

A QUARTERLY JOURNAL ON
HIV PREVENTION, TREATMENT
AND POLITICS

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achieve

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PrEParing Latinos for HIV Prevention

by Richard L. Zaldivar

As PrEP rolls out in communities throughout the U.S., it has become clear that not everyone has equal access to this groundbreaking HIV prevention medication. In many small cities and rural areas, PrEP is still a foreign idea instead of an exciting new approach that can save lives.

While the white gay community has hosted community forums, conducted outreach, and recruited men into prevention programs, there has been a lack of that type of support and enthusiasm from the Latino community. This has left a majority of men of color without knowledge about or access to PrEP. And even those who do know about it are unsure whether they should take it. It's all about cultural differences.

HIV in Latinos

In December of 2015, the CDC reported that new HIV diagnoses declined by 19% from 2005 to 2014. Unfortunately, that number continues to rise among Latino gay and bisexual men, and their new infections are up 24% – the highest increase of any group. New diagnoses of HIV infection rose sharply from 2008 to 2013 among Latino men who have sex with men (MSM), despite an overall decline in infection among Latinos during the same period.

For the Latino community, there are many barriers to accessing PrEP. These became apparent to me when I facilitated a session of a Latino Men's Group last October. This group has met weekly for the past 23 years. Men of all ages and backgrounds attend, and topics range from sex, dating, and career plans

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PrEParing Latinos *continued from first page*

to spirituality. The group also provides a space for self-discovery, community engagement, and learning to become effective social justice advocates.

In the meeting, a member by the name of Victor shared that after many years of having anonymous sex, he finally met someone he was interested in dating. It was then that he decided to start PrEP. He stated that finding that certain special man made him want to make an investment in his own sexual life and this new relationship.

This was a monumental step for Victor. He was going to do something that was proactive in his sexual life and he finally found someone special to share part of his life. In his excitement he posted on his social media page that he had met someone special and that he was going on PrEP.

As soon as he posted it, his ex-partner delivered a harsh comment equating the PrEP regimen to becoming a male whore. Victor fought back, stating that going on PrEP simply makes a statement that he is proud of who he is as a gay

man. It shows his determination to enjoy intimate sex with a man he loves, while staying safe.

Once Victor made up his mind and took action, the world opened up for him. He made a conscious decision to move away from shame to a place of power. With that power came community advocacy.

Starting PrEP

Victor's story is powerful. It takes us on a journey from living under a shell to the normalization of sex, love, health, and wellness. It also highlights several issues specific to Latino culture. The coming-out process looks very different for each individual, and is a lifelong process. For many in our community, an open conversation about sex is still very much a taboo. For many, sex is still about secrets and shame.

A Latino man has to travel a long road to go on PrEP. First, he has to go to a medical provider for an exam. This is not something that most people in our community usually do. Then, he has to engage the doctor in the topic of sex. That can be very difficult for many Latinos, because they have to have a

The Robert Mapplethorpe Clinical Research Program

PRO 140

People with CCR5-tropic HIV, resistance to at least one class of HIV drugs, and a viral load over 400 will take injections of PRO 140 along with other HIV drugs for 24 weeks.

Selzentry

People with HIV who are 18 and older and who have not taken HIV meds will take either Selzentry or Truvada for 22 months. Everyone will also take Prezista with Norvir.

Sovaldi

ACRIA will review the charts of people with HIV who took Sovaldi or peg-interferon for HCV to analyze health resource use before and after treatment.

BMS-663068

People with HIV who are 18 and older will take BMS-663068 or Reyataz for up to 96 weeks. Everyone will also take Isentress and Viread.

Ibalizumab

People with HIV will receive infusions of ibalizumab to study its safety and effect on the immune system.

Ibalizumab

People who have become resistant to their HIV medications will receive infusions of ibalizumab every two weeks.

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conversation that discloses intimate personal information.

That evening, other members of the Latino Men's Group shared that their primary care providers were not knowledgeable about PrEP. Many felt they had to train their providers themselves. Some felt uncomfortable about talking to their doctor about PrEP because the provider seemed unknowledgeable about gay sex – a harsh reality of today's medical training.

Cultural Barriers to PrEP

Here in Los Angeles, clinical trials of PrEP were conducted in primarily white communities, making it difficult for people of color to participate. Even now, as PrEP is becoming more available in large cities, the number of Latinos taking it remains low. One reason is the lack of awareness and education about PrEP in certain groups.

In areas where PrEP is widely available, men are often encouraged to consider it after they have tested negative for HIV. Basic information about PrEP is provided and referrals are made. However, many Latinos are underinsured and visit the doctor only when they are seriously ill. You can't expect them to rush into a doctor's office and request an HIV prevention pill without first hearing some culturally appropriate outreach.

Research shows that many other barriers also contribute to the underuse of health care by Latinos, including poor interactions with providers, perceived health status, and cultural beliefs and traditions. Perhaps most importantly, many Latinos don't feel comfortable about talking about sex with their partners and friends – that's part of our culture.

That discussion during the Latino Men's Group made it clear to me that the current roll-out of PrEP lacks in-depth conversations about the barriers it faces in many communities and the remedies to those barriers. For example, most Latino men do not talk openly about sex. And when we do, the conversation is usually not sex-positive. I try to imagine a Latino man walking into a doctor's office and talking about his sexual activities – not likely.



Victor posted that he was starting PrEP. His ex-partner delivered a harsh comment equating the PrEP regimen to becoming a male whore. Victor fought back, stating that going on PrEP simply makes a statement that he is proud of who he is as a gay man.

Additional barriers to outreach for Latinos are language and cultural sensitivity. Outreach and education efforts for men in New York or Los Angeles should be very different from those in El Paso, Texas, or Kansas City. In addition, there are differences between Puerto Ricans, Mexicans, Caribbeans, and Central Americans. The differences may not be great, but they're still a major factor when providing services to Latino men. The prevention community must be sensitive to the cultural

and ethnic diversity of the area where a program takes place.

According to David Flores of the University of Texas School of Public Health, "Understanding the perceptions of Latinos and their barriers to health care could directly affect health care delivery."

Recommendations

- Prevention efforts that speak to Latino men in their own language are very much needed. Such efforts must

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include outreach and recruitment into an empowering setting that promotes a sex-positive approach. Only then will Latino men feel at liberty to own up to their sexual experiences.

- All social media PrEP campaigns must be culturally competent.
- The CDC must fund research into the barriers that keep Latinos from accessing PrEP, in order to create recommendations for addressing the problem. That funding must also support prevention programs in our communities.
- Although behavioral HIV interventions are becoming a thing of the past, there is still a great need for programs that validate Latino men's sexual orientation and identity. They have to own their sexual experience, validate themselves, and take ownership of their health.
- We must normalize sex as Latino men. The more we do, the more we build pride. Only then will be able to have real conversations about HIV and sexual health.
- More PrEP capacity-building training must be given to health care professionals who work in communities of color. More training is needed in small cities and rural areas, which are usually the last to have access to and implement new practices.

Conclusion

Early in the epidemic, the government supported prevention efforts in communities of color around condom education. PrEP is no different. Men of color need to be provided with information that is culturally relevant. If we want to see more men of color on PrEP, new prevention campaigns are needed that target them. We need the financial and moral commitment to educate our communities about all available prevention options, including PrEP. ■

Richard L. Zaldivar is the Founder and Executive Director of The Wall Las Memorias Project in Los Angeles.



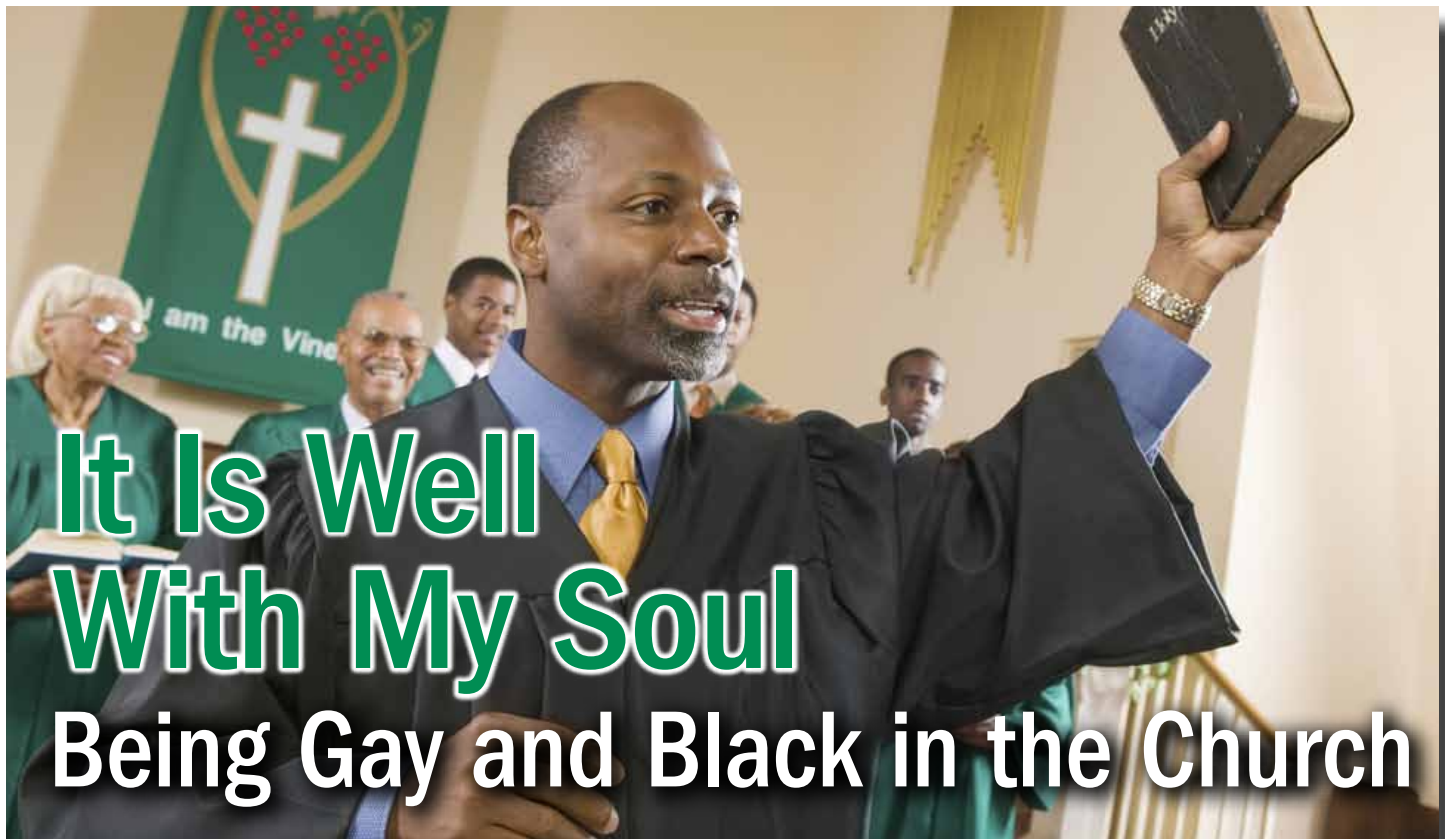
The Wall Las Memorias Project was created in 1993 to construct a monument in Los Angeles to people who had died from AIDS. It was dedicated on World AIDS Day in 2004 – the first AIDS monument in the nation. It includes six murals depicting life with AIDS in the community and two panels with 8,000 names of people who died from AIDS.

The Project provides HIV testing & prevention services and substance abuse and mental health services. It also conducts a community intervention program that provides HIV prevention services to over 900 faith-based institutions.

Community organizing, community engagement, and social justice are the hallmarks of The Wall Las Memorias Project. It often joins forces with labor unions to support worker issues and quality of life matters affecting the Los Angeles area.

The Project has long supported an AIDS hospice in Tijuana, Mexico, that houses over 60 people with HIV or substance abuse issues.

For more information about The Wall Las Memorias Project or to add a name to the monument, visit www.thewalllasmemorias.org.



It Is Well With My Soul Being Gay and Black in the Church

by Kim-Monique Johnson, MSW and
Jill Williams

Recently, Kim-Monique Johnson and Jill Williams got together to watch **Holler If You Hear Me: Black and Gay in the Church**, Clay Cane's documentary on LGBT people in black churches. The documentary, which aired on Black Entertainment Television, opens with a mother talking about her gay daughter and gay people, declaring "the enemy has invaded them, and this is a spiritual war." She reiterates the common homophobic idea that she "cannot believe God makes mistakes like that."

Jill: I was surprised that the documentary began with a young gay woman discussing her roots in the church. How she loved that part of her childhood – going to church every Sunday and even beyond Sunday, saying, "Whenever the church was open, my family was there." How she, as a gay woman, still seeks the rituals of belonging to a church and having that church family. Right away we are seeing the struggle of people who are forced to

choose between being authentically who they are or hiding who they are to lead a faith-based life with their church family.

Kim: Being lesbian myself, I was struck by how much it means for gay people to remain in their church. Here you have a sister who was taught that she is here on this earth to serve God and to be in the church.

Kim: When the leaders of a gay-welcoming church spoke about why gay folk stay in churches that do not affirm them, I remembered what I often hear about victims of domestic violence: "Why don't they just leave?" They discussed young people who are forced out of their homes – both their family and church homes – and used the term "spiritual violence" to

The film discussed young people who are forced out of their homes – both their family and church homes – and used the term "spiritual violence" to describe that kind of victim-blaming.

Jill: She talked about her upbringing – attending Bible study and Sunday school. She loved that part of her life and still seeks to share that with the woman she loves and wants to marry – a woman she met in church.

describe that kind of victim-blaming.

Jill: I'm happy we are seeing these shifts with gay-led churches – it could lead to more opportunities for HIV prevention. But not all gay people want to change churches.

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Kim-Monique Johnson and Jill Williams

It Is Well With My Soul *cont. from previous page*

Kim: For real. Staying in the home church is about long-held family traditions and belonging. And it's also about the deep cultural tradition that shapes who we are as black people. I come from a family where it was not a requirement to attend church every Sunday. But my grandparents and aunts were deep in church and it was a big part of what I learned about being black. Of course, Easter Sunday was not an option! [*laughing*] The Baptist church was and is a huge part of my cultural heritage. I can't imagine having to choose between my heritage and being gay.

Jill: It made me think about my own upbringing. On one side of my family, spirituality and religion were optional, but the other side attended an AME

[African Methodist Episcopal] church, and it was very much ingrained.

Kim: We both had options when it came to going to church or not. Thankfully I wasn't forced out because of my sexuality.

Jill: Why does the church force LGBT people to make a choice? Heterosexuals, whether they are open about their sinning or not, feel welcomed to authentically be who they are. In my mind a sin is a sin, right? So heterosexuals are able to say it is what they do that may be a sin, not who they are. LGBT people aren't given that same pass. It makes it harder to reach them with HIV prevention messages when they are being told, "Not only are your actions sinful, but you are the sin and you don't belong here."

Kim: The young woman in the film wishes her mother could see her as who

she is, not as just a sin. It was heartbreaking to watch her look for her mother as she waited for her bride to come down the aisle, even though she knew her mother would not show up for her wedding.

Jill: So when we think about where the black church is after over 30 years of the AIDS epidemic, we can see that there is more conversation about LGBT people in church. But as the mother said at the start of the documentary, more conversation means more homophobia. I find myself saying, "God does not make mistakes. Being gay is not a mistake!" The overarching lesson is that being Christian is about love and compassion. The golden rule is to love thy neighbor as thyself. It doesn't say love only thy heterosexual neighbor!

Kim: It would seem ideal for people in the church to treat everyone in the congregation the way they want to be treated. But maybe that's part of the problem. I saw a Facebook post that read, "I don't want people to love me as they love themselves, because I see how badly they treat themselves." So many people don't really know what it means to love themselves. It could be that people who focus on what they see as the "sin" of gay folk are not being kind to themselves. They may feel there is something in themselves not worthy of love, so they make themselves feel better by denying others love.

Jill: I think this is all coming up in the church because of President Obama's support of LGBT rights and since marriage equality is now the law across the nation. It's coming up more often, with documentaries and even prime-time television shows like *Empire* that help people have these conversations. Twenty years ago there was no mention of HIV or the word "gay" in church, even though everybody knew who was gay. Back in the '90s, Reverend Calvin Butts talked about the silence in the black church at a critical time in the epidemic.

In spite of all the gay people who had played important roles in the fabric of the church, particularly in music ministries, there was silence as they were dying. I remember him saying it wasn't Christian-like to shun members of the church family during their time of need. He and other black pastors and the organization A Balm in Gilead broke the silence to support gay

church members. So yes, we are talking about HIV more now and supporting people with AIDS more.

Kim: There's a difference between having compassion for someone who is gay and sick versus accepting someone who is gay and healthy and wants to be out and accepted in church. If you're a gay choir director and you're single, sick, and dying, the church is there for you. But what if you're healthy and want to come to church with your partner, who you want to marry? That's something totally different. Black LGBT folk are forming their own churches for that kind of support, but some people don't want to leave their home churches – instead they stay and suffer in silence.

Jill: I have experienced what my church family can do for me as a heterosexual who is married and a parent. I know what that support feels like and I know what it's like to have that privilege. This is where I struggle, because I love my church and it has been instrumental in helping me. I get all the things you want from your church community. But I don't want to sit in church and listen to a sermon condemning gay people when I don't feel that way. And over the years that has happened.

If you're a gay choir director and you're dying, the church is there for you. But what if you're healthy and want to come to church with your partner, who you want to marry?

For example, I recently had the opportunity to speak up about same-sex-loving people during a ministry meeting, and it was very uncomfortable. I had been asked to conduct a sexuality workshop for teen girls who attend our church. Apparently, before a Sunday school lesson, a few of the girls had talked about being lesbian. As we talked during the ministry meeting about the need for a workshop on sexual-

ity for teens in general, I let the leadership know that I was supportive of gay people and would not condemn these girls for identifying as lesbian. The silence was deafening. I said I would be happy to do a workshop on sexuality that covered topics like self-care, safer sex, STDs, and HIV. They were still receptive and agreed that I should do the workshop, but not one person in the room would look at me.

Kim: Good for you and the girls. Even with our supportive black president and the Supreme Court ruling on gay marriage, churches still struggle with open dialogue about sex. I remember hearing what T.D. Jakes, the megachurch pastor, said after the Supreme Court rulings on marriage equality. He said we have to separate church and state, that what the state has done is very different from what God and the church sanction. He said folks are getting all riled up about this for no reason. The church is not bound by the Supreme Court's ruling, but by God's word.

So this notion of a black president and the highest court's support of gay rights do not readily transfer to our churches.

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It Is Well With My Soul *cont. from previous page*

This is a problem for HIV prevention. What leverage do supporters of gay folk in church like yourself have when you want to do more than just care for the sick? You want to have honest dialogue and real sex education so the church can put Christian compassion into action, right?

Jill: That's why it saddens me. The church used scripture to affirm our rights during the civil rights movement, but now scripture is being used to discriminate against people.

Kim: Today's challenge is that black LGBT folk in our communities are shunned and ostracized from a lifesaving support system – a spiritual safety net that can also be a physical safety net, a house of refuge. It could be a place for real talk about sex that helps young people make safer decisions. The film did a good job of featuring the rise of gay-led churches, but we also saw the young brother who did not want to blend his spiritual life with his personal life and join a gay church. Churches will not be able to just leave their gay parishioners for someone else to

deal with. And HIV is not only an issue for LGBT church members.

Jill: As black people, we seem to be fighting to survive in every aspect of our lives: economically, in education, health, mental health, and when dealing with police brutality and violence. I just feel like there's so much we have to fight, and that the church should be a place where you have sanctuary. It saddens me that people do not have this sanctuary if they are fighting these struggles along with LGBT rejection.

Kim: And the struggles you mention are the same ones that can increase HIV risk. Not talking about it leads people to still think HIV is a gay issue only – another barrier to open dialogue.

Jill: I spoke to my church about World AIDS Day. I told them that for the last 24 years, every day has been World AIDS Day for me. I told them that HIV must be fought with science, love, and respect. I added faith to that list. I said, "HIV can be prevented with safer behaviors and with testing, and if you're HIV positive you can get treated." Silence. So it's a long journey, but change is happening faster. It's not going to take another 20

years, because it's a forced move. Young people have always been at the center of social justice movements – just look at the history of the black church. It's the same now – young people organizing, protesting, using tools we didn't have 20 years ago, like social media.

Kim: The story of the young woman in the documentary who was rejected by her mother, left her home church, and who is now marrying her partner in the gay church moves me. She was floored by the number of supportive comments on her Facebook page. One person wrote, "I didn't know you could be gay and Christian!" It showed the power of social media to reach people with messages that matter – support from people they can relate to and trust. That's always been at the heart of HIV prevention and it's still true – even if some churches are slow to recognize it. Soon, they won't have a choice. ■

Kim-Monique Johnson is the principal consultant at InnerVisions Consulting.

Jill Williams is an HIV Care Coordination Trainer in New York City.

Black Men and HIV: Talk About It!

by Corrie Franks

I still remember that moment back in 1988. I needed to get some dope in me fast. I looked at the needle I had borrowed and saw the blood in it. I thought for a second, and shot up – that’s what we did back then. When I was hospitalized for pneumonia the next year, I had no usable veins in my arms, so they had to put the IV in my neck. I stayed two days but was never offered an HIV test. I don’t know why, since they knew I was an injection drug user.

I needed to get some dope in me fast. I looked at the needle I had borrowed and saw the blood in it. I thought for a second, and shot up – that’s what we did back then.

A year later, in jail, I was called down to the clinic. The doctor said that someone thought I might have HIV. I said, “Who thinks that? I’m very healthy – I weigh 195 and play ball all the time!” Still, they asked me to sign papers so they could test me. (Actually, I think they already knew the result but they needed to make it legal.) Two weeks later they told me I was positive. I went back to my room, lay down, and

said to myself, “You can’t blame God – you put that needle in your arm.”

Two months later I was released to a halfway house. While I was there, I saw some residents going through another guy’s stuff. He was in the hospital, dying of AIDS. The first thing that came to my mind was that I was going to die in that halfway house. So I escaped. When they caught me, I ended up in Sing Sing prison, where they had an HIV support group. That helped me so much that now I run my own support group, for heterosexual men like me.

At least nine of the 14 men in our group got infected through heterosexual sex. They never injected drugs, like I did, or had sex with other men. But the stories we hear about men “on the down low” always make people question how somebody got infected. There is still a lot of stigma around this disease, especially when it comes to heterosexual African American males. People don’t think we can get HIV from women because science says that it’s less likely to happen

At least 9 of the 14 men in our group got infected through heterosexual sex. But the stories we hear about men “on the down low” always make people question how somebody got infected.

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that way. But it does happen, and we need to talk about that.

I don't feel like the data around HIV in heterosexual men is clear enough or discussed enough. Most research about HIV transmission is done on men who have sex with men. And there haven't been any successful prevention interventions for heterosexual black men. I'm talking about men coming together and talking about their sexual behavior toward our women, and why we treat them the way we do – why we have more than one partner but don't use condoms when we do.

In fact, what I learned from the street when I was growing up was that you were a hell of a guy if you had two or three girlfriends. Our behavior runs deep, and until we talk more about it and deal with it, the

Over the years, every time I mention the words “heterosexual men” in connection with HIV, the response is, “Really? Who are they? What do they want?” It’s sad that we have to jump up and holler to be recognized 30 years into this epidemic.



generations to come will continue to do the same things. Until we engage heterosexual men and work on changing our behaviors, we will never get a handle on this epidemic.

Over the years, every time I mention the words “heterosexual men” in connection with HIV, the response is, “Really? Who are they? What do they want?” It’s sad that we have to jump up and holler to be recognized 30 years into this epidemic. At the end of the day it comes down to money, but we’re all supposed to be in this together, working to stop the spread of this disease. Well, we’re miles apart when it comes to looking at how gender and race are affecting the spread of HIV. Until we face that this virus affects everyone, including heterosexual black men, we’ll never end AIDS. ■



by Carmen D. Zorrilla, MD, Jessica Ibarra, MD, Yailis Medina, MD, and Ana Mosquera, PhD

The World Health Organization (WHO) and the International Association of Providers of AIDS Care (IAPAC) recently released new treatment guidelines for people with HIV that included recommendations for women. While such guidelines are essential for those of us who provide care, for me the issue has always been personal. So I'll begin with my story of how I started to work with women with HIV.

We began an HIV screening program for pregnant women in Puerto Rico in 1986. I was pregnant myself at the time and provided care to the women who tested positive. There I was, pregnant and caring for pregnant women who were newly diagnosed with HIV. We were forever connected by our life experience – as Latinas, as women of color, and as mothers-to-be – but we faced very different outcomes. Many of my colleagues also feel a special connection with their HIV patients and were always looking to increase access to care and improve that care through activism.

After three decades of working in HIV, I recently searched for new messages for women, particularly women of color, and guess what? The message is still the same: “Please get tested. You don't know where your partners have been.” Most of the women in our clinic with HIV got it heterosexually. But because we trust our partners, and because of our culture, we do

not have many options for prevention – we don't have control of our sexual practices, we feel embarrassed to talk about HIV or question our partners, or we feel we are not at risk. And often our partners don't know they have HIV.

Who Is At Risk?

Because prevention campaigns have focused on men who have sex with men (MSM) – currently the group at highest risk in the U.S. – women might believe they are not at serious risk. Not so.

Many women don't see themselves as being at risk for HIV, often because they are unaware of their partner's risk behaviors or HIV status. There are also many other reasons why women are at greater risk for HIV, such as gender inequality and domestic violence.

According to the CDC, about one in four people living with HIV in the U.S. is a woman. In 2010, the fourth largest number of new HIV infections in the U.S. (5,300) occurred among African American women through heterosexual sex. Of new infections in women, the overwhelming majority were among women of color: overall, 64% were in African Americans, 18% in whites, and 15% in Latinas. These numbers remind me of the most important message I give to my female patients: get tested, and ask your partner to get tested. “Easier said than done” is the response I often get. But many lives would be saved if women followed that advice.

Quality Care

Ideally, providers of women's health services (including reproductive health and family planning) should be aware of the gender-related HIV issues women face and should encourage testing. Women should receive comprehensive care and access to treatment and support. Many providers are experienced in medical management, but they might not have a system in place for checking reproductive health and gynecologic conditions.

Also, many providers are not comfortable offering HIV testing to women (women of color in particular), or providing the comprehensive care they deserve. This is due in part to a reluctance to discuss certain issues. For example, intimate partner violence (IPV) increases women's vulnerability to HIV and pregnancy, and can lead to serious psychological problems.

Because we trust our partners, and because of our culture, we don't have control of our sexual practices, we feel embarrassed to talk about HIV or question our partners, or we feel we are not at risk.

IPV refers to physical violence, sexual violence, stalking, and psychological aggression by a current or former partner. African American women face higher rates of IPV than white women,

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and Native American women are victimized at a rate more than double that of other races. Providers who lack expertise in this area might miss an opportunity to intervene and reduce the impact of violence on risk behavior, emotional health, and treatment adherence.

Access to Treatment

In September 2015, WHO released new guidelines recommending treatment for everyone with HIV, regardless of CD4 count, and PrEP to prevent HIV for everyone at substantial risk of HIV. The guidelines also recommend treatment for all pregnant and breastfeeding women with HIV. The hope is that this will benefit women who were treated during pregnancy but who lose access to medication after giving birth. We now have a strong argument for continuing HIV treatment in women whose HIV was diagnosed during pregnancy.

PrEP for women is still far from being widely used worldwide, or in the U.S. and Puerto Rico. Finding women with a high risk of HIV has been difficult and will make the widespread use of PrEP in women an uphill struggle.

IAPAC Treatment Guidelines

IAPAC recently published recommendations for women with HIV, including:

1. Increase access to services through gender-sensitive programs
2. Integrate community services, including peer programs and programs that engage partners and family
3. Address food insecurity
4. Screen for physical and emotional abuse
5. Provide family planning services and support sexual and reproductive rights
6. Scale up access to care for pregnant and breastfeeding women
7. Scale up services for infants born to HIV-positive mothers.
8. Consider potential interactions between HIV meds and birth control
9. Address the challenges faced by younger women

PrEP for Women

Trials of PrEP for women have reported varying results. According to the WHO guidelines, PrEP is recommended for both men and women. But two PrEP trials in women (FEM-PrEP and VOICE) showed that less than a third of the women in the studies actually took the drug, leading to a lack of effectiveness. On the other hand, PrEP was effective in women in four trials that included both women and men. For example, in a 2012 trial that included both men and women in Kenya and Uganda, Truvada showed 77% effectiveness in women under 30. The results from a recent PrEP study in South Africa (HPTN 067) showed that young women can be adherent – 80% of them had high levels of Truvada in their blood after four weeks and 65% did after 24 weeks.

But PrEP for women is still far from being widely used worldwide, or in the U.S. and Puerto Rico. This is an area that we should be studying for opportunities. Guidelines are needed for the use of PrEP in groups with substantial risk. But finding women with a high risk of HIV has been difficult and will make the widespread use of PrEP in women an uphill struggle.



Adherence

We need to improve strategies to help women control HIV. According to the CDC, 88% of women with HIV in the U.S. have been diagnosed, but only 45% are in care, and only 32% have the virus under control. This has a serious effect not only on women's health, but also on the risk of transmission.

A recent analysis by Jacek Skarbinski, an epidemiologist with the CDC's, found that people with HIV who do not know their diagnosis



or who are not in care account for the majority of the transmissions in the U.S. – 92% of the estimated 45,000 HIV transmissions in 2009. We could potentially end the epidemic if we dramatically increased the number of people with HIV who know their diagnosis and are in care.

Often we connect just because of our gender. As women we understand and support our sisters wherever they are. Our community is larger than our labels. It is our world.

Getting Connected

Women with HIV belong to a special community, and they need to feel safe in order to connect. One of my favorite groups committed to improving knowledge and a sense of community among women with HIV is the Well Project (thewellproject.org). The Well Project is a non-profit whose mission is to change the course of the epidemic through a focus on women and girls. The project advocates that every woman and girl should have access to quality, up-to-date information about HIV. Women who feel isolated or who are just discovering their diagnosis can find a community and support online, and that can be powerful. But personal contact with other women provides information, support, guidance, and a sense of sisterhood.

We know that we tend to connect more easily with people who are “like us” – part of “our” group: women of color, Latinas, women with HIV, activists, mothers, etc. But often we connect just because of our gender. As women we understand and support our sisters wherever they are. Our community is larger than our labels. It is our world.

Making the Global Local

Although the issues in this article apply to women all over the world, we can make them local by emphasizing the issues that our providers notice or that women in our community point out to us. Stigma and discrimination are universal, but they present themselves in different ways in different places and among different groups, and they need to be addressed locally as well as internationally. The same goes for other gender-related issues like violence, access to care, and the need for comprehensive services.

Conclusion

We have witnessed great advances in the fight against HIV, from understanding the disease and its treatment to new forms of prevention. Activist efforts have resulted in 15 million people being on treatment worldwide, leading to a decrease in new infections.

The success of these interventions is directly related to partnerships among providers, scientists, industry, politicians, activists, and people with HIV. Women with HIV are warriors and angels – while they have plenty of burdens, they also have the opportunity to change the world. ■

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A Right To Equal Care



Health Inequalities Among People of Color

by Juan J. DelaCruz

“Health disparities adversely affect groups of people who have experienced obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; or other characteristics that have historically been linked to discrimination or exclusion.” (Healthy People 2020)

The NIH defines health inequalities (or disparities) as the “differences in the...prevalence, mortality and burden of disease...among specific groups in the U.S.” In particular, studies have shown that minority groups in the U.S. have higher rates of chronic conditions and worse health outcomes compared to whites. For example, cancer rates among African Americans are 10% higher than whites, and African Americans and Latinos are twice as likely to develop diabetes. The rate of asthma is 28% higher in African Americans than whites, and they also account for 22% of hepatitis C cases, even though they make up only 13% of the U.S. population.

Who we are and where we live matters to our health. Many factors, alone or in combination, can cause health inequalities, including poverty, location, race, ethnicity, gender, age, sexual orientation, etc. Overcrowded and underfunded clinics or a failure to reach vulnerable people contribute to the problem. Even if policymakers could address some of these underlying problems, health inequalities would remain in other areas. Studies show, for example, that even if we succeeded in eliminating overcrowding in clinics, it would only have a modest effect on quality of life for African Americans, who experience poor health as a group.

Who we are and where we live matters to our health. Many factors, alone or in combination, can cause health inequalities, including poverty, location, race, ethnicity, gender, age, sexual orientation, etc.

Substance use, sexually transmitted diseases, poverty, stigma, and discrimination make Blacks and Latinos more vulnerable to many preventable diseases, including HIV. But health is not a privilege – it is a human right. From a public health perspective, each person should be able to achieve “full health potential” regardless of social and economic factors.

In the U.S., health inequalities often occur due to racial and ethnic differences, but elsewhere in the world it usually refers

to differences arising from economic status and from being a part of certain groups. These differences are often both unfair and avoidable. For example, death rates among new mothers in the U.S. are higher among women of color than among white women, and low birth weight is more common among female newborns than among males. Better policies and interventions and the removal of barriers to health care for minorities could help address these inequalities, even if the causes of the disparities are unknown.

A Global Issue

Economic growth and well-being around the world has been threatened by the HIV epidemic. The epidemic and its related problems are especially dire in developing countries in areas where money and resources are scarce, such as sub-Saharan Africa, South Asia, and the Caribbean. Fortunately, the work of AIDS activists has made HIV treatment and medical services more available in many countries around the world, with foreign aid. Low-cost generic drugs and more effective HIV meds have greatly improved the life expectancy and quality of life of people with HIV, narrowing health inequalities.

Looking at the global HIV epidemic helps us to understand efforts to fight HIV in the U.S. For instance, sub-Saharan Africa is a region with an underdeveloped economic structure, much poverty, and low employment. But highly sophisticated and well-implemented programs have shown success in fighting the region's epidemic. These strategies are part of complex systems involving national and international funding combined with local oversight. The full participation of every stakeholder (civil society, local governments, and foreign providers) is essential to these programs' success.

The sub-Saharan epidemic is especially severe – in Swaziland, for example, 28% of all adults are living with HIV. Most transmissions occur through heterosexual sex. Women are more vulnerable to HIV because they lack economic opportunities and as an effect of their role in society. In particular, younger women can be forced to have sex with older men for money, food, or housing. Many children have been orphaned by HIV and are at risk themselves, while there are few safety nets to help them. Using limited resources, the growth of HIV infection rates has been contained but continues to affect certain groups (MSM, sex workers, women, IV drug users) more than others. And the success of the newer programs has prolonged people's lives so that are also aging with HIV, adding more pressure to the underfunded and overcrowded health care system.

Foreign aid through PEPFAR, the Global Fund, and the U.N. accounts for more than 80% of the effective treatment of HIV-positive people in sub-Saharan Africa. But these funds are vulnerable to cuts. As quality and length of life improve due to greater access to HIV treatment, interventions that provide the best value for money are essential.



A Stubborn Epidemic

In New York City, the number of new HIV infections remains high compared with that in other U.S. cities. HIV interventions in NYC have had some success in slowing infections overall, but have fallen short when it comes to protecting minorities. Here, infections are more prevalent among certain racial/ethnic groups and those engaging in certain risk behaviors. For instance, Africans Americans, Latinos, and women are at greater risk for HIV, and often have lower economic status. HIV rates for these groups are higher compared with those of Whites and Asians. While new HIV infections remain high in NYC (2,718 in 2014), they are declining, particularly in newborns (none were born with HIV in 2014). At the same time, new infections are rising among Black and Latino males and young MSM but are falling in other groups, including IDUs and heterosexuals.

Of equal concern, survival rates five years after an HIV diagnosis vary across these groups. Whites have the highest survival rates (around 98%), while Blacks and Latinos have an average of 92%.

continued on next page

Being economically disadvantaged increases one's risk for HIV, leading to premature death and disability. Rates of HIV infection and deaths from HIV are higher in certain neighborhoods: Chelsea-Clinton, the south Bronx, Harlem-Morningside Heights, and Central/Southeast Brooklyn – all neighborhoods with a majority of residents living below the federal poverty level.

The intersection of drug use and the criminal justice system is an important factor in the spread of HIV in minority groups. The prison system weakens social and family networks, and the family left behind frequently faces lowered income and increased financial challenges. In an effort to address the dual issues of drugs and crime, we have adopted an uneasy mix of public health and public safety approaches. We treat the substance use as a health problem and punish the illegal behavior with jail. But the individuals treated and punished often return to drug use and to jail. These policies have proven to be ineffective in addressing the social problems affecting these historically underserved and underrepresented communities that lead to substance use in the first place.

Africans Americans, Latinos, and women are at greater risk for HIV, and often have lower economic status. HIV rates for these groups are higher compared with those of Whites and Asians.

Since 2009, we have seen great improvements in the numbers of New Yorkers with HIV who are linked to care and have experienced significant viral suppression. But inequalities in these areas remain among minority groups. Women were more likely to gain access to care than men but achieved lower rates of viral suppression. Viral suppression was higher among Whites than among people of color. Furthermore, the percent of people infected with drug-resistant HIV increased from 11% in 2010 to 17% in 2013. If this pattern follows others trends, people of color will be more affected by this than Whites.

New York State's Plan to End the Epidemic focuses on increasing the number of people who achieve and maintain an undetectable viral load, since that leads to a longer life and lower risk of HIV transmission. In a study of 407 people by the Medical Monitoring Project, 62% of New Yorkers reported complete adherence to their HIV meds during the preceding three months. Women, Blacks, and older adults reported the highest adherence levels. Finally, NYC partner notification services assisted in early detection of new cases and linked the newly diagnosed to care. NYC has taken bold steps towards stabilizing of the epidemic but

health inequalities still remain. Hopefully, Governor Cuomo's recent announcement of \$200 million in funds to end the epidemic in NYS will address this longstanding problem.

Health Inequalities Among Latinos

Latinos are the largest minority group in the U.S., making up 15% of the population – a number that will likely double by 2050. The largest Latino ethnic groups are Mexicans, Puerto Ricans, and Cubans, but the breakdown varies among cities. Place of birth, length of time in the U.S., and identification with U.S. language and culture are predictors of Latino health outcomes.

Heart disease is the leading cause of death for Latinos, particularly for Puerto Ricans and those with lower economic status. Some studies show that Latinos have higher levels of depression than Whites, and that Mexican- and Cuban-Americans are at higher risk than other Latinos for circulatory problems, such as atherosclerosis (hardening of the arteries). Smoking is very high among Puerto Rican women and Cubans, compared with other Latinos.

The impact of certain medical conditions on Latinos is not known. For example, there are almost no data on the number of older U.S. Latinos with hearing loss. By the same token, high blood pressure, obesity, and diabetes are very common among Latinos. Very little, however, is known about how this varies by national group and gender.

Disability and early death due to HIV among Latinos in NYC suggest that the epidemic is driven by many factors, not just the virus itself. For instance, the criminal justice system contributes to poor health outcome and adds to existing health inequalities. Income level, education, access to health care, and language barriers lead to poorer overall health in Latinos.

Prevention and treatment efforts must be tailored for Latinos if they are to be effective. We also need better surveillance, to understand the burden of disease in various Latino groups and target resources where they are most needed. We must understand how the epidemic affects all groups before we can know if our efforts to fight HIV work in the real world.

Due to the kind of data we gather today, we are most likely underestimating the barriers to care faced by marginalized groups. These studies focus their attention on the general population and often overlook key groups at higher risk.

Overcoming Health Inequality

The roots of health inequality are complex and embedded in past and current patterns of discrimination, stigma, and lack of opportunity. Decisions about how to address these issues must include those most affected, and should emphasize improvement in the care given to minorities by providers. Providers are key to making an impact on racial inequality and to improving the quality of life of people who are often overlooked by policymakers.

HIV presents a significant risk to health systems around the world because it is an infectious disease whose treatment is costly. More accurate statistics are needed to determine the number of existing and new HIV cases, which will inform the institutional response to AIDS. A clear overview of the epidemic will lead to better and more cost-effective interventions targeted to



High rates of incarceration are a driving force of the epidemic, leading to higher infections among Blacks and Latinos, and the effect of incarceration has particularly affected minority groups.

those most vulnerable. Assumptions based on inaccurate data can be misleading. For example, reductions in the number of people with HIV may be the result of effective interventions, but they may also occur due to a rise in uncounted deaths or to patients who drop out of care. Effective HIV surveillance must include demographic information, behavioral records, and the use of markers like viral load and CD4 counts.

High rates of incarceration in urban areas are likely a driving force of the epidemic, leading to higher infections among Blacks and Latinos, and the effect of incarceration on NYC HIV rates has particularly affected minority groups. But this association has only been widely studied at the national level. Studies of its effect in major cities have been too short and poorly done due to a lack of consensus on how to approach key populations.

Conclusion

We have made great strides in containing the HIV epidemic. In developing countries, foreign aid has been instrumental in stabilizing and even reversing existing health inequality. But more needs to be done to ensure the long-term success of any intervention. We need stronger monitoring and evaluation tools, a research agenda that addresses health inequality, and strategies to reach broader populations. Prevention and treatment approaches should use a combination of medical and behavioral strategies, with cost-effective ways to scale them up.

Improving economic conditions is critical to overcoming health inequality. For instance, higher incomes allows people to move to neighborhoods that have access to medical care, childcare, transportation, healthy food, etc. Saving for the next generation is also key, breaking the cycle of poverty by allowing people to finance their children's education, leading to better job opportunities and working conditions, as well as improving social status.

Scaling up more inclusive HIV strategies in NYC means creating stronger mechanisms for diagnosis, linkage to care, and adherence services. We must link public programs like Medicaid and ADAP with private health care, to ensure culturally appropriate interventions that lessen HIV health inequalities.

The success of current HIV treatment strategies has raised expectations among policymakers, providers, and researchers, who have envisioned the end of the global HIV epidemic in the near future. UNAIDS has set a major goal for 2020: 90% of people with HIV will know their status, 90% of those will be on treatment, and 90% of people on treatment will achieve viral suppression. This would at least triple the number of people who are currently virally suppressed. Attaining this goal would lead to extraordinary gains in health and also great savings, since it would lead to far lower rates of HIV transmission. Cost concerns are paramount as HIV treatment programs expand and health systems become overcrowded and underfunded.

A final thought: economic empowerment positively affects health status, so overcoming poverty remains a priority in the fight against HIV. Promoting higher standards of living and a stigma-free world will greatly benefit society in general.■

Juan J. DelaCruz is Associate Professor of Economics at Lehman College in New York City

Stepping Up With an Open Heart

by Ángel Luis Hernández

Fear? Cowardice? Avoiding my reality? All this led to me getting HIV. Even though my risk behaviors and symptoms alerted me that I had HIV, I was irresponsible and deaf to those signals. I had always been very shy and reserved. It was difficult to express my feelings or to take a firm stand on any issue, most probably due to fighting my own stigma around being a gay man. I also added to that the prejudice and stigma toward gay people in my small rural town in Puerto Rico.

I was diagnosed with AIDS in 2003, at the age of 40. My physical deterioration was so advanced and obvious that family, friends, and colleagues (I was working at the Puerto Rico Medical Center) had already noticed. I experienced subtle stigma and rejection from many of them. But the rejection from my gay friends was the worst of all.

Living with HIV for 12 years in a rural area of Puerto Rico, I have seen – and been part of – the social, economic, personal, and health problems that brings.

About a month after my diagnosis I had my first hospitalization. The young doctor who treated me spoke clearly to me and my family: I had an extremely low chance of leaving the hospital alive. Five days later I was discharged, but for the next year I was in and out of the hospital several times. None of us had much hope that I would survive.

And then my recovery began. Much of that was due to my strict adherence to my HIV treatment. But after accepting my diagnosis, my close fam-

ily gave me unconditional support. They suffered but never stopped supporting me, which was critical. I also received support from a former Catholic priest, a man who never blamed me for my conduct or my sexuality – he just gave me his support and help.

It took me six years to come completely out of the closet about having AIDS. I was dealing with powerful internal stigma and was afraid to socialize. But by the end of 2009 I realized I needed to do something other than just watch life go by. To respond to my own stigma and that I felt from others, I decided to go out again, meet new people, and live life to the fullest.

My first step, in 2010, was to attend a workshop for HIV-positive gay men, based on the “Many Men, Many Voices” intervention. At that workshop I met a group of men who were going through many of the same struggles I was. One of them, José, became my best friend and encouraged me to join some local boards where the voices of people with HIV were needed. He also urged me to join several national organizations.

That workshop was the trigger that got me involved as an activist, fighting HIV stigma. Living with HIV for 12 years in a rural area of Puerto Rico, I have seen – and been part of – the social, economic, personal, and health problems that brings. I share my story in community forums and have inspired others to do the same. My volunteer work has given me much knowledge about the needs of key populations around prevention, treatment, care, and policy issues, and the barriers people with HIV face. As a community educator, I am asked the same questions again and again: “Is HIV the same as AIDS?” “Is it transmitted through casual everyday contact?” These are only two examples of the lack of information people here still have, and why we still need much more of the most basic education about HIV.

Another way of responding to stigma is by being open about my HIV status in all my social groups. I strongly believe in reaching out to communities of color and translating the complexities of HIV into lay terms that are culturally appropriate. We need to help people with HIV empower themselves, using the UNAIDS “Greater Involvement of People Living with HIV” Principle. They state that we must “realize the rights and responsibilities

of people living with HIV, including their right to participation in decision-making processes that affect their lives.” I agree - we must send the message that we need to get involved in all areas of activism, from fair access to treatment to participation in decision-making roles. More education events are needed for people with HIV, to engage them and end stigma.

Our culture in Puerto Rico is based on strong religious beliefs, and machismo is still a powerful force. These traditions often lead to discrimination against drug users, sex workers, and the LGBT community, which prevents people from getting diagnosed.

We're lucky to have a strong network of Federally Qualified Health Centers, with dedicated providers serving people with HIV in rural areas. Besides providing direct care, they help to support all of our needs, including any social issues that might prevent us from being linked to care. But, although we receive quality services, people with HIV have a long way to go before we are seen as essential participants of the health care team.

Our culture in Puerto Rico is based on strong religious beliefs, and machismo is still a powerful force. These traditions often lead to discrimination against drug users, sex workers, and members of the LGBT community, which in turn plays a major role in preventing people from getting tested and diagnosed.

Being a person with HIV has changed me in very positive ways. I hope that my life experience, active involvement, and continued learning may lead other persons with HIV to add their voices to our response to HIV stigma and help to make needed change happen. As I turn 52, I suffer from many HIV-related conditions, including peripheral neuropathy, lipodys-



trophy, muscle mass loss, osteopenia, and osteoarthritis. My purpose in telling this is to create awareness that HIV does not exist alone. Although our life expectancy is now close to normal, the long-term consequences of a positive HIV test can be very difficult. Despite everything I've been through living with HIV, today I am in a great physical and mental state, as never before.

My message to everyone is to accept your sexuality but not the stigma, be responsible with yourself and your partners, and protect yourself. If you engage in risky behavior, do not panic. If by chance in this game of life you receive a positive HIV diagnosis, see it as an opportunity to refocus your efforts. Do not hesitate to seek help and services – there are a lot of them! And seek a support system within your family, among your friends and peers, or from a spiritual guide.

HIV is no longer a death sentence. It is an opportunity to put our lives into perspective. As I heard in a play a few years ago: “Nobody dies of four letters – AIDS. We are people living with three letters – HIV.” And living with HIV means I am indeed living – a positive and full life. ■

HIV Criminalization and People of Color

by Ayako Miyashita and Amira Hasenbush

In December 2015, we published a paper entitled HIV Criminalization in California: Penal Implications for People Living with HIV/AIDS. Thanks to funding from the California HIV/AIDS Research Program, we were able to look at how criminal laws are used to target people with HIV. We were able, for the first time, to analyze statewide data from California to see how California's laws are being used against people with HIV.

About HIV Criminalization

We commonly refer to HIV criminal laws, and the use of these laws, as HIV criminalization. More than two-thirds of U.S. states and territories have passed HIV criminal laws. The original intent of these laws was to “control the spread of AIDS”. Yet some HIV criminal laws do not require exposure to or transmission of HIV. In some states, these laws criminalize conduct that poses a low or almost nonexistent risk of transmission, such as spitting, biting, or engaging in oral sex. Our study revealed the following:

- 800 people were directly affected by these laws.
- Over 40% of them were women, and two-thirds were Black or Latino.
- They ranged in age from 14 to 71 at the time of their first HIV-related criminal incident, with an average age of 37.
- 95% of 1,263 incidents involved a felony offense for solicitation (prostitution) while HIV positive.
- All but one of the 390 incidents involving a criminal charge resulted in a conviction.
- Black and white women and black men were more likely to be charged than white men.

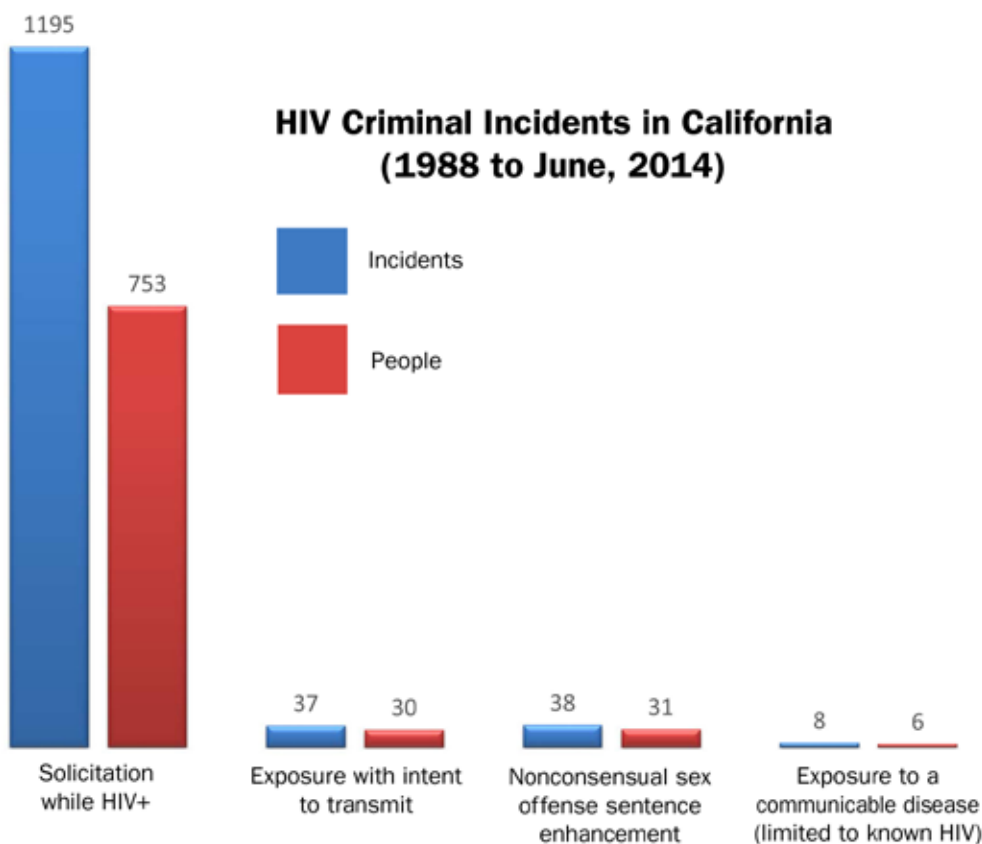
HIV Criminalization Laws in California

In California, there are four HIV-specific criminal laws, and one non-HIV-specific criminal law (it criminalizes exposure to any communicable disease). These laws do not require transmission of HIV, and they can result in misdemeanor or felony charges, or a sentence enhancement (an additional number of years added to a specific criminal sentence).

Code Section	Criminalized Conduct	Statutory Sentence
CA Penal Code § 647f	Solicitation if the person tested positive for HIV in a prior solicitation or other sex offense that resulted in mandatory HIV testing	Felony punishable by imprisonment for 16 months or longer
CA Health & Safety Code § 120291	Consensual sex without a condom in which an HIV-positive person does not disclose his or her status and has a specific intent to transmit the disease to a sex partner	Felony punishable by imprisonment in state prison for three, five, or eight years
CA Penal Code § 12022.85	Having knowledge that one is HIV positive while engaging in a nonconsensual sex crime	Three-year sentence enhancement
CA Health & Safety Code § 1621.5	Having knowledge that one is HIV positive while donating blood, organs, tissue, semen, or breast milk	Felony punishable by imprisonment for two, four, or six years
CA Health & Safety Code § 120290	Willful exposure to any contagious, infectious, or communicable disease (not HIV-specific)	Misdemeanor

The Data Used

The data we used for our research came from the California Department of Justice. These data include the entire criminal history of all individuals who had contact with the criminal justice system under all of the laws in the table above (except the statute on blood/organ donation while HIV positive.) The data covered a period from the time each law was passed through June 2014.



We were able to see who was arrested, who was released, who was charged, who was convicted, and, in some cases, where these events occurred and the length of the sentence for each successful prosecution. No other study has dealt with statewide data, and no other study has had access to such complete data.

Results

Our study found that overall 800 people came into contact with the California criminal justice system under these laws. They were involved in 1,263 incidents where HIV status played some role. The vast majority (95%) of these criminal incidents affected people in sex work or those suspected of sex work.

Overall, 31% of these criminal incidents resulted in charges for an HIV-related crime, 43% did not result in charges, and 26% led to charges for non-HIV-specific offenses. All but one of the 390 incidents in which HIV-specific charges were brought resulted in a conviction. And 91% of those convictions called for immediate time in prison or jail. On average, people were sentenced to about two years. But the lengths of sentences differed between different laws, and we discovered that individuals convicted under two of these laws faced up to a life sentence.

Differences Based on Sex and Race

These data cannot give us information about police activity and whether police target specific groups such as women or people of color when they are enforcing these laws. What they can tell us is that, for people who came into contact with the criminal justice system based on these laws, whether they were charged or not differed according to sex and race.

When arrested with HIV-specific criminal incidents, white men were significantly more likely to be released and not charged, compared to other groups (see graph on next page).

For people engaged in, or suspected of engaging in, solicitation, white men were charged with HIV-specific crimes 12% of the time, while all others were charged for HIV-specific crimes 31% of the time.

What We Still Don't Know

Because information about a person's sexual orientation and gender identity is not collected by the California DOJ, that was not a part of our analysis. Knowing that HIV infection has a disproportionate impact on LGBT people, this gap in the data is significant.

Where Do We Go From Here?

Federal government agencies, including the U.S. Department of Justice (DOJ) and the CDC have recently addressed the topic of HIV criminalization. Guidance provided by the DOJ encourages states to review their HIV criminal laws to understand whether their laws reflect current understanding of HIV. This is particularly important given that so much has changed in HIV treatment and prevention since the 1980s.

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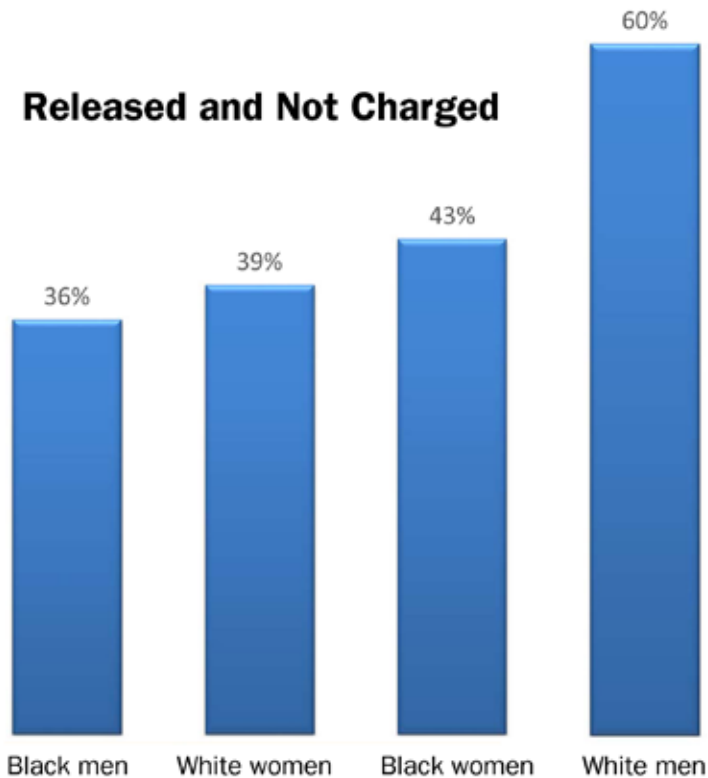
	Overall	Solicitation while HIV positive	Exposure with intent to transmit	Nonconsensual sex offense sentence enhancement ¹	Exposure to a communicable disease (limited to known HIV)
Mean length of incarceration	2.3 years	1.9 years	4.4 years	5.6 years	2.6 months
Shortest Sentence	1 day	1 day	3 years	6 months	1.5 months
Longest Sentence	71 years to life	25 years to life	8 years	71 years to life	3 months
Number of convictions	337	299	8	27	3

¹Often sentences are reported for an entire case, and not divided out by each charge. Therefore, sentences for the sex offense enhancement generally include the sentence for the underlying sex crime as well.

Looking at the data on how these laws have been enforced is an important part of reviewing them. By moving beyond specific facts of individual cases, data allow policy makers and legislators to see how HIV criminalization is affecting people with HIV across

Looking at the data on how these laws have been enforced is an important part of reviewing them. By moving beyond specific facts of individual cases, data allow policy makers and legislators to see how HIV criminalization is affecting people with HIV across their state.

Released and Not Charged

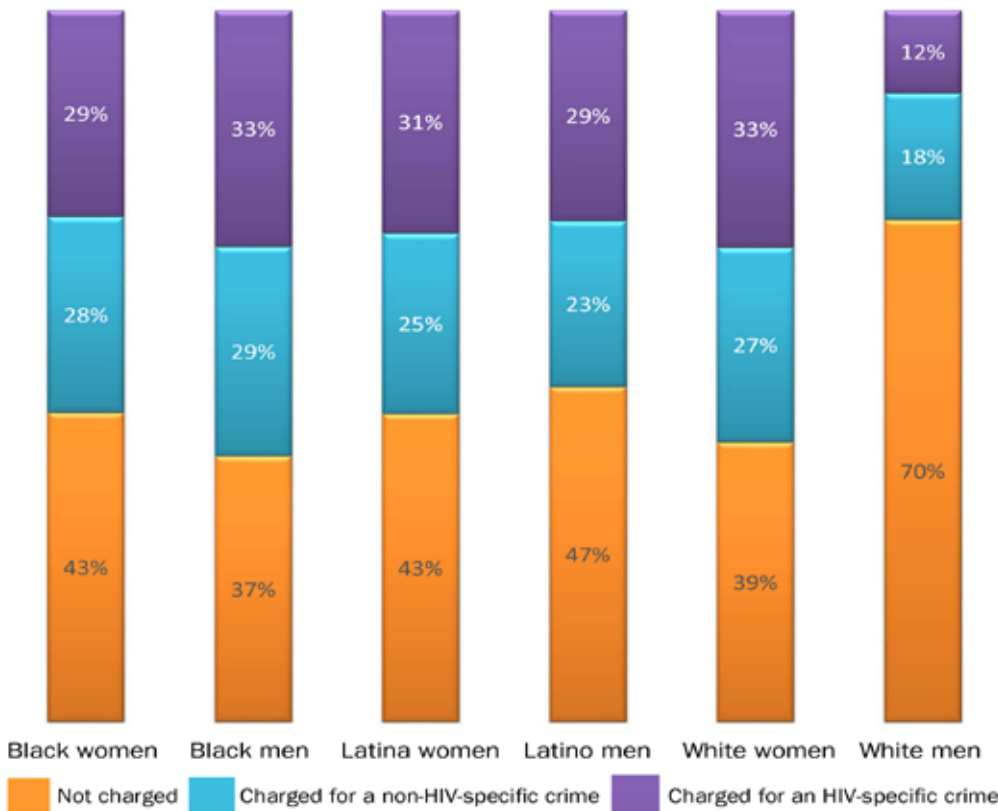


their state. These data point to some race- and sex-based differences in how these laws are used, but because they don't explain the root cause of these differences, more research is needed to better identify the forces that could be leading to these differences.

As researchers, we find it easy to note how novel this study is and how many future research projects we would like to do as a result of what we have learned so far. But what we cannot lose sight of is the real-life effect of these laws. Every incident, every charge, every conviction, and every sentence has had a real impact on a person's life. So given what we know, the question remains: Where do we go from here? We hope that these data put us in a better position to answer this question. ■

Ayako Miyashita is the HIV Law and Policy Fellow and Amira Hasenbush is the Jim Kepner Law and Policy Fellow, both at the Williams Institute of the UCLA School of Law

Charging Rates for "Solicitation while HIV Positive" Incidents



Affordable Housing: Key to Ending the Epidemic

The end of AIDS may be just over the horizon, but the crisis is far from over. Despite years of progress in preventing and treating HIV, the number of new transmissions nationwide remains stuck at 50,000 a year, and continues to disproportionately affect communities of color.

New York is still the epicenter of the epidemic, with more people living with HIV in our state than any other in the country. And here in New York City, a key component to breaking this cycle is making sure every low-income, HIV-positive New Yorker has a safe and stable home.

When New York City's HIV/AIDS Services Administration (HASA) was established, it was one of the first government agencies to respond to the AIDS epidemic. Today, HASA remains among the most comprehensive government programs serving people with HIV, through a variety of life-saving services, including financial housing assistance.

But current HASA regulations exclude about 7,300 New Yorkers with HIV from critical housing benefits. To qualify for HASA housing benefits, people are required to have an AIDS diagnosis or have symptoms of HIV disease. But this disregards the simple fact that New Yorkers with HIV who have no symptoms are often paying high medical bills – a huge financial burden.

Over the years, I have been devastated to see people actually making themselves sicker, intentionally letting their HIV go untreated, in the hopes of receiving desperately needed help to keep a roof over their heads.

For people with HIV, a lack of stable housing is a barrier to care and successful treatment. A growing body of research shows that people who have stable housing are less likely to use drugs, less likely to engage in high-risk sexual acts, and more likely to receive and adhere to the medical treatment they need to stay healthy and keep viral loads low. We know that homelessness is one of the primary drivers of the epidemic and of the progression of HIV disease into AIDS. That's why, if we are serious about ending AIDS within a generation, it is critical to ensure housing security and expand HASA benefits to all New Yorkers with HIV.

Last month, Mayor de Blasio announced his commitment to expand HASA benefits to all people living with HIV in

our city, including to the hundreds who sleep in our shelters on any given night. But there's no guarantee that this will happen.

With the \$99 million price tag that comes with expanding these benefits, it will take real cooperation between our city and state leaders to secure the funding we need to help end this epidemic. It's going to take all of us putting politics aside and working together to tackle this crisis with the urgency it deserves.



And we can't stop there. We have to put a stop to discriminatory housing practices by unscrupulous landlords who are breaking the law in broad daylight.

It is illegal in New York City to refuse to rent or sell housing to people whose income comes from public assistance programs like HASA. Yet, across our city, landlords are blatantly turning away people who pay their rent with HASA vouchers. My office has seen too many HASA clients whose landlords have put in writing that they will not accept the vouchers.

We have come too far to let this stand in New York City.

As the city's Public Advocate, I have worked to put bad landlords on notice, to take cases of discrimination to court, and to help build the political pressure needed to expand HASA benefits.

To be sure, we are making real progress in the fight against HIV. In 2014, New York City recorded its lowest number of new HIV transmissions ever: only 2,718 new cases of HIV – a 35% drop since 2004. But we cannot rest until that number is zero.

As a lifelong New Yorker, I have seen the human toll of this epidemic, as it has affected my friends and neighbors all around me. I was here during those dark years when we barely knew what AIDS was, let alone how to treat it or prevent its spread.

Now that we have a plan to finally end that epidemic, we must be aware that housing is more than just a basic human right. It is one of the most important tools we have to end the AIDS crisis and extend the respect and dignity owed every New Yorker.

Letitia James, NYC Public Advocate

achieve

575 Eighth Avenue
Suite 502
New York, NY 10018
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Come to ACRIA's series of

Living with HIV

workshops, designed for people with HIV who
want to learn more about how to manage their HIV.

The two-hour workshops are held at 575 Eighth Ave.
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Topics will include:

- The New HIV Meds Ain't What They Used To Be
- Keep Your Meds Working: HIV Drug Resistance
- Making Sense of Your Lab Results
- Working with Your Healthcare Provider
- HIV and the Immune System
- HIV Treatment as Prevention
- Hepatitis C Treatment Update
- Aging with HIV

Space is limited! Please contact West at
212-924-3934 x134 or training@acria.org to register.
Metrocards and snacks will be provided.



Have you or someone close to you been diagnosed with HIV in the last 12 months?

Then you might be
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PATH is a research
study for HIV-positive gay and bisexual men
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