Abstract: In 1990, Congress established the Ryan White HIV/AIDS Program (RWHP). The program has since expanded to cover numerous treatments and support services. It's hard to overstate how transformative RWHP has been, but hundreds of thousands of other people had died from the same condition White had, so why did politicians wait to enact serious AIDS healthcare? Bluntly, White's AIDS education activism was sympathetic because he embodied a "moral innocence," a quality the public did not usually extend to gay men, intravenous drug users, or others who suffered from HIV/AIDS. I ask two questions about this delayed political support. First, are there any moral problems with appealing to moral innocence, even if it secures public support and medical care, by hierarchically ranking lives as more or less sympathetic? Second, can we reduce or eliminate these problems, or are they a necessary cost to getting the public to care about marginalized communities?
Keywords: HIV/AIDS, moral innocence, LGBT ethics, marginalized healthcare

Medicine and Moral Innocence

In 1990, Congress passed the Ryan White Comprehensive AIDS Resource Emergency Act, establishing the Ryan White HIV/AIDS Program (RWHP). Initially designed to help lower-income and un(der)insured people with HIV/AIDS afford treatment, RWHP expanded to cover additional services: counseling, hospice, childcare, food, and transportation among several others. Despite high costs (the 2022 budget was $2.3–2.5 billion), RWHP has sustained bipartisan support even after the initial authorizing act expired in 2013. It's hard to overstate how transformative RWHP has been, but hundreds of thousands of other people died from the same condition White had, so why did politicians wait to enact serious AIDS healthcare? Bluntly, I argue that White's AIDS education activism was inspiring, sympathetic, and embodied a "moral innocence," a term I will explicate throughout the paper, that the public did not believe applied to other people with AIDS (PWA). Since no politician proposed legislation honoring gay men, intravenous drug users, or others who disproportionately suffered from HIV/AIDS, then, presumably, these deaths that preceded White's were not seen as tragic enough to act on and secure the unmistakable good from RWHP. In this paper, I ask two questions about this delayed political support. First, are there any moral problems with appealing to moral innocence, even if it secures public support and medical care, by hierarchically ranking lives as more or less sympathetic? Second, is there a way to reduce or eliminate these problems, or are they just an unfortunately necessary cost to getting the public to care about marginalized communities?

Instead of trying to definitively account for what moral innocence is, I will individuate three distinct kinds of moral innocence. The first kind of moral innocence I identify in section one contrasts with guilt or culpability. This contrast showed up in the moralizing rhetoric around "innocent victims," hierarchically ranking people based on how they contracted HIV. In section

two, I focus on another kind of moral innocence that indicates naiveté and vulnerability. This kind of moral innocence shaped how society and innocent victims responded to the latter contracting HIV. I analyze three media archetypes to show that there was a collective and individual naïve belief that "moral choices" would prevent innocent victims from contracting HIV. Because each of these media archetypes foregrounded vulnerability, they paired innocent victims with villains who morally wronged them by afflicting them with HIV and thereby "destroying" their innocence. I argue in section three that White's AIDS education activism embodied another, aspirational, kind of moral innocence. White's wholesome public image and activism helped shift political discourse away from moralizing, making HIV/AIDS a safer political cause for politicians to advocate for.

This approach, appealing to a telegenic posterchild, is a common political strategy to get the public to care about a cause. This newfound public concern leads to resources that marginalized groups would not otherwise have, so waiting for a "deserving" victim is justified as a necessary, if unfortunate, cost to securing those resources. I discuss two problems with this approach in section four. First, designing policies around telegenic victims misconstrues what resources communities need to ameliorate the problem and so neglects the "less respectable" members of that community by misallocating resources. The second problem inflicts a moral injustice because dominant values dehumanize "less respectable" victims by unjustifiably denying their interests as important. I argue that if we reconceptualize appealing to "deserving victims" not just as a way to get material resources, but as a commitment to help everyone who is the same position, regardless of how respectable they are, then we can appeal to moral innocence without encountering either problem.

I. "INNOCENT" AND "CULPABLE" VICTIMS

The first kind of moral innocence I will talk about is based on the folk idea that morality is a system of rules or obligations. Parallel to law, this idea affirms someone is morally innocent until

they choose to break the moral rules, at which point they become guilty. Because moral rules are common knowledge, individuals appropriately deserve the consequences because they knew what was at stake when they chose to violate the moral norms. My goal in this section is to show how this simplistic version of morality shaped historical responses to how people contracted HIV. I won't spend too much time on the conceptual details in this kind of moral innocence, but I do want to note two theoretical issues. First, however intuitive this basic account of morality is about moral rules or wrongdoing, Christopher Gowans (1994) observes that it comes under strain with genuine moral dilemmas and all the competing moral demands (e.g., family obligations, global famine relief) in our life. If someone is morally innocent only if they have not broken a moral rule, then most people are likely only innocent with respect to a particular moral rule.

The second point is historical. Although people used moral language to invoke this kind of moral innocence, they were actually appealing to social conventions about propriety, not any moral theory of desert. These moralizing responses implicated prior judgments about groups that people already (dis)liked, linking illness as punishment for disobeying standards of respectability.

"Innocent victim" was a common, unofficial description of someone who contracted HIV, but was not deemed morally responsible for doing so. The designation was objectionable from the start because it implied that there were other victims who were not innocent because they had done something that made them morally responsible: they broke "moral/social" rules and so "deserved" contracting HIV. Although PWA vigorously denied the victim label altogether (Navarre 1988), the innocent victim category overrode these protests, placing everyone with HIV/AIDS on a "victim continuum" (Albert 1986). People on the innocent end of the continuum "deserved" sympathy because they contracted HIV/AIDS through no fault of their own or through the fault of someone

else, while people on the stigmatized end knew the risks and "did not care enough" to modify their behavior.[1]

Since people did not know how HIV spread, they looked at who was getting sick and then inferred that the illness was caused by something unique to those groups. Instead of careful epidemiology, this inference utilized stereotypes because many of the initial documented cases were in groups that were already marginalized and presumed to be different (Oppenheimer 1988). Sexually active gay men, intravenous drug users (IDU), sex workers, and Haitians were singled out early in the AIDS epidemic not just as people getting sick, but as people who did something to make themselves sick. This culpability imbued HIV/AIDS with a stigmatized social meaning (Sontag 2001). Gay men, for example, were being punished by God for their "unnatural" or "perverted" lifestyle (Altman 1987). IDUs and sex workers "chose" to do drugs or sell sex (Cohen 1999). While being Haitian did not constitute a high-risk behavior itself, exotic stereotypes about voodoo or cultural backwardness insinuated some kind of fault (Farmer 2006). So, the reasoning went, it was no coincidence that the people who were disobeying the conventional rules of an acceptable lifestyle were getting sick and those who were following the rules were not.

But hemophiliacs were also among the early documented cases. These cases lead to the pejorative "4H Club" label—the illness only affected homosexuals, heroin addicts, hemophiliacs, and Haitians.[2] Unlike the other "high-risk" groups, however, people felt sorry for hemophiliacs

---

[1] I say more about this point below, but this outlook selectively chose when to (exclusively) brand someone as a vector of disease, without also considering that someone else transmitted the disease to them, rendering them a victim of the illness too. This assessment omits the normative issue about which risks we, as a society, expect individuals to account for and which ones we are desensitized to—or even see as risks at all (Battin, Francis, Jacobson, and Smith 2009).

[2] This diagnostic tunnel vision skewed which symptoms (e.g., Kaposi's sarcoma, pneumocystis pneumonia) were officially recognized as AIDS-related illnesses. Cisgender women with HIV/AIDS often went undiagnosed because they presented with aggressive and resistant yeast infections or inflammatory pelvic disease. The Centers for Disease Controls and Prevention (CDC) changed the definition in 1993, but without an official diagnosis beforehand, these women did not get the treatment they needed and were denied disability benefits. Activists sardonically pointed out that "women don't get AIDS. We just die from it" (Schulman 2012, 226-69).

not just because they were chronically ill and died young, but because they did not "choose" to engage in socially unacceptable behavior. This background sympathy, about "not choosing to do anything wrong," paved the way for other groups to become innocent victims later. Instead of counting against the idea that illness was a punishment for "immoral" behavior, the fact that respectable people were getting HIV justified the sympathy: the innocent were being punished like the guilty, even though they did not break the rules.

Media stories about HIV infection provided substantially different coverage depending on who it was and how it happened. Innocent victims had interviews with emotional depth and commentary. These stories were an intimate portrait of people who were just trying to live the best life they could with the time they had left (Clarke 2006). News coverage about infected gay men, IDU, or sex workers reported facts, but did not really tell a story: the abstract focus rarely included personalizing details and emphasized the stigmatized behavior (Clarke 1992, 2006). Developing this personalized background made innocent victims individuals with hopes, dreams, and fears. People sympathized with innocent victims because the stories emphasized that their infection was something that just happened to happen to them. As these compassionate profiles circulated on the news, in magazines, or at the watercooler, they coalesced into archetypes in public conversation, policy debates, and political discourse. While the abstract coverage of HIV/AIDS in gay men or IDUs also created archetypes, these were faceless menaces to society: "the sex pervert" or "the junky" (Lupton 1999, Clarke 2006). Instead of learning how each stigmatized person contracted HIV/AIDS, the lack of media representation meant that the public used stereotypes to fill in details. The point of contrast, then, was culpability: innocent victims were not doing anything "immoral" and so could not anticipate infection, rendering them blameless, while people on the opposite end

of the victim continuum "knew the risks" from their immoral behavior and were branded as responsible for what they chose.

It would be easy, though inaccurate, to conclude that each end of the victim continuum was uniformly positive or negative. Moral innocence and blame were ambivalent generalities rather than universals because appraising how someone contracted HIV *as a victim* simultaneously raised concerns about them *as a vector* of contagion (Battin, Francis, Jacobson, and Smith 2009). In 1983, for example, Anthony Fauci hypothesized in the *Journal of the American Medical Association* that "routine close contact, as within a family household, can spread the disease" (1983, 2376). Other researchers (in the same issue) disputed his claim, but reporters, newscasters, and politicians raised the alarm. So, while people did feel sympathy for friends, family members, and innocent victims, this compassion was sometimes mixed with fear, even after scientific consensus (and Fauci himself) disconfirmed the casual contact thesis later on in 1983. But the damage was done and there was a haunting uncertainty throughout the 1980s.

When children with HIV/AIDS wanted to continue attending school, for example, other children's parents appropriately asked what the risks were to their HIV-negative children. While doctors assured parents that casual contact infection was a myth and that the risk of contracting HIV in school was near zero, parents wanted a 100% guarantee and protested with contrived "what-ifs" (Glantz, Mariner, and Annas 1992). Ryan White, a hemophiliac, found in 1986 that adults in his hometown did not want him to be in school with other children after he was diagnosed with AIDS because of these exaggerated fears. As a compromise, White phoned into classes until the Board of Health forced the school to readmit him. When he returned, almost half of the student body stayed home; bowing to parental pressure, the school prohibited White from attending. Even after White won a lawsuit to be readmitted, the school board asked him to comply with humiliating

compromises (e.g., use a separate bathroom, eat with disposable utensils), which he did. Some parents still pulled their children out to collectively homeschool (White and Cunningham 1992). In a more extreme case, Ricky, Robert, and Randy Ray were three brothers living in Arcadia, Florida, with hemophilia and AIDS. After they were diagnosed in 1986, they tried to go back to school and faced the same obstacles White did. The Ray family won a similar lawsuit, but left their hometown because an arsonist burned down their house after the win. Parents weren't wrong to ask about contagion risks, but the fact that they branded White and the Rays almost exclusively as vectors, rather than people deserving respect and understanding, meant that they were not asking questions in good faith (Battin, Francis, Jacobson, and Smith 2009). While moral innocence contrastively created two groups of people on the victim continuum, this fear about contagion from innocent victims means that culpability was not confined to one end.

Similarly, but ambivalently in the middle, there were mothers with HIV/AIDS. Although people universally pitied infants with HIV, their mothers endured complicated reactions. Women were innocent victims if they contracted HIV from a dishonest partner or a blood transfusion, but they were maligned as vectors if they did something "immoral" to contract HIV because it exposed their child to risk during pregnancy, regardless of when the immoral exposure happened (Cohen 1999, Schulman 2021). This transmission-based distinction preserved the victim continuum by contrasting "good" mothers with "bad" mothers: "good" mothers had respectable pasts that did not expose them to HIV; "bad" mothers did something to contract it. "Good" families, then, falsely concluded that they did not have to worry about HIV/AIDS because a good mother would not have chosen anything that would endanger her children or husband with HIV/AIDS, nor would she risk leaving her family without a wife or mother (Juhasz 1990). Concerningly, these reasons presumed

marriage or motherhood as an eventuality, implying that a woman should not contract HIV for her (eventual) child or husband's sake, not her own.

This good/bad mother distinction also showed up in policy and personal decisions about medical care. Pregnant women who got tested for HIV were "good" mothers because they would then get treatment to reduce the possibility of vertical transmission. But this assessment passed over questions about treatment affordability, availability ("was it regularly stocked?," "how far (and often) did rural patients have to travel?"), continuing treatment afterwards, if the diagnosis exposed them to stigma or abuse, or if the treatment during pregnancy and delivery reduced (but did not eliminate) the chances of vertical transmission at the cost of the mother developing antiretroviral resistance. These questions are clinically and morally important, but the propensity to blame women for making the "wrong" choice branded them as dangerous vectors to their children without seeing them as people making difficult choices in difficult circumstances (Battin, Francis, Jacobson, and Smith 2009). So, in addition to unduly stigmatizing guilty victims, this kind of moral innocence could turn on the very people it said were deserving of sympathy.

The stigmatized end of the victim continuum was not totally devoid of sympathy. The "wrath of God" explanation was loudly present in religious, political, and social discourse, but there was also a strong, if quieter, current of Christians enacting the obligation to care for the marginalized (Petro 2015, O'Loughlin 2021). Ditto for drug use and sex work; not that there was religious approval of the behavior itself, but there were outreach efforts to get people clean, find places to live, access medical care, or make funeral preparations. Similarly, some healthcare professionals declined to admit or treat patients with HIV/AIDS, but many heroically rose to the occasion, both during treatment and while advocating for institutional changes in local hospitals or state agencies (Bayer and Oppenheimer 2002).

Writing from the stigmatized end of the victim continuum during the early days of the AIDS epidemic, Randy Shilts recounts that "there was a prevailing sentiment that was sympathetic and at times compassionate but still detached and ultimately uncaring, as if to imply that, somehow, this whole mess is your own fault" (2007, 519). That notion of fault leaves room for concerns about those who "chose" the risks, but these pro-attitudes are possible *noblesse oblige* add-ons, not the default reaction. By contrast, the scorn that innocent victims experienced had to overcome the default concern by citing some other factor as more morally important. This kind of moral innocence explains the difference in default concern in terms of moral culpability: guilty victims knew the risks and had done the conventionally prohibited behavior anyways, while innocent victims followed the conventional rules and so were innocent; it was only when innocent victims "posed a threat" as vectors that they lost public sympathy or support.

Now I turn to a second kind of moral innocence that shaped our response to innocent victims contracting HIV. We associate this second kind of moral innocence with moral naiveté and vulnerability. I will argue that this naïve moral innocence shows up in the collective and individual belief that innocent victims made "moral" choices that inoculated them from contracting HIV. In turn, the only reason that innocent victims did get sick was because someone else had victimized them by infecting them. So, while the first kind of moral innocence (culpability) emphasizes what people do (not) do as individuals, this second kind of moral innocence (naïve and vulnerable) is interpersonal because it pairs innocent victims with villains who took advantage of an innocent victim's trust.

II. "INNOCENT" VICTIMS AND GUILTY VILLAINS

The second kind of moral innocence is associated with moral naiveté and vulnerability. On both an individual and collective level, people were shocked when innocent victims found out that

they had HIV/AIDS. Building on section one, my argument here is that part of this astonishment was based on the naïve belief that if someone lived by the rules of propriety, then they would be safe from HIV. This rhetorical framework further moralized contracting HIV not as a matter of infection, but as a change in moral status, which meant that for every innocent victim, there had to be a villain who did the victimizing.

Naiveté limits moral reasoning by taking overly simplified moral rules as reliable guides for life. Peter French (1992, 2010) and Zachary Goldberg (2016, 2017) characterize this naiveté in terms of how children learn about morality. Developmentally, these simplified moral lessons are appropriate because children are still learning right and wrong (e.g., sharing, punishment), but part of a parent's responsibility is to teach children that moral life is more complicated: things will not always end with happily ever after, doing your best will not always accomplish your goals, people will not always believe you when you tell the truth.

Although pat moral lessons familiarize children with good and evil as concepts, they only do so from a distance. Children may know who the hero and villain are in stories, but part of the morality tale is that the heroes and villains are easily identifiable: the villain enters with an ominous soundtrack, while the hero saves the day to fanfare (McKenna 2008). Insofar as children believe that fairy tales and Disney movies are instructive about real life, French and Goldberg warn that they form a naïve expectation that it is easy to recognize good and evil, which makes them morally vulnerable. This naiveté creates an imagination constraint for children because they cannot conceive of the possibility that candy from a stranger is an insidious offer or online attention from adults is predatory. It's not that children just need more time to think the overtures through, they simply are not dangerous from the child's perspective, which is why French and Goldberg stress it is important for parents to teach their children about evil (e.g., don't drink anything at a party

you didn't see poured or pour yourself). There is, then, a deep sense of individual and collective moral anger when someone loses their moral innocence to evil.

While French and Goldberg characterize this kind of moral innocence as developmental and something children mature out of, either by parental instruction or succumbing to experience, I want to take the discussion in a new direction by showing how this moral innocence shaped media narratives around innocent victims. French and Goldberg are right that moral innocence, as a general psychological outlook is usually confined to childhood, adolescence, or ingenu(e), but my goal in this section is to show how this moral naiveté and vulnerability showed up in a more localized kind of moral reasoning about HIV transmission. The reason the public was outraged when unsuspecting women, infected patients, or people with hemophilia reported having HIV/AIDS was because media stories emphasized these "innocent victims" trusting someone who betrayed that trust and morally wronged them by infecting them with HIV. My point is not to cynically dismiss trust in general, but rather I want to emphasize that this trust was largely based on a naïve moral expectation that conventionally proper choices protected someone from infection.

As a rhetorical archetype, unsuspecting women were innocent victims because they trusted their partners not to have an affair. But it's not just that unsuspecting women were caught off guard, their stories had shock value precisely because their partner's double life was beyond her (and society's) imagination. No one goes into a relationship expecting to be cheated on, and time or trust can decrease the odds of infidelity, but it is naïve to believe that they make it impossible.[3] Unsuspecting women were also sympathetic archetypes because media narratives explained her imagination constraint as a wholesome belief in her fidelity. Even if media stories portrayed

[3] I am not claiming that wise partners are always on the look-out for infidelity. My point is just that the morally innocent would not think to ask questions about a dating app on their partner's phone (it's just to make platonic friends).

unsuspecting women as recognizing that *other* people could be cheated on or lied to in *their* relationships, she, as rhetorical archetype, did not believe that it could happen to *her* because she was doing the right thing by being monogamous. The unsuspecting woman's disappointment, then, draws on a general naïve belief that bad things won't happen to us if we do the "right thing."

But the archetypical unsuspecting woman's imagination constraint is more specific. By the end of 1983, scientists and medical researchers had confidently identified that HIV spread through infected bodily fluids. Building on this conclusion, public health officials announced in 1984 that HIV likely caused AIDS. This new information about transmission took time to percolate through society for at least three reasons. First, there was lingering professional disagreement among researchers and objections about non-progressors from activist-scientists (Epstein 1996). Second, this information about transmission had to be assimilated to the previous classifications of "high-risk groups," misconceptions about transmission, and the stories that people saw in the media or heard in whispers about gaunt strangers with tell-tale purple lesions (Patton 1990). Third, most of the documented cases were still in the "high-risk" groups, so there was a persistent belief that HIV/AIDS would stay within those "natural limits" (Grover 1988, 28). And yet, by 1986, the ethically neutral fact that HIV spread through infected bodily fluids was common knowledge (Rushing 1995). So, it's not that the unsuspecting woman archetype couldn't do the moral math, that one and one sometimes make an unwanted three, but rather that she (and society) could not imagine that her unfaithful partner could contract HIV, especially from sex with men.

This kind of moral innocence depends on trusting in overly simplified moral beliefs. One of the reasons that gay men were scapegoats for the AIDS epidemic is because they were already marginalized. Without many positive representations of gay men to the contrary, being gay was marked as deviant, unnatural, or at least not part of conventional and respectable society. The

inverse, then, of that stigma meant that no one who was conventional or respectable was gay, which promoted the naïve moral belief that women who followed the conventional rules, of being in a (from her perspective) monogamous relationship with a respectable man, would live a safe life. This naïve trust didn't just happen to the individual unsuspecting women, it was also built into the archetype and our social imagination because there was collective surprise on her behalf.

This naïve trust exposed women to HIV, implicating the vulnerability aspect of moral innocence. The rhetorical archetype accentuated this component when media reports and public health advertisements cautioned against the "duplicitous" bisexual" (Cohen 1999). Bisexual men, especially bisexual men of color, were already derogated as sex perverts, so villainizing them was easy. Bisexual men or men on the Down Low were maligned as caring more about sex than their partner's life (McCune Jr. 2015). IDU were demonized for choosing drugs over their partner's health (Cohen 1999). So, the innocent victim category did not just brand a separate group of PWA as culpable for their own choices, it implicated a moralizing sense of astonishment and anger when HIV/AIDS struck respectable members of society who were making the "right choices," because someone else "took advantage" of their unwitting trust.

Patients who contracted from a HIV-positive healthcare professional during treatment were another archetype. Kimberly Bergalis epitomized this archetype because she stressed her betrayed trust in the medical establishment and insisted on her moral innocence. One reason that Bergalis' infection attracted national attention was because she exemplified propriety: young, White, middle class, college-educated, drug-free, and a virgin. Because she never had a blood transfusion, public health officials suggested that she may have contracted HIV from her dentist, Dr. David Acer in 1987, when he extracted two of her wisdom teeth. Testing found that Bergalis and Dr. Acer had similar strains of HIV, suggesting that, while he had worn gloves and a mask during surgery, he

had infected her (Coukos 1991).[4] When it came to light that four of Dr. Acer's other patients also had AIDS, Bergalis, reporters, public health officials, and politicians raised the specter that HIV-positive healthcare providers endangered their patients.

Another reason Bergalis' infection was national news was because she prioritized blaming both Dr. Acer and the medical establishment that did not require him to tell her that he had HIV. Dr. Acer died a month after he learned that he and Bergalis had similar strains of HIV. Without many people advocating for him in public, Dr. Acer became the villain that had not only victimized Bergalis, but also implicated other healthcare professionals. Because Middle America identified with Bergalis, they worried that she stood in for them. In interviews and her testimony in Congress, Bergalis insisted that she was being punished, even though she did nothing wrong. Bergalis added that while it was too late for her, something had to change because others should not be punished for trusting their healthcare providers. Politicians took up Bergalis' *cri de coeur* and proposed three different bills in the Senate to either require HIV-positive medical professionals to disclose their serostatus during the informed consent process or prohibit HIV-positive medical professionals from doing invasive procedures (Cavender 1992). Although the measures did not come to a vote in the House of Representatives, the most punitive proposal passed in the Senate, 81-18.

Bergalis' solution and each of the Senate proposals assumed that people were the risk, not medical practices. If we could prevent the "risky individuals" from doing invasive operations or ensure they disclosed that they were "risky individuals," then, the solution promised, that others would not suffer the same fate that Bergalis did. This solution is naïve because we do not live in a

[4] Commentators on Bergalis' case point out that iatrogenic infection is incredibly rare. Using insurance records from Dr. Acer's other patients, Stephen Barr (1994) reasons that they may not have been infected by him: one patient admitted that he was with a prostitute who later died of AIDS-related illnesses. Another patient's insurance records indicated that she had only been to Dr. Acer's office once, instead of multiple times as she said, and even then, only had her teeth cleaned by a hygienist. Barr articulates the awkward possibility that Bergalis lied about her sexual history. Following Barr, Bergalis and Dr. Acer may have had similar strains of HIV from a common sexual partner.

risk-free world. If the rationale for informing patients was that HIV/AIDS compromised providers' abilities to do the procedure safely, regardless of precautions, then the procedure itself would be advertently negligent, and informed consent would provide no protection (Glantz, Mariner, and Annas 1992). Even if providers submitted to mandatory testing, a test is not indicative of anything afterwards. So, testing would have to be every day and instantaneous. But no test is 100% accurate, so, even granting instantaneous results, false positives and negatives still mean that patients could never have the absolute certainty Bergalis demanded and that each Senate bills tried to implement.[5] Instead of reacting to a particular healthcare provider, we can instead focus on the conditions providers were acting in. Establishing and adhering to universal precautions (e.g., gloves, masks) lets us recognize that "the opposite of high risk is *low* risk, not no risk" (Murphy 1994, 84). Accepting that risk is part of life and can happen to anyone moves past moral naiveté because it acknowledges that bad things can still happen, even when everyone does their best.

I close this section by addressing the hemophiliac innocent victim archetype. In the 1970s, hemophiliacs began using Factor VIII, a clotting agent that transformed hemophiliacs' quality of life. Hemophiliacs depended on pharmaceutical companies, the government, and their advocacy group, the National Hemophilia Foundation (NHF) to ensure Factor VIII's safety. This collective oversight was too close-knit: the NHF financially depended on contributions from pharmaceutical companies that produced Factor VIII; people would alternate between working as state regulators and the blood product industry (Keshavjee, Weiser, and Kleinman 2001). Although hemophiliacs were among the early documented cases of AIDS-related conditions in 1981, the NHF assumed that they had nothing in common with the "high-risk cases and dismissed them as minimal risk.

[5] Testing consumes resources (e.g., time, money) that could be spent in other parts of a healthcare system. Given that iatrogenic infection is incredibly rare, there are utilitarian and material justice objections to prioritizing those recourses on such a remote risk (Daniels 1995).

Following suit, most blood product manufacturers did not change safety standards, citing that doing so would disrupt supply.

In 1982, the CDC identified several other hemophiliacs who had AIDS, including an infant, which strongly suggested that HIV could be transmitted through contaminated blood products. Echoing the NHF, most blood product companies denied that these additional cases were sufficiently high to change safety protocols, rejecting both surrogate testing and heating treatment for Factor VIII. Again, the reasoning was that testing was unnecessary because it was too expensive and not enough cases warranted it; firms that did implement the safety measures were denounced as overreacting (Bayer 1999, 27-31). When the number of transfusion-related cases of AIDS grew, the NHF considered a recall in early 1983, but insisted that blood product manufacturers should determine which individual units were possibly tainted. Pharmaceutical companies used this conclusion to pressure the FDA into not issuing a general recall—because the numbers were too low and doing so would only panic the public. Nero's fiddle played until late 1984, when the number of transfusion-related cases hit a tipping point. In 1985, the blood industry would adopt the now-standard heating treatment.

Historically, hemophiliacs were not a political group. The NHF represented their interests by interfacing with pharmaceutical companies and the government. That non-involvement shifted in the 1980s. Dismayed by the institutional indifference and still reeling from their diagnoses, families began burying their loved ones. As individuals were coming to terms with the extent of their loss, parents found their former friends and neighbors petitioning school boards to keep their children with HIV/AIDS out of school. The collective feeling of betrayal, the shared sense of loss, and the discrimination created a "deep memory" of trauma and injustice, unifying individual experiences into a community (Langer 1991).

While the institutions responsible for blood product safety did not have a malevolent plan, they nevertheless did evil. When the institutions tasked with risk-assessment said there were too few cases, they were not expressing Panglossian optimism that everything would work out, they were worried about profits (Shilts 1987). This denial was willful ignorance, not moral naiveté. Hemophiliacs, however, trusted each organization because they had promised to look out for them and had successfully coordinated producing Factor VIII, a sign of good faith. And yet hemophiliacs later rued this trust as naïve during legal hearings. As the deep memory of trauma percolated, it came with a "never again" mentality. Because their prior trust was what let the organizations ignore the cases, there was a collective vow in the emerging hemophilia community to become politically active in their healthcare (Keshavjee, Weiser, and Kleinman 2001). So, while hemophiliacs themselves recognized that they were among the early documented cases of AIDS-related illnesses, they naïvely believed that corporations would not value profits over their health and that the state would step in if citizens were in danger.

I've touched on two harms from moral innocence. I showed in section one that we relied on pre-existing prejudice to malign some PWA as morally culpable for contracting HIV. I argued here that another kind of moral innocence, based on moral naiveté and vulnerability, illuminates an additional harm: by promoting the naïve belief that innocent victims were not at risk for HIV if they lived "moral lifestyles," media and politicians placed the blame at the feet of villains who did moral evil by taking advantage of the innocent victim's trust. These reactions to innocent victims contracting HIV moralized the discussion in terms of changing someone's moral status—where one person had to became the innocent victim and the other the predatory villain.

III. AIDS EDUCATION AND ASPIRATIONAL MORAL INNOCENCE

The last kind of moral innocence I will talk about is aspirational. Aspirational innocence indicates an idealized way the world could be if individuals or society put in the work. I spend this section showing how White's AIDS education activism was built around humanizing PWA. As his efforts gained national attention, White's public persona embodied this aspirational innocence by emphasizing what people could do going forward. Unlike the first kind of moral innocence, that blamed people for making "bad moral choices," White's aspirational moral innocence stressed that behaviors carried risks for contagion. Some behaviors were riskier than others, but that did not say anything about someone's moral character or "irresponsibility." Unlike the naïve kind of moral innocence, White's emphasis on education was meant to both empower people about decision-making while also stressing that vulnerability to HIV/AIDS was just a part of life. As a result, White de-moralized the rhetoric around contagion and vulnerability by reframing HIV/AIDS as a medical, not moral, status.

White became a national figure in 1986 when he tried to go back to school after his AIDS diagnosis. During and after the trial, White repeatedly said he wanted to have a normal life. Like many other teenager boys, White wanted to hang out with friends, graduate high school, have an afterschool job, learn to drive, and find a girlfriend. While this normalcy was central to White's narrative, it is at odds with his actual life (Jordan 2011). It's not that White misrepresented himself, it's just that most teenage boys do not regularly get interviewed by national media, speak about AIDS education across the country, meet celebrities, have a movie made about their life, or testify before Congress. So, one of the reasons White's public persona resonated with people was because it embodied a hope to be normal. This widespread sympathy and identification with White changed how, and to what extent, reporters and analysists covered HIV/AIDS (Rogers et al. 1991). While

his unwanted fame was at odds with his desire for normalcy, White's longing for it made his public persona an easy political cause for others to latch onto.

Recall that many of these same qualities also made Bergalis a public figure. White was a teenager, lower-middle class, White, the boy-next-door, and, like Bergalis, people thought of him as an innocent victim because he had not "done" anything wrong. Unlike Bergalis, White didn't think of himself as innocent and was more interested in meeting people where they were rather than blaming them: he could have refused his school's humiliating compromises with another lawsuit, but he didn't. White was frustrated and hurt when he became the subject of rumors, the butt of "Ryan White" jokes, and was accused of trying to infect people, but he wasn't bitter in interviews. White did publicly reflect on his mistreatment, but more to express his disappointment that people sometimes wouldn't listen to the facts about HIV/AIDS.

This disappointment was the aspirational foundation for White's forward-looking project. AIDS education was something everyone had a stake in because it affected everyone, either by direct risk of infection or indirectly in terms of how PWA could (not) participate in society. While focusing on behavioral risk and general vulnerability was initially disquieting, people learned the information that helped attuned them to HIV/AIDS as a risk, but White never taught it as a morality lesson. As proof of concept, White routinely mentioned how his life changed when his family moved to Cicero, Indiana, where people included him because they had educated themselves about HIV/AIDS. So, there are two other reasons that White's public persona was popular: (1) White appealed to the better angels of our nature by not blaming the people in his hometown, even when they mistreated him, and instead hoped they would get educated; (2) by focusing on implementing AIDS education, he was offering an opportunity that could turn sympathy into political change.

Although there were political battles over what to include in AIDS education, White started from the premise that everyone could contract HIV. While White affirmed that "not having sex is absolutely safe. So is sex with one faithful, long-term partner who is not HIV positive," he also discussed condoms, getting tested, and other safer sex practices (White and Cunningham 1992, 305). White sidestepped the political flashpoint by informing audiences that even if abstinence and seronegative monogamy shielded someone from sexual vectors, they were still vulnerable to other vectors. Virgins, like White, would increase their risk of contracting HIV if they shared unsterilized needles. White also mentions drugs among other less stigmatized activities (e.g., acupuncture, ear piercing), stressing that the vector is sharing unsterilized needles, not intravenous drug use *per se*. Enumerating the behavioral risks made White's education activism politically neutral: stating the risks of sharing unsterilized needles was compatible with, though not committed to, either needle exchange programs or just saying "no" to drugs. This neutrality was appealing because it showed that White was interested in solving the problem of AIDS-ignorance, not scoring political points.

Important for our purposes, White's AIDS education disarms the harms from sections one and two by replacing the victim continuum with a risk continuum. If anyone could do the behavior that put them at risk, and AIDS education informed people of risks, then the rationale for sorting people based on moral agency fell apart because everyone, innocent victims included, would know the risks. The fact that White did not build his activism around blaming shows that he did not see HIV as inflicting a moral status change—it impacted his well-being and caused an early death, but by conceptualizing HIV/AIDS as a medical condition that anyone could have, he redirected our attention to vulnerability, not victimization.

White was not the only one doing something. Celebrities (posthumously) disclosing their serostatus had helped humanize the public conception of HIV/AIDS, that it didn't just happen to

"those people" (Murphy 1994). Allies (e.g., Elizabeth Taylor) campaigned against stigma and fundraised for HIV/AIDS research and treatment. Other individuals and organizations, like the gay press, Gay Men's Health Crisis, San Francisco AIDS/KS Foundation, Shanti Project, and AIDS Coalition to Unleash Power (ACT UP), had been working to educate people, care for the sick, and protest governmental indifference. ACT UP's agitprop, insider/outsider protests, and direct-action commanded attention and produced results. Although it was a decentralized group, ACT UP strategically chose targets and came prepared with practical demands. This approach reshaped insurance policies, restructured how scientists ran clinical trials, lowered drug prices, got PWA a say in government agencies, increased housing for PWA, started a (then illegal) needle exchange, protested discrimination in hospitals, and challenged attitudes towards sex and gender (Schulman 2021). ACT UP's defiance did not go unnoticed, least of all among the bureaucrats they harangued into helping, but it prioritized anger. This motivation conflagrated with desperation, pride, shame, outrage, and grief, all of which manifested in intentionally accusatory slogans. Calling complacent bureaucrats "murderers" or wielding "Silence=Death" logos underneath an inverted pink triangle (harkening back to concentration camps), provoked people to make them make a change (Gould 2009). But those same tactics made people uncomfortable (that was the point) and so while ACT UP was effective in initiating substantive institutional changes, it never (by design and response) found a place in mainstream politics.

In contrast, White's apple-pie public persona made it more respectable to discuss or support HIV/AIDS. Iris Marion Young's (2011) distinction between responsibility and blame illuminates why. Young sees responsibility as a forward-looking commitment, a job that people have to do, while blame refers to holding individuals accountable for what they did in the past. There is an understandable urge to blame people who did wrong, but Young worries that it distracts us from

moving forward for two reasons. First, by focusing on blaming individuals, we ignore that institutions empower individuals to act. Second, because no one likes being blamed, people will expend a lot of effort to shift the blame to someone else.[6] Because ACT UP came with actionable demands on how to change institutions, they offered the people they were blaming a forward-looking responsibility. That approach worked when ACT UP took over the Food and Drug Administration's main building or negotiated with the National Institutes of Health, but it just wasn't possible to similarly disrupt the daily routines of society and demand changes in how people voted or what they donated money to. When ACT UP protested individual politicians, the accused referenced their (insufficient) track-record or pushed back with behavioral critiques (Gould 2009). So, prioritizing blame, even if it came with a follow-up forward-looking responsibility, had limited appeal.

To be clear, White did not see himself in a competition with ACT UP, he was doing what he thought would help. Framing AIDS education as a forward-looking invitation for everyone complemented White's normal public persona by aiming to bring people together. Following Young, people "had a job to do," educate themselves and use that education to live their normal lives, which meant living and interacting with PWA. Instead of just emphasizing people's shared vulnerability to HIV/AIDS, White's public persona offered an ideal of what living with AIDS could be like. Peter Johnson (1988) suggests that this "aspirational moral innocence" expresses hope for how the world could be. Even if we recognize that the proposal is not realistic (e.g., everyone does their part), it articulates an ideal we work towards. White's optimism, even after

[6] Martha Nussbaum (2011) presses that Young must recognize that responsibility can turn into blame when an individual fails to do what they are responsible for. Young can meet this objection by reframing culpability in terms of how holding someone accountable will advance the cause.

being ostracized in his hometown, made his public persona credible because he stayed committed to that ideal when others would have been embittered by the pariah-status.

That optimism resonated. Citing international headlines and analyzing the media coverage about White's passing in 1990, Deborah Lupton found that "White, the 'boy next door,' was portrayed as courageous, a martyr, a hero and a warrior who had lost the 'battle' he had waged against death. His fame was such that the American President paid 'tribute' to him, and 'nation weeps' when he died" (1994, 100-01). White's death coincided with a key piece of legislation, the Comprehensive AIDS Resource Emergency Act (CARE), which Senators would later name in his honor. Jeanne, White's mother, went to Washington DC shortly after her son's funeral to rally support for the bill, which was starting to stall. When Senators offered condolences, she asked them for their support and is credited with singlehandedly recruiting 29 additional co-sponsors for the bill. The press covered Jeanne's day-long vigil in the Senate gallery during the vote: the Ryan White CARE Act passed 95-4 in the Senate and 408-14 in the House of Representatives (Wallack et al. 1993, 194-98). President George H.W. Bush demurred that AIDS was getting "special treatment," but anticipating an override, he signed the bill into law.

While no one factor was determining public opinion throughout the AIDS epidemic, some did exert more influence than others. Although "the rapidly increasing number of people who were diagnosed with AIDS or who had died from the epidemic was tragic," it did not influence how the media covered AIDS as a national issue that affected everyone (Rogers and Shefner-Rogers 1999, 409). Instead, stories like Rock Hudson's death or White's struggles with his hometown and subsequent education activism, did change the media agenda-setting because it helped humanize AIDS and show people what they could do about it (Rogers and Shefner-Rogers 1999). This media interest and indifference mirrored the political conversation preceding RWHP. Legislators clarified

that even though they were honoring White, the bill was for all PWA. While PWA benefited from the legislation, whatever it was called, it seems unlikely that politicians would have proposed or stood by "The Intravenous Drug User with HIV/AIDS Act" or the "Gay Sex and HIV/AIDS Act." The fact that Jeanne played a vital role in passing the bill suggests that political willpower was stalling, which means that it was not sufficient to pass AIDS legislation before she intervened. It helped that White was a sick White boy from Indiana who didn't do drugs, hadn't sold sex to survive, didn't have a complicated immigration situation, nor was associated with any lurid sexual practices.

The issue isn't that the bill honors White, he did remarkable things to make everyone's life better. The concern I raised in the beginning is that there would be no political support for honoring these *others*, even though they had died of the same AIDS-related conditions. White's aspirational moral innocence may defuse some of the problems with the other two kinds of moral innocence, but, since legislators and policymakers chose not to spotlight these other lives (and deaths), it does suggest that they were aware of an informal, but widely accepted, hierarchical indifference about what happened to these other lives. I spend the final section exploring how this hierarchy generates two moral problems for people who are ranked lower and how politicians, activists, and policymakers can avoid those problems.

IV. PROBLEMS WITH APPEALING TO MORAL INNOCENCE

An intuitive response here is to regretfully concede that waiting for a sympathetic victim, like White, is a necessary, if unfortunate, cost of getting the public to care about an unpopular cause. What matters is getting politicians and policymakers to allocate resources (e.g., healthcare, support services) and appealing to a sympathetic victim is, realistically, the only way to vouchsafe those resources through public support. While there is something right about this strategy, there

are two problems. First, designing policies around respectable victims institutionalizes the idea that the problem only happens to them, which leaves out the needs that less respectable, and more vulnerable, victims who are facing the same problem have. Second, while waiting for a sympathetic victim is politically prudent, it unjustly excludes the other less respectable victims in the meanwhile by indefensibly setting back their interest in accessing basic needs (viz. healthcare). I argue that we can reconceptualize the appeal to sympathetic victims as a commitment to secure resources which are extrinsically valuable in reducing the conditions that devalue other, less respectable people in the first place. To the extent that we make good on that commitment, we avoid each problem.

Philosophers have objected to relying on sympathetic or respectable victims, even if they secure political gains. Dean Spade explains that activists' propensity to wait for "perfect plaintiffs" is politically expedient because it showcases a member of a marginalized group who is employed, does not have immigration issues, no criminal record, is White, middle class or rich, and would be like everyone else if not for the discrimination against that one in-group characteristic (2015, 44). Instead of getting distracted by these other issues, the public focuses on the one in-group characteristic against a background of respectability. Since perfect plaintiffs have everything else going for them, Spade objects that they skew which needs get associated with that marginalized group. The political changes, therefore, only end up benefiting the people who are best off in the marginalized group because people who previously were not involved with the cause end up (inadvertently) concluding that the perfect plaintiffs represent the typical cases and needs in that marginalized community. The most vulnerable members of a marginalized group, the people who are everything the perfect plaintiff is not, do not really see their life chances improve because the

thorny issues about, say, drug use or homelessness are not "safe" political issues to endorse. Call this objection "Misallocated Resources" because the people who need help do not get it.

The second problem is that it inflicts an injustice on the people activists pass over while waiting for a sympathetic victim. For example, Rosa Parks heroically resisted segregation by refusing to give up her seat on the bus to a White man. Activists presented Parks as a middle-aged employed Black lady who was trying to get home after a long day of work. But Parks wasn't the first, nor the only, Black woman who refused to give up her seat. Nine months before Parks resisted, Claudette Colvin had also been arrested for the same reason. Terry Lovell explains that civil rights activists rallied around Parks because Colvin was "too dark-skinned, too 'rough' in class terms, too young, too loud, and pregnant but unmarried" (2003, 12). Jose Medina (2013, 234-49) adds that this choice, Parks over Colvin, shows that people were not really responding to the injustice of segregation because they were only concerned when it happened to respectable people like Parks. So, while no one disputes that her defiance was significant, the problem is that by choosing Parks over Colvin we hierarchically ranked her injustice as more tragic than Colvin's injustice, even though they were the same.

While Parks was the prudent choice, I want to explain why choosing her case was unjust to Colvin. First, Parks and Colvin were using the bus seat to protest the system of segregation. This political context matters because it shows that the reason Parks, Colvin, or any person of color was denied the seat was not because they didn't pay for it, but because the law picked out an indefensible characteristic to base that exclusion on. Mari Mikkola argues that this treatment dehumanizes people by indefensibly setting back their legitimate human interest, where that set back constitutes a moral injury (2016, 8).[7] Segregation dehumanized both Parks and Colvin

[7] While "dehumanizing" invokes Kantian language on valuing people as ends-in-themselves, Mikkola clarifies that she grounds her argument in a much thinner biological conception of human-being that we have a particular biology,

because the bus seat was a stand-in for the rest of Jim Crow, both as an institution and a widespread public outlook.

Second, activists dehumanized Colvin when they did not take up her case because she was not respectable. Being "took dark-skinned, too 'rough'" and all the other reasons were not defensible moral reasons to not help Colvin. This point is crucial because, and not in spite of, the fact that activists were accurately predicting how society would respond to Colvin. Mikkola rightly adds that while individuals can dehumanize others as individuals, they also can do so as individuals drawing on "wider and more diffuse social prejudices and structural assignments" that sustain the unjust barriers to someone's interests (2016, 166). Colvin had an interest in accessing a public good (bus seat) *and* having her injustice taken seriously. By relying on the respectability standards they did, activists further dehumanized Colvin by concluding that they should not waste their political capital on her. Call this problem "Moral Inequality," because Colvin and Parks were treated differently even though they experienced the same initial injustice.

One response is that the material goods from RWHP outweigh Misallocated Resources and Moral Inequality. Without associating HIV/AIDS with White's aspirational moral innocence, politicians would have been less likely to support RWHP. Jeanne's personal intervention and subsequent media coverage on their interactions was paramount in getting Senators to cosponsor, not just vote for, the bill. Given that these individuals had not advocated or signed on to bill before, despite recruiting efforts by Ted Kennedy and Orin Hatch, two influential Democratic and Republican Senators respectively, suggests that Jeanne's appeal to her late son's public persona

---

psychology, and range of emotional needs because of the kind of species we are. Mikkola also contrasts her position with Martha Nussbaum's (2000) capabilities argument, concluding that injustice wrongs someone not because it prevents them from flourishing as a human being, but by indefensibly denying their interests on a more minimal level. I appeal to Mikkola's account for ease of exposition, but my conclusion is equally compatible with both Kantian and capability conclusions.

(what they would have known about him from media coverage), was what swayed them. Recall that the legislative response to Bergalis' call-to-arms was a year after RWHP passed, meaning there wasn't a sea change in attitudes towards HIV/AIDS. So, there was a limited political window to act and, as I argued above, it's likely that appeals to White's public persona was decisive in swaying the votes. Since RWHP increased funding for PWA, paving the way for expanding the supporting services PWA could access, and these benefits depended on appealing to White's public persona, then, the good from RWHP was more important than the problems with appealing to White's public persona, which embodied his aspirational moral innocence.

This response helps resolve Misallocated Resource because RWHP has steadily increased the number of services that PWA can access and is tailored to help the most vulnerable (those without health insurance). Even conceding that RWP is not perfect, it could include pre-exposure prophylactics (PrEP) (Killelea et al. 2022) or needle exchanges[8] to reduce HIV infections, the perfect is not the enemy of the good. If RWHP continues its expansionism towards accessibility, then it reduces the force of Misallocated Resources. Even granting that RWHP leaves out some PWA, the choice was that politicians could vote for it to help some people or not vote for it and help no one. Even if RHWP never covers PrEP or needles exchanges, those who lose out from not having these policies would still gain from the other services.

It is less clear that this approach resolves Moral Inequality. Before RWHP passed, PWA had an interest in accessing healthcare. While there is an extensive literature on if there is a positive/negative right to healthcare, following Mikkola's theory of dehumanization, I will focus on the non-ideal circumstances PWA confronted because what matters is the reasons why they,

[8] While controversial policies, needle exchanges dramatically reduce HIV infections among IDU, in some cases up to 60% (Broz et al. 2021). While RHWP funds can support syringe service programs (e.g. wages, overhead, mobile clinics), they cannot be used for needles/syringes and related equipment (Bosh, Crepaz, Dong, et al. 2019).

specifically, were denied healthcare. Some hospitals limited their intake census by drumming up clinical precautions (e.g., private rooms); providers could legally, if disingenuously, cite lack of familiarity with a particular (rare) comorbidity to refer the patient away; there was outright patient dumping (Oppenheimer and Bayer 2000). Bureaucrats working in public housing, Medicaid, or social security either denied coverage or used loopholes to disqualify applicants (Schulman 2021, 231-33). While they covered other chronic and/or fatal conditions, insurance companies classified HIV/AIDS as a preexisting condition, did not include a stop loss on policies, or restricted open enrollment periods for people to access healthcare (Daniels 1995, Schulman 2021). None of these restrictions or denials were based on principled arguments about accessing healthcare in general, they were tailored to exclude people because they had HIV/AIDS. This reason indefensibly sets back PWA's legitimate interest in accessing healthcare and, in addition to diminishing their wellbeing, morally injured them by denying that they, in virtue of having HIV/AIDS, were not worth medical resources.

This exclusionary treatment existed alongside political inaction. Whatever politicians personally felt about HIV/AIDS, there was a noticeable lack of AIDS funding and legislation. For the sake of argument, let's assume good intentions: politicians wanted to act, but needed to wait for someone with White's morally innocent public persona. Even so, other PWA during that waiting period suffered the same kind of injustice that Colvin did. By hypothesis, politicians were recognizing the widespread institutional practices and public indifference about what happened to PWA. Instead of taking a political stand to affirm that these other PWA mattered, politicians who waited were reinforcing the institutional and community values that disregarded those other PWA as worth the political capital. There is, then, a justificatory gap between the good from RWHP's material resources and the wrong from the dehumanizing injustice.

Instead of trying to bridge that gap by arguing that X amount of medicine or Y number of support services sufficiently compensate for the dehumanizing injustice, I argue that the resources from RWHP are extrinsically valuable for reducing the conditions that created the dehumanizing injustice in the first place. Reducing these conditions (e.g., PWA lacking agency, indifference to PWA dying) is intrinsically valuable because they inhibit citizens and the state from showing equal respect and concern for all citizens (Anderson 1999). On my approach, we can reconceptualize the relationship between appealing to morally innocent victims, like White, and the two problems I identified, Misallocated Resources and Moral Inequality, in terms of a two-step commitment to get the public to care about an issue they previously did not. First, appealing to an innocent victim gets people and policymakers to care about a particular vulnerability. The second step gets people and policymakers to expand that concern, from the sympathetic victim to everyone who is similarly vulnerable, regardless of how respectable they are. If people and policymakers make good on this two-step commitment, to help everyone and not just the telegenic posterchild, then they do not cause Misallocated Resources or Moral Inequality. While I have framed this conclusion as a conditional, it is not a single, one-time event. Preventing or resolving each of these problems is a commitment that takes time and depends on various interactions in the public sphere.

Moral Inequality objected that dominant values designated some lives as more worthy than others. While RWHP increases access to programs and resources, this access has a transformative effect on PWA's agency. Cheshire Calhoun (2018, 64-67) reminds us that meaningful living means that we can plan our lives into the future. Being able to not only plan out, but live to accomplish, long-term or deeply involved goals enriches our lives. Calhoun emphasizes that health enables us to take on these goals because it sustains or restores our agency. Without health, it's hard for our present-self to identify with or envision a meaningful connection to our future-self. So, while it's

important RWHP makes a substantial difference to PWA's welfare, what really matters is that it gives PWA the resources that empower them to (continue to) make meaningful decisions about their own lives. I add that as PWA live and live longer on the resources from RWHP, they have the tools and the time to challenge the dominant values that initially dismissed their lives as morally lesser. This transformative possibility is not guaranteed, but it does create space for PWA to create what Medina calls "emblems of resistance," which are acts that defy or resist dominant norms (2013, pp. 246-49). By challenging those norms, people show that there is an alternative way to value individuals or actions. Medina qualifies that these emblems are successful when others echo them. This process of echoing creates a chain of resistance that links individuals together and connects them to institutions or prevalent values.

Aided by improved treatment, this conceptual transformation is already underway by reframing HIV/AIDS as a chronic condition, not a death sentence. Just as PWA resisted the victim terminology, so too does thinking about AIDS as a chronic condition indicate that people can live with it, rather than only die from its complications. So, following Calhoun, as RWHP continues to provide PWA the enabling conditions for long-term agency, it gives them the opportunity to decide how they make meaning in their lives. As these lives unfold, PWA can form relationships and live lives that they would not have been able to without RWHP. As these effects accumulate in the social world, they chip away at the devaluing standards that support Moral Inequality. As PWA and their allies make a bigger mark on the political landscape, they can advocate and demand for more resources, which reduces Misallocated Resources' force. Neither of these possibilities are guaranteed, but they do show that appealing to aspirational moral innocence only creates problems for people to the extent that we let it.

V. Conclusion

I identified three different kinds of moral innocence and argued that they each showed up in how we responded to people contracting HIV. I also argued that each kind of moral innocence caused moral problems. Classifying some people as innocent victims unduly blamed others for how they contracted HIV. Falsely assuring innocent victims that they were not at risk for HIV if they lived conventionally wholesome lives created villainous foils. While White's public persona enacted an aspirational moral innocence that defused these two problems, it also inadvertently introduced two others. I argued that these moral problems exist to the extent that we tailor legislation and resources to telegenic or members of a group. So, if we start with these sympathetic members to get people to care about how the issue affects everyone, then we gradually reduce each problem. To the extent that we stop our efforts with the telegenic members of a group, then we do inflict these problems on everyone else because we indicate that those people are not as worthy of help.

Bibliography

Albert, Edward. 1986. "Acquired Immune Deficiency Syndrome: The Victim and the Press." *Studies in Communication*. *3*(1): 135-58.

Altman, Dennis. 1985. *AIDS: In the Mind of America*. New York: Doubleday.

Anderson, Elizabeth. 1999. "What is the Point of Equality?" *Ethics*. *109*(1): 287-337.

Barr, Stephen. 1994. "What if the Dentist Didn't Do it?". *The New York Times*. April 16, 1994.

Battin, Margaret, Francis, Leslie, Jacobson, Jay, and Smith, Charles. 2009. *The Patient as Victim and Vector: Ethics and Infectious Disease*. Oxford: Oxford University Press.

Bayer, Ronald. 1999. Blood and AIDS in America: Science, Politics, and the Making of an Iatrogenic Catastrophe. In *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*, eds. Eric Feldman and Ronald Bayer, 19-58. Oxford: Oxford University Press.

---, Oppenheimer, Gerald. 2002). *AIDS Doctors: Voices from the Epidemic*. Oxford: Oxford University Press.

Bosh, KA, Crepaz N, Dong X, et al. 2019. "Opioid Overdose Deaths Among Persons with HIV Infection, United States, 2011-2015." [Abstract number 147]. Abstract presented at the 2019 Conference on Retroviruses and Opportunistic Infections; March 7, 2019; Seattle Washington.

Broz, Dita, et al. 2021. "Syringe Services Programs' Role in Ending the HIV Epidemic in the U.S.: Why We Cannot do it Without Them." *American Journal of Preventative Medicine*. *61*(5S1): S118-129.

Cavender, Jeffery. 1992. "AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case." *Georgia Law Review*. *26*(2): 539-600.

Clarke, Juanne. 1992. "Cancer, Heart Disease, and AIDS: What do the Media Tell Us About these Diseases?". *Health Communication*. *4*(2): 105-120.

---. 2006. "Homophobia Out of the Closet in the Media Portrayal of HIV/AIDS 1991, 1996, and 2001: Celebrity, Heterosexism, and the Silent Victims." *Critical Public Health*. *16*(4): 317-330.

Cohen, Cathy. 1999. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago: University of Chicago Press.

Coukos, Pamela. 1991. "The Bergalis Case." *Courts, Health Science and the Law*. *2*(1): 18-27.

Epstein, Steven. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press.

Farmer, Paul. 2006. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press.

Fauci, Anthony. 1983. "The Acquired Immune Deficiency Syndrome: The Ever-Broadening Clinical Spectrum." *Journal of American Medical Association*. *249*(17): 2375-76.

French, Peter. 1992. *Responsibility Matters*. Lawrence: University of Kansas Press.

---. 2010. *War and Moral Dissonance*. Cambridge: Cambridge University Press.

Glantz, Leonard, Mariner, Wendy, and Annas, George. 1992: "Risky Business: Setting Public Health Policy for HIV-Infected Health Care Professionals." *The Milbank Quarterly*. *70*(1): 43-79.

Grover, J.Z. 1988. "AIDS: Keywords" in *AIDS: Cultural Analysis, Cultural Criticism*, Douglas Crimp (ed.). 17-30.

Goldberg, Zachary. 2016. Moral Innocence as the Negative Counterpart to Moral Maturity. In *Innocence Uncovered: Literary and Theological Perspectives*, eds. Carl Findley and Elizabeth Dodd, 167-182. New York: Springer.

---.2017. "Moral Innocence as Illusion and Inability." *Philosophia*. *43*(2): 355-66.

Gould, Deborah. 2009. *Moving Politics: Emotion and ACT UP's Fight Against AIDS*. Chicago: University of Chicago Press.

Gowans, Chrisopher. 1993. *Innocence Lost: An Examination of Inescapable Moral Wrongdoing*. Oxford: Oxford University Press.

Jordan, Mark. 2011. *Recruiting Young Love: How Christians Talk about Homosexuality*. Chicago: University of Chicago Press.

Juhasz, Alexandra. 1990. "The Contained Threat: Women in Mainstream AIDS Documentary." *The Journal of Sex Research*. *27*(1): 25-46.

Keshavjee, Salmaan, Weiser, Sheri, and Kleinmann Arthur. 2001. "Medicine Betrayed: Hemophilia Patients and HIV in the US." *Social Science & Medicine*. *53*(8): 1081-94.

Killelea, Amy et al. 2022. "Financing and Delivering Pre-Exposure Prophylaxis (PrEP) to End the HIV Epidemic. *Journal of Law, Medicine, & Ethics*. *50*(S1): 8-23.

Langer, Lawrence. 1991. *Holocaust Testimonies: The Ruins of Memory*. New Haven: Yale University Press.

Lovell, Terry. 2003. "Resisting with Authority: Historical Specificity, Agency, and the Performative Self." *Theory, Culture, & Society*. *20*(1): 1-17.

Lupton, Deborah. 1994. *Moral Threats and Dangerous Desires: AIDS in the News Media*. New York: Routledge.

---. 1999. "Archetypes of Infection: People with HIV/AIDS in the Australian Press in the mid 1990s." *Sociology of Health & Illness*. *21*(1): 37-53.

McCune Jr., Jeffrey. 2014. *Sexual Discretion: Black Masculinity and the Politics of Passing*. Chicago: University of Chicago Press.

McKenna, Michael. 2008. "The Loss of Innocence and the Things that Remain." *APA Newsletter*. *07*(2): 5-9.

Medina, Jose. 2013. *The Epistemology of Resistance*. Oxford: Oxford University Press.

Murphy, Timothy. 1994. *Ethics in an Epidemic: AIDS, Morality, and Culture*. Berkely: University of California Press.

Navarre, Max. 1988. Fighting the Victim Label. In *AIDS: Cultural Analysis, Cultural Activism*, ed. Douglas Crimp, 143-46. Cambridge: MIT Press.

Nussbaum, Martha. 2000. *Women and Human Development: The Capabilities Approach*. Cambridge: Cambridge University Press.

--- 2011. "Foreword." *Justice and the Politics of Difference*. Princeton: Princeton University Press.

O'Loughlin, Michael. 2021. *Hidden Mercy: AIDS, Catholics, and the Untold Stories of Compassion in the Face of Fear*. Minneapolis: Broadleaf Books.

Oppenheimer, Gerald. 1988. In the Eye of the Storm: The Epidemiological Construction of AIDS. In *AIDS: The Burdens of History*, eds. Elizabeth Fee and Daniel Fox, 267-300. Berkeley: University of California Press.

Patton, Cindy. 1990. *Inventing AIDS*. New York: Routledge.

Petro, Anthony. 2015. *After the Wrath of God: AIDS, Sexuality, and American Religion*. Oxford: Oxford University Press.

Rogers, E.M., Dearing, J.W., and Change, S. 1991. *AIDS in the 1980s: The Agenda-Setting Process for a Public Issue*. Columbia: *Journalism Monographs*.

---. Shefner-Rogers, Corinne. 1999. Diffusions of Innovations and HIV/AIDS Prevention Research. In *Power in the Blood: A Handbook on AIDS, Politics, and Communication*, ed. Willaim Elwood, 405-14. Mahwah: Lawrence Erlbaum.

Rushing, William. 1995. *The AIDS Epidemic: Social Dimensions of an Infectious Disease*. New York: Routledge.

Schulman, Sarah. 2022. *Let the Record Show: A Political History of ACT UP*. New York: Picador.

Shilts, Randy. 2007. *And the Band Played On: Politics, People, and the AIDS Epidemic*. New York: St. Martin's Griffin.

Spade, Dean. 2015. *Normal Life*. Durham: Duke University Press.

Sontag, Susan. 2001. *Illness as Metaphor and AIDS and Its Metaphors*. New York: Picador.

Wallack, Lawrence et al. 1993. *Media Advocacy and Public Health: Power for Prevention*. New York: Sage.

White, Ryan, Cunningham, Ann Marie. 1992. *Ryan White: My Own Story*. Berkley: Signet.

Young, Iris Marion. 2011. *Justice and the Politics of Difference*. Princeton: Princeton University Press.