



# HIV/AIDS Inequality: Structural Barriers to Prevention, Treatment, and Care in Communities of Color

## Why We Need A Holistic Approach to Eliminate Racial Disparities in HIV/AIDS

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### Introduction

For the first time in more than two decades the International AIDS Conference returns to the United States and this week more than 20,000 delegates from nearly 200 countries are in Washington D.C. discussing a wide array of HIV/AIDS related issues, including the troubling racial disparities of our domestic HIV epidemic, specifically:

- African Americans, who make up only 14 percent of the U.S. population, make up 44 percent of the HIV-positive population.<sup>1</sup>
- Latinos face three times the HIV infection rates as whites.<sup>2</sup>
- Men who have sex with men represent 2 percent of the U.S. population but account for 61 percent of all new HIV infections.<sup>3</sup>

While the Obama administration has taken steps toward the elimination of these disparities through the National HIV/AIDS Strategy and Implementation Plan,<sup>4</sup> there is still much work to be done. This brief highlights underexplored explanations for these disparities and outlines possible solutions to begin addressing them.

Oftentimes, popular culture has offered unfortunately erroneous explanations for the stark racial disparate impact of HIV/AIDS. The mass media, for example, has suggested that black men “on the down low” infect black women by secretly sleeping with male partners, acting as a bisexual “bridge” between gay and straight communities.<sup>5</sup> But public health scholars have found little support for this theory.<sup>6</sup> Many may assume that black people suffer from greater HIV prevalence because they are considered less sexually responsible than whites. Yet several studies have shown that black women and black men who have sex with men—the two groups most severely impacted by HIV/AIDS—have similar numbers of

sexual partners and use condoms as often as their white counterparts.<sup>7</sup> Thus, behavioral risk factors, while important, cannot fully explain the racial disparity.

Instead, the racial HIV gap and the racial health gap in general, is strongly correlated with the racial wealth gap, which in turn is the direct outcome of both historical and contemporary processes of segregation in housing, education, employment, and health care as well as racially skewed mass incarceration. In this way, race—as it intersects with poverty, gender, and sexuality among other factors—becomes the embodiment of a multifaceted social exclusion and the rationalization for massive health inequities.<sup>8</sup>

The high rates of HIV/AIDS we see among communities of color are not the result of high-risk behavior in these communities, but structural inequalities that make them more likely to come in contact with the disease and less likely to treat it.

The racial dimensions of the HIV/AIDS epidemic are best understood in this light. The glaring health inequities revealed by the distribution of HIV/AIDS demonstrate that race is a social index of isolation and impoverishment, disregard, and disempowerment rather than a proxy for divergent sexual attitudes or behaviors—much less genetic traits.<sup>9</sup>

Addressing the structural forces that shape the spread of infectious disease—or what the World Health Organization has termed “the social determinants of health”—represents a fundamental and necessary shift from the historic approach to the domestic HIV/AIDS epidemic.<sup>10</sup>

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## Social determinants are a better predictor of HIV outcomes than risk behaviors

The social determinants of health—“the conditions in which people are born, grow, live, work and age, including the health system”—weigh more heavily in the cause and course of every leading category of illness than do any attitudinal, behavioral, or genetic determinant.<sup>11</sup> This is the case for heart disease, diabetes, and cancer and it is equally true for the HIV/AIDS epidemic.

In fact, the effects of the social determinants of health may be even starker with respect to HIV/AIDS because of its communicable nature. For example, a social determinant like residential segregation influences a community’s access to crucial resources such as housing, education, and health care, and also plays a role in determining with whom, with what frequency, and on what terms people interact with others, both publicly and privately.<sup>12</sup> Similarly, the acute and chronic stress that stems from poverty and experiences of racism, sexism, and other power and resource disparities,<sup>13</sup> can have profound impacts on health outcomes in the case of exposure to HIV/AIDS.<sup>14</sup>

Therefore, attempting to combat HIV/AIDS through attitude adjustment and behavior modification alone is incomplete and ineffective. A strictly behavioral focus may also be misleading and increase stigma by implying that individuals' bad decisions are solely to blame for their poor health outcomes. Raising public awareness about the social, political, and economic conditions that exacerbate HIV/AIDS may combat the racial stereotype that blacks and Latinos suffer from higher HIV/AIDS prevalence because of their irresponsible sexual practices or hyper-homophobic cultures.<sup>15</sup>

Governmental entities—international and domestic—have already begun to focus on the social determinants framework. The World Health Organization recommends that we focus on improving daily living conditions; tackling the inequitable distribution of power, money, and resources; and measuring and understanding the impact of interventions,<sup>16</sup> to promote health equity. To this end, the National Institute on Minority Health and Health Disparities, an entity within the U.S. Department of Health and Human Services, has launched the Social Determinants of Health Initiative, which sets out to perform this research. Meanwhile, the Centers for Disease Control and Prevention published a White Paper on the social determinants of health as they relate to inequities in HIV, viral hepatitis, sexually transmitted infections, and tuberculosis in the United States.<sup>17</sup>

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## Addressing structural inequalities is necessary to eliminating racial disparities

This brief builds on the holistic framework promoted by these agencies and further explains the structural forces underlying the stark reality depicted in President Obama's National HIV/AIDS Strategy.<sup>18</sup> The Obama administration's efforts have cast an important light on the gross disparities in the distribution of HIV/AIDS in the United States, especially those affecting men who have sex with men, racial and ethnic minorities, youth, and populations of the Northeast and the South.<sup>19</sup>

Ultimately, this brief spotlights what the National HIV Strategy recognizes (although the media largely overlooked this development when the president released the strategy): We must move beyond exclusively targeting the so-called risk behaviors of the most vulnerable groups to also address the root causes of those structural inequalities—the distribution of wealth, power, and resources based on real or perceived differences of race, class, gender, sexuality, national origin, and immigration status—that constrain individual and collective agency, generate chronic stress, erode immune system functioning, and block access to effective treatment.

In our emphasis on the structural dimensions of HIV disparities, we do not aim to undermine the efficacy of behavioral interventions that have been successful. Rather, our goal is to draw attention to the fact that such interventions alone will never be able to mitigate the harsh racial disparities that HIV statistics depict.

By focusing on the structural conditions that perpetuate the high rates of HIV/AIDS among communities of color and the poor in addition to existing behavioral strategies, we can create comprehensive interventions that will yield populationwide results, benefiting racial minorities and others.

Building on this insight, this brief identifies key areas related to HIV/AIDS outcomes that are in need of reframing and rethinking if we are to mitigate the epidemic, specifically:

- Residential segregation and housing discrimination
- Education
- Criminal justice, including HIV exposure laws
- Immigration

In each case, we offer new directions for research and policy recommendations. Let's examine each in turn.

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## Residential segregation and housing discrimination

Geography is one of the key factors that explain the HIV/AIDS-related disparities we see among racial and ethnic minorities across the United States. The effects of residential segregation and regional disparities combine to raise the prevalence and burden of HIV/AIDS on minority communities. HIV infection rates are so high in some minority-dense urban poverty areas that they are on par with levels seen in Ethiopia and Haiti and meet the United Nations's definition of a "generalized HIV epidemic."<sup>20</sup>

With the average white person living in a community that is 80 percent white, an average black person living in a community that is more than 50 percent black, and an average Hispanic person living in a community that is 46 percent Hispanic, residential segregation by race and ethnicity remains a reality for many Americans.<sup>21</sup> Americans who live in low-income, predominantly minority neighborhoods are significantly less likely to receive early HIV testing<sup>22</sup> and treatment if they are infected.<sup>23</sup> These differences appear to stem from the deteriorated physical conditions and environmental stressors of these neighborhoods<sup>24</sup> and from their relative remoteness to quality medical testing and health care sites.<sup>25</sup>

This segregation condenses a community's social networks, which ultimately increases the "community viral load"—an aggregation of the individual viral loads across a community.<sup>26</sup> An individual viral load is "an important measurement of the amount of active HIV [in] the blood of someone who is HIV positive," and reflects the likelihood that an individual will transmit HIV.<sup>27</sup> Therefore, the community viral load is directly correlated with HIV/AIDS risk.<sup>28</sup>

A person who engages in an unprotected sexual act with a partner from a distressed neighborhood where the community viral load is relatively high, incurs a much greater chance of contracting HIV than a person who engages in the same sexual act with a person from a more affluent neighborhood with a lower community viral load.<sup>29</sup> Just as an individual's viral load reveals whether the person is receiving HIV therapy and the effectiveness of that therapy, changes in community viral load can indicate effective or ineffective interventions on a broader level.

Regional differences in the transmission and treatment of HIV infections also exacerbate racial differences related to HIV/AIDS in this country. As a group, people living in the southern United States are significantly less likely to obtain treatment once infected with HIV, and non-White Southerners may be nearly five times more likely than those in all other regions of the United States, Canada, Australia, and Brazil, to experience serious medical complications once infected.<sup>30</sup> Much of the problem is structural. The persistence of abstinence-only education,<sup>31</sup> failed incarceration policies,<sup>32</sup> and resistance to harm-reduction programs combine to make the risk of acquiring, transmitting, and dying of HIV/AIDS higher in the South than in any other region of the country.<sup>33</sup> Stigma is part of the problem as well. Many residents of the South—particularly regular churchgoers—report that they would delay diagnosis and treatment due to embarrassment about sexually transmitted infections.<sup>34</sup>

An emerging line of research has also posited that racially distinctive sexual networks may play a role in increasing exposure to and subsequent infection with HIV.<sup>35</sup> While the media tend to depict men who have sex with men as a threat to black women—either because they reject black women for a “gay lifestyle” or they surreptitiously sleep with women and men on the “down low”<sup>36</sup>—black women and black men who have sex with men have much in common.<sup>37</sup> In particular, they face a dearth of eligible black male partners because of factors such as high unemployment, mass incarceration, and violence and they are constrained to dense sexual networks of disproportionately black partners.<sup>38</sup> As the National Strategy recognizes,<sup>39</sup> these patterns, which can be explained by the combination of racial preferences and pervasive residential segregation,<sup>40</sup> may perpetuate and facilitate continued racial disparities in HIV transmission. Studies suggest that nonblack potential romantic partners view both black women and black men who have sex with men as less desirable than whites and other people of color.<sup>41</sup> Whether they prefer black partners or struggle to attract nonblacks, black women and black men who have sex with men often face limited romantic options. These limited options may reduce a person's leverage in sexual relationships and make it harder to insist on condom use and/or monogamy, which may increase HIV risk.<sup>42</sup> Because experts such as Greg Millett have identified sexual networks as an important possible explanation for racial disparities in HIV transmission,<sup>43</sup> this brief calls for greater funding of innovative research to test this theory.

## Recommendations

- **Redistribute HIV/AIDS funding to reflect the disproportionate burden in the South.** The Centers for Disease Control Division of HIV/AIDS Prevention, or DHAP, has committed to focus on high impact prevention by modifying their funding formula to focus on need. Congress must approve these funding modifications to ensure that funding streams are concentrated in the South, as well as in pockets of the black and Latino communities that experience the most significant HIV burden.
- **Modify the funding formula for the Housing Opportunities for Persons With AIDS, or HOPWA, program.** Facilitating stable housing is a key preventative step to supporting people living with AIDS. The U.S. Department of Housing and Urban Development should modify the funding formula to allocate money based not on a cumulative morbidity from AIDS, but rather on the incidence of people living with the disease in a given area.<sup>44</sup>
- **Pass the Housing Opportunities Made Equal, or HOME, Act.** Gay and transgender Americans, including those living with HIV, continue to experience high rates of discrimination in housing and rental markets. The HOME Act would amend the Fair Housing Act to prohibit discrimination and intimidation on the basis of sexual orientation or gender identity, and provide the attorney general with appropriate pre-litigation investigative power to enforce the law. The robust enforcement of existing antidiscrimination laws will also go a long way toward dismantling residential segregation.
- **Increase funding of research designed to determine the role that sexual networks play in racial disparities in HIV transmission.** The Centers for Disease Control should expand its research on sexual networks in order to highlight the structural factors that influence those networks and inform the policies and programs of the relevant agencies. For example, research on the impact of incarceration on black women's sexual networks could help to inform the Department of Justice's policies and programs around criminal justice and reentry.

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## Education

Many HIV prevention and risk-reduction interventions have focused on HIV knowledge, sex education, and the promotion of condom use.<sup>45</sup> Although such policies have effectively decreased sexual risk behaviors,<sup>46</sup> conservatives have often opposed programs such as condom education and distribution.<sup>47</sup> This has led to state and federal support for abstinence and abstinence-only programs.<sup>48</sup>

Policies that promote abstinence as the only choice or that withhold important health information place individuals at risk for making unhealthy decisions.<sup>49</sup> Whether or not

one prefers abstinence as the solution for unmarried teenagers, the reality is that many young people are sexually active and at risk for HIV/AIDS and other sexually transmitted diseases.<sup>50</sup> In addition, many sex education policies provide a predominantly heterosexual perspective, excluding the health needs of lesbian, gay, bisexual, and transgender adolescents, while indirectly stigmatizing them.<sup>51</sup>

Resources, in the form of culturally sensitive information and condoms, must be freely and easily available and offered to all populations but most importantly, to those disproportionately impacted by HIV/AIDS. As the National Strategy notes—“[i]t is important to provide access to a baseline of health education information that is grounded in the benefits of abstinence and delaying or limiting sexual activity, while ensuring that youth who make the decision to be sexually active have the information they need to take steps to protect themselves.”<sup>52</sup>

## Recommendations

- **Provide comprehensive and free health and sexual health education.** State governments in particular should eliminate barriers that would restrict or deny free access to health information. Abstinence only programs, for example, that withhold or limit information on HIV/AIDS and sexually transmitted infections in general leave young people at risk.
- **Provide free condoms.** Prevention messages cannot succeed if individuals cannot afford condoms. A recent Washington, D.C. program shows that providing female condoms to women has been particularly useful in reducing HIV transmission rates, reducing prevention costs, and empowering women.<sup>53</sup> Studies also show that black gay men use more condoms than white gay men, when they have access to them.<sup>54</sup> So, agencies that support public education campaigns, such as the Centers for Disease Control, should also pair those efforts with resources for condom distribution.

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## Criminal justice

Incarcerated populations and those under criminal justice supervision (such as parole and probation) represent a large and growing segment of the U.S. population. These groups experience elevated rates of HIV, STIs, and other diseases.<sup>55</sup> Nearly 11 million Americans (who are disproportionately black and Latino) are incarcerated at some point of each year, and an estimated 17 percent of those individuals are living with HIV/AIDS—a rate substantially higher than that of the general population.<sup>56</sup> Many incarcerated people experience repeated arrests and releases over their lifetimes. Hence, interventions carried out with incarcerated populations have the potential to benefit both the criminal justice system through reduced morbidity and mortality among those for

whom government is legally obligated to provide medical care, and the larger society to which incarcerated individuals will return.

In-custody transmission of HIV, which can occur through sexual activity, including sexual assault, needle-sharing for drug injection, and tattooing with unsterilized equipment is an important concern.<sup>57</sup> Despite the high risk,<sup>58</sup> less than 1 percent of jails and prisons in the United States make condoms accessible to incarcerated individuals.<sup>59</sup> In the absence of such access, those in custody may engage in unprotected sex or turn to crude methods of protection, such as barriers made from food wrappers or gloves, which are far less effective.<sup>60</sup> In-custody condom distribution has been successfully implemented in most Western European countries and many countries in other parts of the world.<sup>61</sup> Further, although in-custody needle exchange programs have been successfully implemented in a number of international settings, no U.S. prison or jail facilities provide needle exchange.<sup>62</sup>

For inmates who are diagnosed with HIV prior to or during custody, continuity of HIV-related treatment post-release is a major concern, as the National HIV Strategy recognizes.<sup>63</sup> Both HIV transitional case management programs and collaborations between treatment providers in custody and community settings have the potential to increase the likelihood that HIV-positive people who are released from custody connect to and remain in care. Other strategies, such as releasing those on treatment with 30-days worth of HIV medication, also are promising.<sup>64</sup>

Although a few state and local governments and organizations are employing these strategies, they are not sufficiently coordinating their efforts and standards to institutionalize them widely.<sup>65</sup> Federal resources to identify model programs and make available the necessary information for replicating them may facilitate more widespread adoption.

Particular attention must also be focused on the ongoing impact of incarceration on relationship stability and male-female sex ratios in black and Latino communities.<sup>66</sup> The removal of potential and actual sexual partners from society through incarceration has dramatic impacts on the partners and families left behind.<sup>67</sup> Specifically, this removal can condense sexual networks and as a result, increase HIV risk.<sup>68</sup>

Further, criminal prosecution has additional dire consequences for individuals, their loved ones, and their communities due to the collateral consequences of conviction such as the termination of government benefits (including housing, food assistance, and financial aid for higher education) that are essential to keeping HIV-positive people in care,<sup>69</sup> difficulty seeking employment due to requirements to disclose prior convictions (and for those convicted of HIV exposure crimes, discussed below, HIV status),<sup>70</sup> and the loss of parental rights.<sup>71</sup>

## Recommendations

- **Increase prevention efforts in custody settings, including prisons, jails, juvenile detention centers, and immigrant detention facilities.** The Stop AIDS in Prison Act of 2011, for example, would provide condoms and routine opt-out HIV and STD testing for federal prisoners.<sup>72</sup>
- **Promote rapid linkage to care on release.** Post-incarcerated individuals are likely to engage in sex and are at highest risk of negative health outcomes soon after release.<sup>73</sup> The Office of Minority Health, Department of Justice, and other agencies providing prisoner re-entry programs and wraparound services should ensure that individuals with HIV are linked to care along with the other basic needs like housing, clothing, employment, etc. Coordinated efforts between agencies are critical to safeguarding the health and wellness of both the individuals and the communities to which they return.
- **Additional study of HIV risk in prison/jail.** There is inadequate research on the risk of HIV transmission in prisons and jails as opposed to outside.<sup>74</sup> Further study is needed to identify precise policy interventions to ensure that the state adequately protects prisoners and the communities to which they will return.

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## HIV exposure laws

Criminalization under HIV exposure laws is a significant structural factor that deters individuals from accessing HIV testing and perpetuates stigma. As of 2012, 38 states and U.S. territories have laws that specifically criminalize HIV exposure<sup>75</sup> through consensual sex, needle-sharing, or through spitting and biting.<sup>76</sup> Some states do not have HIV-specific laws, but instead utilize general criminal laws like attempted murder or assault, to prosecute HIV-positive people for HIV exposure.<sup>77</sup>

A majority of the HIV-specific laws do not differentiate between protected and unprotected sex or require actual transmission of HIV or proof of intent to transmit HIV. Further, they often criminalize conduct that carries little or no risk, such as oral sex.<sup>78</sup> Therefore, the punishment is often grossly disproportionate to the risk/culpability. Moreover, sexual partners of HIV-positive women sometimes use these laws as tools of harassment.<sup>79</sup>

Importantly, exposure laws contradict public health messages by putting the full responsibility for HIV prevention solely on the person living with HIV, rather than encouraging all people to ask their sexual partners about their HIV status and to use condoms. In general, a person's knowledge of his or her HIV-positive status and failure to disclose that status prior to sexual activity with another person is all that is needed for a successful prosecution. This system effectively penalizes HIV-positive people for knowing their HIV status and results in one person's word placed against another's as to whether the positive person

disclosed his or her status, with the HIV-positive person usually losing.<sup>80</sup> Because people who do not know their HIV status are much more likely to transmit HIV than those who know they are positive, these misguided laws fail to address the root problem.<sup>81</sup>

The Obama administration and the United Nations have criticized HIV exposure laws. The U.S. National HIV/AIDS Strategy encourages governments to eliminate or amend such laws to reduce HIV stigma, which is a barrier to testing and leads to poor health outcomes.<sup>82</sup> In a recent hearing hosted by the Global Commission on HIV and the Law in High-Income Countries, U.S. HIV exposure laws were identified by the Global Commissioners as “harm[ing] already marginalized communities facing heightened risk of HIV infection—including migrants, women, MSM, sex workers and people who use drugs.”<sup>83</sup> HIV exposure laws therefore exacerbate the structural forces shaping the HIV epidemic and do not effectively prevent the transmission of HIV.<sup>84</sup>

Moreover, HIV transmission laws dangerously feed into this nexus of disparities for blacks and Latinos, conflating the much-needed HIV prevention and care sector with the criminal justice system and often using public health officials as tools of criminalization.

## Recommendations

- **Support the REPEAL HIV Discrimination Act.**<sup>85</sup> The federal bill “creates incentives and support for states to reform existing policies that use legal authority to target HIV-positive people for felony charges and severe punishments for behavior that is otherwise legal or that poses no measurable risk of HIV transmission”<sup>86</sup> Accordingly, state-based laws that criminalize those living with HIV should be dismantled.
- **Develop programs that facilitate voluntary HIV status disclosure.** People may not disclose their status for a number of reasons, including fear of intimate partner violence, discrimination and HIV-related stigma, and lack of accurate information about living with HIV. Community-based organizations working with HIV/AIDS positive individuals can be a conduit for counseling and support individuals regarding disclosure.

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## Immigration

Immigrants face complex structural obstacles, which may contribute to their increased vulnerability to illness and a limited range of choices related to their health and well-being. The challenges associated with the migratory process itself are often compounded by having to acclimate to a new environment, lack of documentation, and adjusting to a new language.<sup>87</sup>

Several studies demonstrate that foreign-born individuals living in the United States are more likely than those born here to enter into HIV care late, to have low T-cell counts and as a result have a weakened immune system at the time of diagnosis, and to be diagnosed with HIV concurrently with AIDS.<sup>88</sup> Various structural factors explain these patterns.

Undocumented immigrants fear “the system,” including the risk that seeking medical help could lead to deportation or other adverse legal consequences.<sup>89</sup> Further, the prospect of HIV disclosure to family members may pose a barrier to diagnosis and treatment.<sup>90</sup> Stigma-management becomes compounded when non-English speakers (often parents) must rely on English-speaking relatives (often their children) to communicate with health care providers.<sup>91</sup> In order to obtain testing or treatment, such immigrants may have to sacrifice a reasonable expectation of medical privacy. People who are known to be HIV-positive may face considerable stigma. The fear of the possibility of domestic violence, for instance, is a strong factor shaping women’s negotiation of access to care, condom use in intimate relationships,<sup>92</sup> and disclosure of an HIV diagnosis.<sup>93</sup>

Diversity within immigrant populations also leads to different HIV risk profiles. Diversity of country of origin is one important consideration to develop a better appreciation of specific epidemiological profiles and risk factors across mobile populations.<sup>94</sup> One study, for example, calls for a more consistent recording of country of origin data to help distinguish foreign-born from native-born blacks. In some of the localities lumping both these groups into the category African American could be misleading in crucial ways.<sup>95</sup> The structural barriers facing African Americans may be specifically related to institutionalized racism and poverty, while black immigrants may face these in addition to challenges other immigrants face, such as language barriers.

Similarly, researchers must pay attention to diversity among Hispanic groupings in terms of countries of origin as well as mobility, because these characteristics could impact their risk and protective behaviors.<sup>96</sup> For instance, Dominicans may negotiate HIV risk and protective behaviors in relationship to the centrality of family reunification as a strategy of immigration among much of this population. By contrast, such negotiations may look quite different for Mexican and Central American emerging immigrant settlements on the East Coast where there tend to be large demographic imbalances between immigrant male presence and largely absent or very small numbers of women. In both cases, men may have sexual activity with partners outside of a primary relationship. Nevertheless, the conditions for risk and protective behaviors among men and women in both populations need to be understood in their distinctness—an important nuance that is often glossed over by relying on terms such as “Hispanic” or “Latino” when describing these populations.

Lesbian, gay, bisexual, and transgender immigrants face multiple challenges,<sup>97</sup> which are often rendered invisible by the predominant view of immigrants as heterosexual. Emerging research suggests that sexual minorities access geographical mobility through

the resources available through biological families and nonkin relations.<sup>98</sup> This suggests that immigration itself may help immigrants negotiate disclosure, discrimination, and privacy concerns by creating distance between immigrants and their biological families. This separation, however, means that any ongoing support they may need from family abroad will require discretion. Sexual minority immigrant access to HIV prevention or related resources may also require identification and involvement with gay-identified groups, which may or may not appeal to immigrants of various sexual identifications or gender expressions.<sup>99</sup> In addition, the lack of access to federal recognition of their partners or spouses relationships means that family reunification statutes in immigration law do not apply to them.<sup>100</sup>

Furthermore, the ongoing need for support from within immigrant communities suggests that migration does not detach these immigrants from the social norms they may seek to escape in the first place. Those living with HIV and migrating to escape stigma may continue to confront stigmatizing views, including within sexual minority communities (based on their immigration status, race/ethnicity, and/or HIV status).<sup>101</sup> The mental health effects of stigma might increase the vulnerability of sexual minority immigrants toward patterns of behavior that put them at increased risk for HIV,<sup>102</sup> such as injection drug use, alcohol consumption, and unprotected anal sex.<sup>103</sup> Women and gender nonconforming people may face the additional challenge of vulnerability to rape and violence.

## Recommendations

- **Increased cultural competency among HIV/AIDS providers, public health officials, and advocates.** Cultural sensitivity training for advocates and care providers should integrate specific information about local immigrant communities, their characteristics, and their challenges in order to help immigrants navigate their unique challenges to HIV testing, disclosure, and access to treatment. Further, since immigrant communities are subject to immigration rights laws and regulations, which vary by state, public health officials must be educated on the impact of those laws on the ability for HIV positive immigrants to access care.
- **Repeal the Defense of Marriage Act, or DOMA, 104 or pass the Uniting American Families Act, or UAF.**<sup>105</sup> Ensuring that immigrants that are in same-sex relationships can access family-based immigration would help reduce vulnerability they face.

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## General strategies for reducing HIV/AIDS-related disparities and inequities

In addition to the previous action items addressing specific social determinants, it is important to note high-level recommendations that more generally address reducing

HIV-related health disparities and inequities. Many of these recommendations originate from the National HIV/AIDS Strategy, but are proposals where full implementation has yet to occur.

### Collaborative funding streams

The Ryan White Program is the largest federally funded program specifically designed for people living with HIV/AIDS in the United States, and also the most flexible.<sup>106</sup> In fiscal year 2011, the Health Resources and Services Administration, which administers the Ryan White funds, will allocate \$2.312 billion dollars to states, cities, and providers. Funds are allocated based on geographic locations, hardest hit populations, types of services, and system needs.<sup>107</sup> This extensive allocation system ensures that community based organizations can provide wraparound services that support general quality of life issues such as shelters for the homeless, substance abuse counseling programs, and job training.

By contrast, other smaller HIV/AIDS funding sources such as the Centers for Disease Control (\$573 million), Housing Opportunities for Persons With Aids (\$298 million), Substance Abuse and Mental Health Services Administration (\$128 million), and Office of Minority Health (\$4.5 million) are far less flexible.<sup>108</sup> The Centers for Disease Control, while making strides in its impact on hard hit communities, still mainly funds for testing and prevention.<sup>109</sup> Housing Opportunities for Persons With Aids funds are also mostly narrow in scope, and the agency encourages grantees to form strategies and partnerships with other community organizations.<sup>110</sup> More collaborative work between these HIV/AIDS funding sources would help to bridge the gaps and ensure more supportive wraparound services.

### Interagency workgroup coordination

In efforts to create a national strategy, the Office of National AIDS Policy, or ONAP, created the Federal HIV Interagency Working Group comprised of HIV practitioners and policy-makers to outline a comprehensive plan. In addition to their own expertise, the working group analyzed suggestions from the public and formulated recommendations around incidence, access, and disparities that ultimately formed the National HIV/AIDS Strategy.<sup>111</sup>

Since the publication of the National HIV/AIDS Strategy, the working group has continued to meet on a quarterly basis to coordinate and implement high impact practices across agencies, but there has been little transparency around the outcomes of these meetings or the specific programs and practices that are being used to implement the strategy.<sup>112</sup> The Office of National Aids Policy should ensure that advocates and the general public are informed of the progress of this work, and have opportunities to weigh in and help guide the process.

Further, the interagency coordination must extend beyond the beltway of Washington, D.C. and take place at the regional, state, and local levels in order to ensure that the work of the group is informed directly by the communities most impacted by the disease. For example regional directors for each agency (Health and Human Services, Housing and Urban Development, Labor, etc.) should also be directed to meet regularly to ensure coordination of HIV-related support services.

States like New York and Texas already have coordinating working groups in place, which can serve as models for other states.<sup>113</sup> The New York State Interagency Task Force on HIV/AIDS, established in 1983, is a national leader. As a state with one of the highest incidences of HIV/AIDS, New York biannually convenes this meeting group of state agency leaders to identify opportunities for collaboration and coordination that address the epidemic.<sup>114</sup> This level of coordination needs to be established for all regions, specifically in those states in the South with the greatest incidents of HIV.

### The Affordable Care Act

The Affordable Care Act will greatly improve health care access by extending coverage to millions of uninsured people, including those living with HIV/AIDS. Since lack of health insurance and access to care is often a key barrier to managing HIV, this coverage expansion will go a long way toward supporting those with the highest incident rates. The Affordable Care Act will also facilitate increased testing by integrating HIV/AIDS tests into routine care services for women.<sup>115</sup>

The Affordable Care Act, however, may also have unintended consequences for the community-based organizations who have been major providers of care. The Affordable Care Act has increased support for community-based organizations that provide health care services. However, many of the community-based organizations serving those living with HIV/AIDS offer social services rather than medical ones. As the biomedical interventions for HIV/AIDS expand it is important to ensure that nonmedical community-based organizations that provide HIV/AIDS testing and counseling services continue to be funded to engage with the community. Such centers are often the first point of access for people of color, and serve as a pipeline to care for those testing positive.<sup>116</sup> So it is important to continue to support their work of community-based organizations.

### Reducing stigma

One of the biggest barriers to health equity surrounding HIV/AIDS is the stigma and relative silence associated with the disease. In communities of color in particular, the stereotype of HIV/AIDS as the consequence of an individual's deviant behavior has perpetuated shame and discouraged people from knowing their status and treating it.

By expanding the frame of HIV/AIDS to also discuss the structural factors that contribute to the high rates among blacks and Latinos, we can shift the stigma away from individuals and extend the burden of responsibility for addressing the crisis to the systems and communities themselves. Further, the structural conditions that impact HIV rates are often the same ones that create health inequities in general for communities of color. So an integrated focus on health and wellness will go a long way toward reducing stigma.

Act Against Aids is a model national program launched by the Centers for Disease Control and the White House to counteract this inequity. This program educates the public on testing and prevention as well as reducing the stigma surrounding HIV/AIDS.<sup>117</sup> This program should be ramped up and promoted across agencies.

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## Conclusion

The National HIV Strategy, and Implementation Plan, put forth by the Obama administration two years ago, acknowledges the role of structural factors in perpetuating the alarming rates of HIV/AIDS that we see in communities of color and among men who have sex with men. By recognizing that the impact of HIV is not colorblind or class-blind, the strategy begins an important, forward thinking, conversation. Yet, beyond this, insufficient progress has been made in developing and implementing structural interventions that would mitigate the social determinants laid out in this brief.

Just as solutions must recognize inequalities among communities in terms of HIV risk, such solutions must also account for the underlying source of these inequalities. The source is not behavioral differences, but rather structural factors. Therefore, behavioral solutions, while effective, alone will not suffice to curb the gross disparities.

We must take a holistic approach to dramatically reduce the racial inequities in the incidence rates and outcomes of people living with HIV/AIDS. Moreover, it is incumbent upon the administration to aggressively execute the tenants laid out in the Implementation Plan in order to do so. Community-based health organizations must also focus on the holistic health and wellness of their clients in order to boost outcomes.

Acknowledging the structural barriers is just a first step, eliminating them will require the development of tangible intervention models that are implemented across agencies in addition to a sustained focus on behavioral interventions. This comprehensive approach is the only way we will begin to bridge the gap for communities of color.

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This brief was produced by the University of California, Berkeley Law Working Group on HIV and Inequality in conjunction with the Fighting Injustice to Reach Equality, or FIRE, Initiative of the Center for American Progress.

The University of California, Berkeley Law Working Group on HIV and Inequality, comprised primarily of scholars and community advocates who are lesbian, gay, bisexual and/or transgender people of color, emerged from two workshops held in 2010 and 2011. In March 2010, Professor Russell Robinson convened a one-day workshop at UC Berkeley School of Law to discuss the potential of the Obama administration's National HIV/AIDS Strategy to change the public conversation about the relationship between HIV/AIDS and race. The working group analyzed the risks and benefits of emphasizing that blacks and Latinos are disproportionately affected by HIV/AIDS. This conversation led to a consensus that the Working Group should produce a policy brief to supplement the National HIV/AIDS Strategy by highlighting the structural conditions, including poverty, mass incarceration, and immigration-related barriers that produce the racial disparities in HIV/AIDS transmission and treatment. A subset of the Working Group met at a retreat at the Center for American Progress in October 2011 to begin work on the brief.

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## Endnotes

- Centers for Disease Control and Prevention, "HIV Among African Americans" (2011).
- Centers for Disease Control and Prevention, "HIV Among Latinos" (2011).
- Centers for Disease Control and Prevention, "HIV Among Gay And Bisexual Men" (2011).
- "National HIV/AIDS Strategy for the United States" (2010) available at <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf>.
- See Russell Robinson, "Racing the Closet," *Stanford Law Review* 61 (2009): 1463, 1469-78.
- See, E.g., Chandra L. Ford and others, "Black Sexuality, Social Construction, And Research Targeting 'The Down Low' ('The DL)," *Annals Of Epidemiology* 17 (2009) (2007).
- Anjani Chandra and others, "Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data from the 2006-2008 National Survey of Family Growth," *National Health Statistics Reports* 36 (2011); Gregorio A. Millett and others, "Greater Risk for HIV Infection of Black Men Who Have Sex with Men: A Critical Literature Review," *American Journal Of Public Health* 96 (2006): 1007; 1013.
- For a recent discussion of the racial wealth gap, see Rakesh Kochhar and others, "Twenty-to-One: Wealth Gaps Rise to Record Highs Between Whites, Blacks, Hispanics" (Washington: Pew Research Center, 2011), available at <http://www.pewsocialtrends.org/2011/07/26/Wealth-Gaps-Rise-To-Record-Highs-Between-Whites-Blacks-Hispanics/>. For a history of the racial wealth gap, see Meizhu Lui and others, *The Color of Wealth: The Story Behind the U.S. Racial Wealth Divide* (New York: The New Press, 2006). On the racial health gap, see Office Of Minority Health, Generally *Closing The Health Gap Campaign* (U.S. Department of Health and Human Services), available at <http://minorityhealth.hhs.gov/Templates/Content.aspx?Id=2840&Lvl=3&Lvlid=24>. On the embodiment of inequality, see Clarence Gravlee, "How Race Becomes Biology: Embodiment Of Social Inequality," *American Journal of Physical Anthropology* 47 (2009): 139.
- Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2010); Dalton Conley, *Being Black, Living in the Red: Race, Wealth and Social Policy in America* (The University of California Press, 2009); Douglass Massey, *Categorically Unequal: The American Stratification System* (New York: Russell Sage Foundation, 2007); Francis Fox Piven and others, *Keeping Down The Black Vote: Race and the Demobilization of American Voters* (New York: The New Press, 2008); Dorothy Roberts, *Fatal Invention: How Science, Politics and Big Business Re-Crete Race in the Twenty-First Century* (New York: The New Press, 2011).
- World Health Organization, "Social Determinants of Health Key Concepts," available at [http://www.who.int/social\\_determinants/final\\_report/key\\_concepts\\_en.pdf](http://www.who.int/social_determinants/final_report/key_concepts_en.pdf).
- Ibid.*
- David H. Chae and others, "Discrimination, Attribution, and Racial Group Identification: Implications For Psychological Distress Among Black Americans In The National Survey Of American Life," *American Journal of Orthopsychiatry* 81 (2011): 498. Facing discrimination—on the basis of race, gender, sexual orientation, or membership in another socially devalued group—may in and of itself cause stress. Discrimination based on race or sexuality can lead to negative psychological responses, including poor self-concept, depression, and anxiety, and as a result undermine the ability to engage in healthy behaviors, including safer sex practices. Sarah L. Szanton and others, "Racial Discrimination Is Associated With A Measure Of Red Blood Cell Oxidative Stress: A Potential Pathway For Racial Health Disparities," *International Journal of Behavioral Medicine* (2011), <http://www.springerlink.com/content/8200t796v1860m73/fulltext.pdf>; David R. Williams and Chiquita Collins, "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations," *Annual Review of Sociology* 21 (1995): 349; David R. Williams, "Socioeconomic Differentials In Health: A Review And Redirection," *Social Psychology Quarterly* 53 (1990): 81.
- Williams & Collins, "U.S. Socioeconomic And Racial Differences In Health"; Rita B. Effros, *Telomere/Telomerase Dynamics Within The Human Immune System: Effect Of Chronic Infection And Stress*, *Experimental Gerontology* 46 (2011): 135.

- 14 For an in-depth exploration of the social determinants of health across a range of public health problems, consult the documentary film "Unnatural Causes: Is Inequality Making Us Sick?" (California Newsreel, 2008).
- 15 National Institute On Minority Health And Health Disparities, "Social Determinants Of Health Initiative," available at <http://www.nimhd.nih.gov/Recovery/Gosocialdeterm.asp>.
- 16 U.S. Centers For Disease Control and Prevention, "Establishing A Holistic Framework To Reduce Inequities In HIV, Viral Hepatitis, Stds, and Tuberculosis in the United States" (2010), available at <http://www.cdc.gov/Socialdeterminants/Docs/Sdh-White-Paper-2010.pdf>.
- 17 "National HIV/AIDS Strategy for the United States."
- 18 *Ibid.*
- 19 Paul Denning and Elizabeth Dinunno, "Communities In Crisis: Is There A Generalized HIV Epidemic In Impoverished Urban Areas of the United States?" (Atlanta: Centers for Disease Control and Prevention, 2010), available at <http://www.cdc.gov/Hiv/Topics/Surveillance/Resources/Other/Poverty.htm>.
- 20 U.S. Housing Scholars & Research & Advocacy Organizations, "Residential Segregation And Housing Discrimination In The United States 2" (2008); Luis Sanchez and others, "Racial And Ethnic Residential Segregation In The United States: Residential Patterns Of Hispanics/Latinos, 1980-2009" (State College, 2010); See also, Douglas S. Massey and Nancy A. Denton, "American Apartheid: Segregation And The Making Of The Underclass," 1993.
- 21 Chandra L. Ford and others, "Perceived Everyday Racism, Residential Segregation, And HIV Testing Among Patients at A Sexually Transmitted Disease Clinic," American Journal of Public Health 99(2009): S137.
- 22 Michael Arnold and others, "Race, Place And Aids: The Role Of Socioeconomic Context On Racial Disparities In Treatment And Survival In San Francisco," Social Science and Medicine 69 (2009): 121, 127.
- 23 Deborah Cohen and others, "Broken Windows" and the Risk of Gonorrhoea," American Journal of Public Health 90 (2000): 230. ("A 'Broken Windows' index measur[ing] housing quality, abandoned cars, graffiti, trash, and public school deterioration . . . explained more of the variance in gonorrhoea rates than did a poverty index measuring income, unemployment, and low education."); D. Phuong D and others, "Does Place Explain Racial Health Disparities? Quantifying The Contribution Of Residential Context To The Black/White Health Gap In The United States," Social Science and Medicine 67 (2008): 1258, 1266. ("[O]ur results suggest that neighborhood context per se explains a moderate to substantial portion of the black/white health gap . . ."); Robert G. Wallace, "AIDS In The Haart Era: New York's Heterogeneous Geography," 56 Social Science and Medicine 56 (2003): 1155; Phill Wilson, "Race Matters: Race, Poverty and Aids in Black America," July 20, 2010, RH Reality Check, available at <http://www.rhrealitycheck.org/Blog/2010/07/19/Race-Still-Matters-Race-Poverty-Aids-Black-America>.
- 24 P. Todd Korthuis and others, "Impact of Patient Race on Patient Experiences of Access and Communication in HIV Care," Journal of General Internal Medicine 23 (2008): 2046.
- 25 See Moupali Das Et Al., "Decrease In Community Viral Load Are Accompanied By Reductions In New HIV Infections In San Francisco," 5 Plos One E11068 (2010).
- 26 Mark Cichocki, "Hiv Viral Load - What Is It And Why Is It Important?," About.com (Oct. 11, 2007), [Http://Aids.about.com/Od/Technicalquestions/F/Viralload.htm](http://Aids.about.com/Od/Technicalquestions/F/Viralload.htm).
- 27 *Ibid.*
- 28 *Ibid.*
- 29 Amie L. Meditz and others, "Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection," Journal of Infectious Diseases 203 (2011): 442, 443-444.
- 30 Human Rights Watch, "Southern Exposure: Human Rights and HIV in the Southern United States 1" (2010), available at <http://www.hrw.org/News/2010/11/26/Southern-Exposure>; Southern Aids Coalition, "Southern States Manifesto: Update 2008 4" (2008), available at <http://www.hivlawandpolicy.org/Resources/Download/462>.
- 31 Bronwen Lichtenstein and others, "Public Tolerance, Private Pain: Stigma And Sexually Transmitted Infections In The American Deep South," Culture, Health and Sexuality 7 (2005): 43.
- 32 Trista A. Bingham and others, "The Effect Of Partner Characteristics On HIV Infection Among African American Men Who Have Sex With Men In The Young Men's Survey, Los Angeles, 1999-2000," Aids Education and Prevention 15 (2003): 39. ("Compared with white participants, a higher proportion of African American participants reported that their male anal-sex partners were mostly of a different age and were African American."); Millett and others, "Greater Risk For HIV Infection Of Black Men Who Have Sex With Men."
- 33 Taigi Smith, "Deadly Deception," Essence, August 2004, p. 148.
- 34 Robinson, "Racing the Closet."
- 35 *Ibid.*
- 36 "National HIV/AIDS Strategy for the United States," p. 12-13.
- 37 H. Fisher Raymond and Willi Mcfarland, "Racial Mixing And HIV Risk Among Men Who Have Sex With Men," AIDS and Behavior 13 (2009): 630. (Finding that non-black MSM in San Francisco reported that their friendship networks and gay social spaces rarely included black men.)
- 38 M. Belinda Tucker and Claudia Mitchell-Kernan, "Social Structural And Psychological Correlates Of Interethnic Dating" Journal of Social and Personal Relationships 12 (1995): 341, 348. (Reporting that white men in southern California survey were more likely to express an unwillingness to marry a black woman than women of any other race, and their opposition to a black wife far exceeded that of white women to a black husband); Patrick A. Wilson, "Race-Based Sexual Stereotyping And Sexual Partnering Among Men Who Use The Internet To Identify Other Men For Bareback Sex," Journal of Sex Research 46 (2009): 399. (Finding pervasive stereotyping of black MSM). Studies also suggest that Asian MSM, like black MSM, are devalued and stereotyped in gay communities. See *Ibid.*, p. 406-407. Researchers should direct greater attention toward Asian MSM, racial discrimination, and HIV risk.
- 39 See Adaora A. Adimora and Victor J. Schoenbach, "Social Context, Sexual Networks, and Racial Disparities In Rates of Sexually Transmitted Infections," Journal of Infectious Diseases 191 (2005): S115, S117, S119. (Showing that imbalanced sex ratio leads some black women to involvement in overlapping sexual relationships within the black community).
- 40 Millett and others, "Greater Risk For HIV Infection Of Black Men Who Have Sex With Men," p. 1013.
- 41 Department of Housing and Urban Development, "Implementing the National HIV/AIDS Strategy: A report to the White House Office of AIDS Policy" (2011), available at <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-operational-plan-hud.pdf>
- 42 Centers for Disease Control and Prevention, "Compendium Of HIV Prevention Interventions With Evidence of Effectiveness" (2001).
- 43 Adaora A. Adimora and Judith D. Auerbach, "Structural Interventions for HIV Prevention in the United States," Journal of Acquired Immune Deficiency Syndrome 55 (2010): S132.
- 44 John Santelli and others, "Abstinence and Abstinence-Only Education: A Review Of U.S. Policies and Programs," Journal Of Adolescent Health 38 (2006): 72.
- 45 Laura Duberstein Lindberg and, "Changes In Formal Sex Education: 1995-2002," Perspectives on Sexual Reproduction and Health 38 (2006): 182; Santelli and others, "Abstinence and Abstinence-Only Education."
- 46 Santelli and others, "Abstinence and Abstinence-Only Education."

- 47 Chandra and others, "Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States."
- 48 *Ibid.*
- 49 "National HIV/AIDS Strategy for the United States," p. 20.
- 50 David R. Holtgrave and others, "Cost–Utility Analysis of a Female Condom Promotion Program in Washington, D.C.," *Aids And Behavior* 16 (2012): 1115, 1119, available at <http://www.springerlink.com/Content/21790257155T6651/>.
- 51 Zach Ford, "Study: Condom Use Habits Among Gay Couples Vary by Race," *ThinkProgress*, June 23, 2012, available at <http://Thinkprogress.org/Lgbt/2012/07/23/565451/Study-Condom-Use-Habits-Among-Gay-Couples-Vary-By-Race/>.
- 52 National Commission On Correctional Health Care, "The Health Status Of Soon-To-Be-Released Inmates: A Report To Congress" (2002).
- 53 Anne C. Spaulding and others, "HIV/AIDS Among Inmates of and Releasees From U.S. Correctional Facilities, 2006: Declining Share Of Epidemic But Persistent Public Health Opportunity," *PLOS One* 4 (2009):6.
- 54 F. Brewer and others, "Transmission of HIV-1 Within A State-wide Prison System," *AIDS* 2 (1988): 363; K. Castro and others, "HIV Transmission In Correctional Facilities." In program and abstracts of the Seventh International Conference On AIDS (1991); Centers for Disease Control and Prevention, "HIV Transmission Among Male Inmates in a State Prison System—Georgia, 1992–2005," *Morbidity and Mortality Weekly* 55 (2006): Rep. 421; C. Robert Horsburgh Jr. and others, "Seroconversion to Human Immunodeficiency Virus in Prison Inmates," *American Journal of Public Health* (1990):209; Christopher P. Krebs and Melanie Simmons, "Intrajail HIV Transmission: An Assessment of Whether It Occurs, How It Occurs, and Who Is At Risk," *Aids Education Prevention* 14 (2002): 53; Grace E. Macalino and others, "Prevalence and Incidence of HIV, Hepatitis B Virus, and Hepatitis C Virus Infections Among Males In Rhode Island Prisons," *American Journal of Public Health* 94 (2004): 1218; Abe Macher and others, "HIV Transmission In Correctional Facility," *Emerging Infectious Diseases* 12 (2006): 669; Randal C. Mutter and others, "Evidence Of Injail Spread of HIV Infection," *Archives Internal Medicine* 154 (1994): 793.
- 55 Theodore M. Hammett and others, "The Burden of Selected Infectious Disease Among Inmates of And Releasees From U.S. Correctional Facilities, 1997," *American Journal of Public Health* 92 (2002): 1789; Laura M. Maruschak, "HIV In Prisons And Jails, 1999," *Bureau Of Justice Statistics Bulletin* (2001).
- 56 John P. May and Earnest L. Williams Jr., "Acceptability of Condom Availability In A U.S. Jail," *Aids Education and Prevention* 14 (2002): 85.
- 57 Ari B. Bloomekatz, "L.A. County Sheriff Considers Expanding Condom Distribution In Jail," *Los Angeles Times*, June 29, 2009, p. A3.
- 58 World Health Organization, United Nations Office On Drugs And Crime and UNAIDS, "Interventions To Address HIV In Prisons: Prevention Of Sexual Transmission" (2007).
- 59 Ralf Jürgens and others, "HIV And Incarceration: Prisons and Detention," *Journal of International AIDS Society* 14 (2011): 26; Centers for Disease Control and Prevention, "HIV/AIDS Education and Prevention Programs For Adults In Prisons And Jails And Juveniles In Confinement Facilities—United States, 1994," *Morbidity and Mortality Weekly* 45 (1996): Rep. 268.
- 60 "National HIV/AIDS Strategy for the United States," p. 12 ("There is evidence that some people with HIV who had received medical care while incarcerated have difficulty accessing HIV medications upon release—affecting their health and potentially increasing the likelihood that they will transmit HIV.")
- 61 National Commission on Correctional Health Care, "Administrative Management of HIV In Correctional Institutions" (2005), available at [http://www.ncchc.org/Resources/Statements/Admin\\_hiv2005.Html](http://www.ncchc.org/Resources/Statements/Admin_hiv2005.Html).
- 62 Sandra A. Springer and others, "Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components," *Clinical Infectious Diseases* 53 (2011): 469
- 63 Incarceration, combined with racial preferences, can work in tandem to shrink the size of some sexual networks, therefore increasing risk for sexual risk.
- 64 Urban Institute, "Families Left Behind: The Hidden Costs of Incarceration and Reentry" (2003), available at <http://www.urban.org/Publications/310882.Html>; Adimora and Schoenbach, "Social Context, Sexual Networks, and Racial Disparities In Rates of Sexually Transmitted Infections," p. 5119; Nina T. Harawa and Adaora A. Adimora, "Incarceration, African Americans and HIV: Advancing A Research Agenda," *Journal of the National Medical Association* 100 (2008): 57.
- 65 See notes 35-42 and accompanying text.
- 66 Margaret E. Finzen, "Systems Of Oppression: The Collateral Consequences of Incarceration and Their Effects on Black Communities," *Georgetown Journal on Law and Poverty Policy* 12 (2005): 299.
- 67 Jessica S. Henry and James B. Jacobs, "Ban the Box to Promote Ex-Offender Employment," *Criminology and Public Policy* 6 (2007): 755, available at <http://www.nelp.org/Page/-/Scip/Henry-Jacobs.banthebox.article.oct-07.Pdf>.
- 68 Jeanne Flavin, *Our Bodies, Our Crimes: The Policing of Women's Reproduction In America* (New York: New York University, 2008) p. 158-62.
- 69 H.R. 3547, 112th Cong. (2011).
- 70 Becky L. Stephenson and others, "Sexual Behaviours of HIV-Seropositive Men and Women Following Release from Prison," *International Journal of STD and AIDS* 17 (2006): 103; Ingrid A. Binswanger and others "Release From Prison — A High Risk Of Death For Former Inmates," *New England Journal of Medicine* 356 (2007): 157.
- 71 The studies on this point have been largely regional. See, Mary Sylla, "Prisoner Access To Condoms In The United States – The Challenge Of Introducing Harm Reduction Into A Law And Order Environment" (Community HIV/AIDS Mobilization Project, 2008), available at [http://www.champnetwork.org/media/Prisoner\\_Access\\_to\\_Condoms\\_in\\_the\\_United\\_States-Sylla.pdf](http://www.champnetwork.org/media/Prisoner_Access_to_Condoms_in_the_United_States-Sylla.pdf).
- 72 Positive Justice Project, Center For HIV Law & Policy, "Ending and Defending Against HIV Criminalization: State and Federal Laws and Prosecutions 222 (2010)."
- 73 Laws criminalizing spitting and biting by HIV-positive people ignore the fact that the CDC has determined that spitting and biting pose no significant risk of HIV transmission. Centers for Disease Control and Prevention "HIV Transmission: Questions and Answers," <http://www.cdc.gov/Hiv/Resources/Qa/Transmission.htm>
- 74 *People v. Beuford*, No. B196860, 2008 WI 5091389 (Cal. Ct. App. Dec. 4, 2008) (Confirming a conviction for making criminal threats when a defendant was resisting arrest and made comments to police officers including, "I'll make your life miserable because I'm infected with HIV" while spitting at an officer); See also Brent Curtis, "Aids Patient Faces Felony for Spitting At City Officer," *The Rutland Herald*, July 30, 2009, available at <http://www.rutlandherald.com/Apps/Pbcs.dll/Article?Aid=/20090730/News01/907300377/> (Noting a 31-year-old, HIV-positive man in Vermont was charged with aggravated assault for spitting in the face of a police officer.); "State Can Try To Detain Man Who Spread H.I.V.," *The New York Times* (July 19, 2010), [http://www.nytimes.com/2010/07/20/Nyregion/20Nushawn.html?\\_R=1&Ref=Nushawnjwilliams](http://www.nytimes.com/2010/07/20/Nyregion/20Nushawn.html?_R=1&Ref=Nushawnjwilliams). (Noting that Nushawn Williams pleaded guilty to two counts of statutory rape and two counts of reckless endangerment and was sentenced to 12 years imprisonment in 1997. Although Williams served his sentence, prosecutors sought to keep Williams incarcerated using New York state's civil confinement law.)
- 75 Carol L. Galletly and Steven D. Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 *J. L. Med. & Ethics* 327, 328 (2004).

- 76 "Why Should HIV Criminalization Matter to You?" Positive Women's Network, December 16, 2010, <http://www.pwn-usa.org/Tools-And-Resources-2/Tool-Kits-And-Presentations>; Brook Kelly, "The Modern HIV/AIDS Epidemic and Human Rights in the United States: A Lens Into Lingering Gender, Race, and Health Disparities, and Cutting Edge Approaches to Justice," *University of Baltimore Law Review* 41 (2012): 355, 365-66.
- 77 Positive Justice Project, Center For HIV Law & Policy, "Ending and Defending Against HIV Criminalization," p. 37. (Recounting stories of individuals being punished under these laws.)
- 78 Gary Marks and others, "Estimating Sexual Transmission of HIV from Persons Aware and Unaware That They Are Infected With the Virus In the USA," *AIDS* 20 (2006): 1447, 1449.
- 79 "National HIV/AIDS Strategy for the United States," p. 36-37.
- 80 Global Commission on HIV and the Law, "Report of the High Income Countries Regional Dialogue of the Global Commission on HIV and the Law 13" (2012).
- 81 Keith J. Horvath and others, "Should It Be Illegal for HIV-Positive Persons to Have Unprotected Sex Without Disclosure? An Examination Of Attitudes Among U.S. Men Who Have Sex With Men and the Impact of State Law," *AIDS Care* 22 (2010): 1221. (Showing that HIV specific criminal exposure and transmission laws do not affect risk behaviors).
- 82 H.R. 3053, 112th Cong. (2011).
- 83 Congresswoman Barbara Lee, "Lee Introduces Bill to Fight Discrimination Against People Living With HIV: Congresswoman Calls For Repeal of Unfair Criminal and Civil Laws," Press release, September 23, 2011, available at <http://Lee.house.gov/Index.cfm?Sectionid=57&Itemid=2444>.
- 84 Michele G. Shedlin and others, "Initial Acculturation and HIV Risk Among New Hispanic Immigrants," *Journal of the National Medical Association* 97 (2005): 325.
- 85 Nadine E. Chen and others, "A Systematic Review of HIV/AIDS Survival and Delayed Diagnosis Among Hispanics in the United States," *Journal of Immigrant and Minority Health* 14 (2012): 65; Tim Crawford and others, "Foreign Born Status And HIV/AIDS: A Comparative Analysis Of HIV/AIDS Characteristics Among Foreign and U.S. Born Individuals," *Journal of Immigrant and Minority Health* 14 (2012): 82; Bich N. Dang and others, "Sociocultural and Structural Barriers to Care Among Undocumented Latino Immigrants With HIV Infection," *Journal of Immigrant and Minority Health* 14 (2012): 121.
- 86 Michele G. Shedlin and others, "Research Participant Recruitment In Hispanic Communities: Lessons Learned," *Journal of Immigrant and Minority Health* 13 (2011): 352, 358; Anitra Pivnick and others, "Accessing Primary Care: HIV Plus Caribbean Immigrants in the Bronx," *Journal of Immigrant and Minority Health* 12 (2010): 496.
- 87 Marianne Yoshioka and Amy Schustack, "Disclosure of HIV Status: Cultural Issues of Asian Patients," *AIDS Patient Care and STDs* 15 (2001): 77.
- 88 Kristen Perry, "Genres, Contexts, And Literacy Practices: Literacy Brokering Among Sudanese Refugee Families," *Reading Research Quarterly* 44 (2009): 256; Nina Wu and Su Yeong Kim, "Chinese American Adolescents' Perceptions of the Language Brokering Experience as a Sense of Burden and Sense of Efficacy," *Journal of Youth and Adolescence* 38 (2009): 703.
- 89 Holly Swan and Daniel J. O'Connell, "The Impact of Intimate Partner Violence on Women's Condom Negotiation Efficacy," *Journal of Interpersonal Violence* 27 (2012): 775; Yeon-Shim Lee and Linda Hadeed, "Intimate Partner Violence Among Asian Immigrant Communities: Health/Mental Health Consequences, Help-Seeking Behaviors, And Service Utilization," *Trauma Violence and Abuse* 10 (2009): 143.
- 90 Lee and Hadeed, "Intimate Partner Violence Among Asian Immigrant Communities."
- 91 Michele G. Shedlin, "Immigration And HIV/AIDS in the New York Metropolitan Area," *Journal of Urban Health* 83 (2006): 43.
- 92 Roxanne Kerani and others, "HIV Among African-Born Persons in the United States: A Hidden Epidemic?" *Journal of Acquired Immune Deficiency Syndromes* 49 (2008): 102.
- 93 Sherry Deren and others, "HIV Risk and Prevention Among Hispanic Immigrants in New York: The Salience of Diversity," *Substance Use & Misuse* 46 (2011): 254.
- 94 In this brief, gay and transgender may be used to reference lesbian, gay, bisexual, and transgender people.
- 95 Martin F. Manalansan, *Global Divas: Filipino Gay Men In The Diaspora* (Durham: Duke University Press, 2003); Manolo Guzman, *Gay Hegemony/Latino Homosexualities* (New York: Routledge, 2005); Lionel Cantu, *The Sexuality of Migration: Border Crossings and Mexican Immigrant Men* (New York: New York University Press, 2009); Hector Carrillo, *The Night Is Young: Sexuality in Mexico in the Time of AIDS* (Chicago: University of Chicago Press, 2002).
- 96 Manalansan, *Global Divas*; Carlos Ulises Decena, *Tacit Subjects: Belonging and Same-Sex Desire Among Dominican Immigrant Men* (Durham: Duke University Press, 2011).
- 97 Defense of Marriage Act, Pub. L. No. 104-199.
- 98 Jaime Cortez, *Sexilio/Sexile* (Los Angeles: The Institute for Gay Men's Health, 2004).
- 99 Hirokazu Yoshikawa and others, "Do Family and Friendship Networks Protect Against the Influence of Discrimination on Mental Health and HIV Risk Among Asian and Pacific Islander Gay Men?" *16 AIDS Education and Prevention* 16 (2004): 84.
- 100 Rafael M. Diaz, *Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior* (New York: Routledge, 1997).
- 101 Respect for Marriage Act, H.R. 1116, 112th Cong. (2011).
- 102 Uniting American Families Act, H.R. 1537, 112Th Cong. (2011).
- 103 Kaiser Family Foundation, "HIV/AIDS Policy" (2009), available at [http://www.kff.org/HivAids/Upload/7582\\_05.Pdf](http://www.kff.org/HivAids/Upload/7582_05.Pdf).
- 104 Health Resources and Services Administration, *About the Ryan White HIV/AIDS Program: Legislation* (U.S. Department of Health and Human Services, 2009), available at <http://Hab.hrsa.gov/AboutHab/Legislation.html>.
- 105 "Total Federal HIV/AIDS Grant Funding" (2010), available at <http://www.statehealthfacts.org/comparabletable.jsp?ind=528&cat=11>.
- 106 Center for Disease Control and Prevention, "CDC's New High-Impact Approach to HIV Prevention Funding for Health Departments" (2011), available at <http://www.cdc.gov/Hiv/Topics/Funding/Ps12-1201/Resources/Factsheet/Pdf/Foa-Partner.pdf>. "Total Federal HIV/AIDS Grant Funding" (2010), available at <http://www.statehealthfacts.org/comparabletable.jsp?ind=528&cat=11>.
- 107 U.S. Department of Housing and Urban Development, "Housing Opportunities for Persons with AIDS (HOPWA) Program," available at [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/comm\\_planning/aidshousing/programs](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing/programs).
- 108 Office of National AIDS Policy, "Implementing the National HIV/AIDS Strategy" (2011), available at <http://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-operational-plan-overview.pdf>.
- 109 New York State Department of State, "New York State Interagency Task Force on HIV/AIDS," available at <http://www.health.ny.gov/Diseases/Aids/Reports/Taskforce.htm>; Texas Department of State Health Services, "Interagency Coordinating Council for HIV and Hepatitis" (2012), available at [www.dshs.state.tx.us/Hivstd/Reports/Interagencycouncil-report.pdf](http://www.dshs.state.tx.us/Hivstd/Reports/Interagencycouncil-report.pdf).
- 110 New York State Department of State, "New York State Interagency Task Force on HIV/AIDS."
- 111 Center for Disease Control and Prevention, "Program Collaboration and Service Integration," available at <http://www.cdc.gov/Nchhstp/Programintegration/About.htm>.
- 112 Act Against AIDS, "About Act Against AIDS," available at <http://www.actagainstaids.org/About/>