to AIDS poster depicting a Black woman leaning on a crib and the tagline, "I Didn't Know I Had AIDS. Not Until My Baby Was Born With It."

This (ir)responsibility placed on the shoulders of this Black mother is both paralleled and contrasted with the image of the Latina mother in Figure 3, reflecting both an attack on women of color and creating a hierarchy of (ir)responsibility through the contrast of Black and white-passing models. Like the mother in Figure 2, this mother is burdened with the onus of being the responsible partner in a relationship. The poster positions the Latina mother as an “active, more culpable vector” in reducing AIDS transmission, placing the burden and blame on women of color and playing into stereotypes of hypersexualized Latinas (Scott 2003, 86). At the same time, the use of a white-passing model for this advertisement contrasts the irresponsible and uneducated Black mother with an assertive and knowledgeable white-passing mother who has prioritized her children’s health. The mother in Figure 3 tells the viewer, “Listen. I’m a single mother with two boys, and I love them very much. Yes, I like to date, but I need to tell you that I’m taking precautions against AIDS. In fact, if you shoot drugs or have a problem with wearing a condom, I suggest you stay away from me. Sure I want a man to share my life with. But also I love myself and my boys too much to make any mistakes” (CDC 1988b). This final line is antagonistic to the mother in Figure 2, implying a moral judgment about lacking AIDS education and not loving oneself because of the decision to choose a partner regardless of risk.



Figure 3. “A Message to the Third Man in My Life.” Poster from America Responds to AIDS campaign, 1991.

Alt text: America Responds to AIDS poster showing a Latina mother hugging her two children with the tagline, “A Message to the Third Man in My Life.”

While the CDC designed the ARTA campaign to educate populations about AIDS prevention, the juxtaposition of “everyone is at risk” with overrepresentation of Black models sent a mixed message: not only are some individuals at more risk than others, but these same individuals also threaten the body politic because “everyone is at risk.” The lack of specific information to targeted Black communities was a source of criticism from the US National Commission on AIDS (1992, 14). In a 1992 congressional hearing of the Health Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, Reggie Williams, founder and executive director of the National Task Force on AIDS Prevention, testified that despite working with ARTA for three years, they did not listen to his repeated request to be more specific with their messaging to populations being disproportionately impacted by AIDS. In his testimony, he unequivocally states that “One of the major reasons for high HIV infection rates in [the Black] community and other communities of color is that we did not see ourselves in the messages early on in this epidemic” (US House of Representatives 1992, 167). As evident in Figures 1 and 2, PSAs from the early years of ARTA included racialized models but with little specific information to that community and messaging built more on essentializing than educating (C. Cohen 2009, 139–43). As noted by Gary Rose in his 1994 testimony to the subcommittee on Health and the Environment Subcommittee of the House Committee on Energy and Commerce, prevention materials depicted women, specifically those from poor communities of color, as “sexual partners of intravenous drug users [and] denigrated as either the mothers of children at risk or as vectors for disease transmission” (US House of Representatives 1994, 43). What Rose describes is evident in Figure 2 and is emblematic of his criticism of ARTA for its “message about prevention that internalizes explicitly our society’s phobias about ‘faggots,’ ‘junkies’ and welfare queens” (US House of Representatives 1994, 40).

These criticisms illustrate the autoimmune response of these campaigns. While seemingly well intended to protect the body politic, the rhetoric of these PSAs underscores existing prejudice, thereby discriminating in the act of combatting infection. Ultimately, they depict Black communities “more as *risky* or threatening than as *at risk*” (Scott 2003, 87). As autoimmunity, these PSAs paradoxically distinguish and blur the self and non-self, targeting Black communities through visual images and stereotypes, but repeating claims of “everyone is at risk.” Removing the distinction of specific risk to specific populations both increases the risk of transmission within that group—seen in the 1.5 increase of AIDS prevalence among Black folk during the ARTA campaign (CDC 2001, 434)—and grants a false immunity to others from internalizing such messaging, ultimately inflaming rather than quelling viral and social infection.

Another Autoimmune Flare-Up: Ohio's Response to COVID-19

While early public health responses to the COVID-19 pandemic were quicker and more robust than those of the AIDS pandemic, they faced their own political limitations, particularly in the US where some government and public figures politicized and discredited basic public health measures to reduce disease transmission. Unlike AIDS, which the CDC designated initially as a disease impacting certain people and only later expanded to an "all are at risk" campaign, initially the US government depicted COVID-19 as a disease that could impact anyone, with subsequent public health campaigns targeting certain high-risk groups including those who are immune-compromised. The political rhetoric of COVID-19 included the othering of the disease itself, with former President Trump calling it the "Chinese virus" and "Kung Flu," thereby paralleling the harmful and stigmatizing early labels of AIDS as the "gay plague" (Quinn et al. 2021). These constructions of the pandemic that looked to external, xenophobic causes of the disease soon included internal blaming of Black communities for higher infection rates and for disease transmission (Kendi 2020), most vocally from far-right groups that saw Black Lives Matters protestors as both spreading the disease and being immune from the public health social distancing guidelines (Diamond 2020). Such dangerous claims both victim-blamed historically marginalized populations and created an artificial sense of security from the disease for others, a continuation of the autoimmune processes in place during the AIDS pandemic.

During the first months of the pandemic, the Ohio Department of Health launched the Together Ohio campaign (with the slogan "In this Together Ohio"), which echoed ARTA in that it focused on collective risk and collective action to combat disease transmission in responding to the COVID-19 pandemic. Like ARTA, this campaign relied on an overrepresentation of Black models in its PSAs, specifically those about COVID-19 testing sites. In advertisements appearing on social media from June to December 2020 (Figure 4), 96 percent featured Black models, even though only 13.2 percent of Ohio's population identifies as Black (US Census, n.d.). Both the oversaturation in predominantly white communities (such as Proctorville at 95.2 percent) and communities with large Black communities (such as Bedford Heights at 77 percent) is problematic (US Census, n.d.). Such overrepresentation can lead to assumptions that testing is for the population visually represented on the poster, which can result in a false sense of immunity. Conversely, Mohammed El Hazzouri and Leah Hamilton (2019, 373–74) report that people of color respond more favorably to white models in PSAs distributed widely due to concerns that using models of color could result in stereotyping when public health advertisements appear outside their own communities, as in this case with these advertisements. The result can lead to alienation of both white and Black communities, resulting in less testing rather than more and ultimately endangering the health of all Ohioans.



Figure 4. Ohio Department of Health, “In This Together Ohio” digital poster shared on social media to promote COVID-19 testing, September 30, 2022.

Alt text: Ohio Department of Health poster advertising COVID-19 testing in Proctorville showing a racialized model in a mask.

Ohio House Minority Leader Emilia Strong articulated the falseness of the slogan “in this together Ohio,” noting that the slogan “evokes a sense of shared struggle, of sacrifice and of commitment to one another. But the reality is that since the onset of this pandemic—and for the greater part of a generation or more—Black and Brown families have seen the worst of it” (Ohio House of Representatives 2020). Like the AIDS pandemic, COVID-19 disproportionately impacted Black communities. While the Black, non-Hispanic/white infection rate ratio neared 1:1 in July 2022, other rate ratios remained high: Black, non-Hispanic persons were 2.2 times more likely to be hospitalized (an indicator of severe infection) and 1.7 times more likely to die from COVID-19 (CDC 2022). This is an improvement on rates in the early months of the pandemic, which saw the Black, non-Hispanic/white death rate ratio as high as 3:57 (Lawton et al. 2021). Addressing this health disparity became a priority for state public health departments. Ohio launched several targeted health campaigns in response to the disproportionate impact of COVID-19 on Black Ohioans: by August 2020 the Black, non-Hispanic/white death ratio was 1:4, the infection rate ratio was 2:5, and the hospitalization rate ratio was 3:2 (Ohio Department of Health 2020a). However, such campaigns often focused on downstream initiatives and largely (or completely) ignored the structural factors that created such health inequity. To Strong’s point, Ohioans were not in this together—either in terms of the impact of COVID-19 or in terms of the campaign’s visual imagery and messaging.

Other public health campaigns in Ohio replicated this pattern of exclusionary rhetoric, specifically those targeting Black communities, which further emphasized the autoaffective fiction of a togetherness campaign. In 2020, before vaccinations were available, local and statewide public health messaging in Ohio focused on masking and testing to protect all communities but particularly Black communities. For many Black folx, masking, specifically the use of cloth masks, was a concern in light of stereotyping Black men as dangerous and the rise in police violence toward Black folx (Kahn and Money 2021). This double bind is exemplified in tweet by a Black Ohioan: "I don't feel safe wearing a handkerchief or something else that isn't CLEARLY a protective mask covering my face to the store because I am a Black man living in this world. I want to stay alive but I also want to stay alive" (Thomas 2020). The timing of this tweet corresponds with Franklin County Public Health department's release of its "COVID-19 General Guidance on Wearing Face Masks for African Americans and Communities of Color," which recommends avoiding "fabrics that elicit deeply held stereotypes [and] bandanas that are red or blue, as these are typically associated with gang symbolism [and] a scarf just simply tied around the head as this can indicate unsavory behavior, although not intended" (2020, 1–2). After outcry on social media, the health department issued an apology on Twitter, stating that "some of the language used came across as offensive and blaming the victims," ultimately perpetuating the victim-blaming through a backhanded apology that claims the racist messaging is in the receiver's perceptions and not the communicator's intentions (Franklin County PH 2020). Such guidance implies the need to protect the body politic from constructed violent threats from Black persons, turning to an autoimmunity of intolerance for one population as a means of protecting the whole—rather than protecting the most vulnerable.

Another autoimmune response to the impact of COVID-19 on Black Ohioans was the Ohio Department of Health's initiative *More than a Mask*, designed to provide communities of color (and specifically Black communities) with essential information and resources about COVID-19. The Department of Health developed this initiative in collaboration with Governor Mike DeWine's creation of a Minority Health Strike Force in April 2020 to address the disproportionate impact of COVID-19 on communities of color. The thirty-second PSA produced for this campaign features Black persons in locations across Ohio wearing masks and describing the campaign's promise to provide information to Black communities and empowering the community to help themselves, with one individual stating, "it's about us helping us" (Ohio Department of Health 2020b). The PSA concludes: "If we're going to beat COVID-19 in our community, we're going to need a mask and more."

The PSA featured Black Ohioans to create a sense of community and shared responsibility to each other, beginning with wearing masks and leading toward empowerment through education and collaboration. The problem, however, is

that the Department of Health aired the PSA outside the targeted communities, which can lead to racial stereotyping (El Hazzouri and Hamilton 2019, 374) through purposeful misreading—implying that Black communities had higher infection rates because they were not masking, instead of structural inequities (which are never mentioned in the PSA). Ohio senator and physician Stephen Huffman perpetuated such victim-blaming when he asked in a June 2020 Senate Health Committee hearing, “Could it just be that African-Americans or the colored population do not wash their hands as well as other groups or wear a mask or do not socially distance themselves. Could that be the explanation of why the higher incidence?” (Gabriel 2020). The racist language, coupled with centuries-old racist claims of inferior hygiene (Washington 2008, 160), perpetuated a false belief that the disproportionate impact of COVID-19 on communities of color was a product of their own doing. Moreover, the promise of “more than a mask” went largely unrealized in the year following the campaign’s launch: initiatives to address structural causes of health disparities within communities of color were underfunded.²

Social media backlash to the More than a Mask campaign (directed at DeWine’s Facebook page) largely fell into two categories: the rejection of masking entirely and claims about the falseness of racial inequities and COVID-19. Of this latter category, commentators blamed Black folx for a higher incidence of COVID-19 within their community, citing claims of looting and rioting (DeWine 2020). These responses about COVID-19 and race demonstrate how the body politic can invoke an autoimmune response: here prejudice and racism are coupled with the health of the Ohio population, implying the threat to both health and freedom (often conflated during the COVID-19 pandemic) comes from Black communities, rather than recognizing the inverse and the threats to health and freedom this community has experienced and continues to experience.

Like the ARTA campaign, the COVID-19 health campaigns in Ohio sought to both unite the body politic and single out portions of that body that were impacted disproportionately. The immune response of defending from an external threat of disease turns into an autoimmune response in this decision to treat the body as a whole *and* to target specific populations: the focus becomes conflated in an overrepresentation of communities, which contributes more to intolerance and division than unification. Like an autoimmune response, such campaigns do not intend to harm the body politic, nor do they even mean to harm a portion of that body but ultimately cause harm through the inability to reconcile the self and non-self.

Reflecting on the Mirror of Self and Non-self

The epigraph to this article reveals one of the fundamental challenges of autoimmunity: the (in)ability to reflect on self when faced with the perception that otherness is merely a distortion of self. Both the spatiality and temporality of

a flare-up such as a pandemic diminish the opportunity for the self to recognize the non-self as a projection of the self's anxieties onto the non-self, othering the non-self so that it becomes the mistaken infection that needs to be redressed. Public health campaigns that rely on overrepresentation of communities of color project an anxiety of not doing enough for these communities—an anxiety based in the reality of structural racism—and fail to address the root causes of these anxieties, ultimately leading to “a failure to recognize and tolerate ‘self’” (W. Anderson 2014, 609). This mirror of otherness contributes to the myopic approaches to the AIDS and COVID-19 pandemics that failed to address historical and structural factors contributing to disease burden but rather focused exclusively on the present outcomes.

The temporal challenge of meaningful reflection in pandemic autoimmunity is a product of the severity of the event and therefore the need for an immediate and robust response. Reflection in the moment is challenging, all the more so if the response is an attempt to concentrate on the downstream issue of poor health outcomes and not address the underlying cause. However, the distance of time provides the opportunity for such reflection: for instance, criticism of ARTA and the CDC's overuse of models from minoritized communities in its AIDS campaigns could have informed how communities of color were represented in COVID-19 health campaigns. That public health departments seemed to overlook or ignore the lessons of the AIDS campaigns suggests a latent autoimmunity that emerges in flare-ups and actively divides the self and non-self. Both the pandemics and the time between them mark an autoimmunity that “calls into question the unity and purity of any ‘body’ and any ‘concept’” (N. Anderson 2017, 95). Such public health campaigns seek unity, but in doing so, reveal the cracks of both that proposed unity and the supposed purity of both society (presumed non-racist) and public health (presumed to prevent harm). In other words, the effort to help quickly becomes an act of harm to both the individual body and the effort to support a unified body politic—as well as harmful to the immune system itself (that of public health).

The autoimmune responses to the AIDS and COVID-19 pandemics are not parallels but rather a continuum of an autoimmunity, emergent during disease flare-ups but foundational to the development of public health. Some public health campaigns have perpetuated historical acts of blaming Black communities for disease transmission in the guise of overcorrection and overrepresentation that provide surface-level solutions and fail to meaningfully address structural barriers to care. The US Department of Health and Human Services identified health disparities for minoritized and historically marginalized communities in the mid-1980s and identified systemic racism as a root cause of these health disparities at the end of the last century (Gibbons 2005), and in April 2021 the CDC declared racism “a serious public health threat” (Walensky 2021). Decades of evidence and posturing have failed to address these issues; an overreliance on

rhetoric and representation has instead continued the racism inherent in the autoimmune response to disease.

At the time of writing, the US and the world are facing another possible flare-up in the form of the Mpox outbreak: signs of the same continuity of autoimmunity are emerging. Debates about whether to focus on an “everyone is at risk” message or target messaging to at-risk groups (currently, the gay community) is merely cycling back to those of the AIDS pandemic and specifically ARTA. “Everyone is at risk,” notes Dan Royles (2022), “can feel like a well-intentioned attempt to paper over the very real effect that monkeypox is having on gay and bisexual men.” The continued autoimmune response to disease outbreak threatens the efforts of immunity—yet perhaps such a flare-up in the context of looking in the mirror to view the whole self might finally move us from the paradox of autoimmunity to the paradigm that exposes “the embodied substrate of subjectivity rather than sameness or one-ness” (E. Cohen 2004, 11). Critiques of public health campaigns as autoimmunity offer the type of self-reflection Lisa Weasel and others have demanded, “dismantling the self/non-self dichotomy” in favor of “a conception of health as bodily balance and equilibrium” (Weasel 2001, 40), a commitment to social and health equity.

Notes

¹ For a thorough account of American responses (and delayed political responses) to AIDS, see Brier 2011, esp. 78–121.

² In September 2021, Advocates for Ohio called out the health department and Governor DeWine for not fulfilling the promise of more research and resources to address health disparities within communities of color detailed in the April 2020 *COVID-19 Minority Health Strike Force Blueprint* (Bergfeld 2021). While the 2022–23 state budget has allocations for some of the recommendations from the *Blueprint*, Policy Matters Ohio notes that this funding is not sufficient (Patton et al. 2021).

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Author Bio

Amanda M. Caleb is Professor of Medical Humanities at Geisinger Commonwealth School of Medicine. Her research includes pandemic rhetorics and representation, the history and representation of eugenics, and narrative humility.