



Town Hall Meeting

***AIDS, Color and Equality:
Removing Barriers to HIV Prevention***

April 11-12, 2007
The Equality Center
Washington, DC

Summary of April 12 Session

Shelley Hayes, Chair of the ABA AIDS Coordinating Committee, opened the meeting by welcoming participants and explaining that one of the purposes of the Town Hall was to help inform ABA policy.

Mike Wenger, from the Joint Center for Political and Economic Studies, introduced "A 'Shout-out' from Youth to Our Nation's Leaders: Report of the Youth Taskforce on the Sexual and Reproductive Health and Behavior of Young Men of Color." He stressed the importance of involving young people in research and policy-making on HIV/AIDS-related issues.

Irene Natividad, moderator for the morning panel on HIV/AIDS in women and children, asked why society has such negative perceptions of youth sexual behavior, particularly of minority youth, even though statistics show that incidence of STD and teen pregnancy is decreasing? Town Hall participants responded:

- The media portrays African American youth, especially young black men, negatively. Negative stories and statistics are considered newsworthy. Should black media be responsible for countering these negative images?
- People of color absorb negative values through environment. How do people of color promote themselves?
- What are the values of the Black middle class? Is upward mobility the same in communities of color as in other communities? How are values of blacks in cities different from values of blacks in suburban areas? Color may not have anything to do with values after adjusting for SES.
- There is a long and painful history of racial tensions and discrimination that continues today, as exemplified by the recent scandal over racist comments made by Don Imus. This sets progress back and reinforces negative images.
- Cultural change is very difficult to undertake – legislation alone cannot do it.

Should sex education be mandatory in schools? Town Hall participants responded:

- The government is increasing funding for abstinence-only education, but some educators do talk about safe sex (albeit very quietly).
- Abstinence and delay of sexual debut is important. Older youth can negotiate sex better. Children need to be empowered to delay having sex. Role models are needed.
- There is a misunderstanding about what sex education entails. People think you will teach kids how to have sex. But safe sex education is more than just instruction on using condoms.
- Sex education should be gender-specific.

How do we determine what information should be given in schools?

- Important to look at evidence. Comprehensive approaches are most effective, and studies show that they do not increase sexual activity among youth. Abstinence-only education has a high failure rate.
- There is a moral argument for comprehensive sex education. We can't limit options as to how we treat youth STD and HIV and pregnancy. We wouldn't do that with adult illnesses.
- Churches have a major impact in some communities and can play an important role in sex education.
- Empowerment of youth is key.

Denise Halfors, Senior Research Scientist at the Chapel Hill Center, introduced her paper on "Sexual and Drug Behavior Patterns and HIV/STD Racial Disparities: The Need for New Directions." Town Hall participants commented:

- Gender-specific sex education is necessary. Girls think there is a lot of shame attached to sex, and not that much benefit. Boys think there is a lot of benefit, but not much shame.
- It is important to encourage delay of sexual debut.
- There is a relationship between early sex behavior and school achievement, which has important implications for the success of young black men.
- It is important to distinguish between north and south, rural and urban youth. There are significant disparities in knowledge about sexuality and safe sex.
- White people go to therapy, black people go to church. Important to use church to teach safe sex.

What can lawyers do? Town Hall participants commented:

- Legislators are either not aware of issues surrounding comprehensive sex education, or are not paying attention to constituents who want it. Lawyers can help advocate on state and local levels.
- The ABA needs to get behind comprehensive sexual education policies and legislation.
- Empower those who are living with HIV through social and legal support.
- Engage in issues surrounding healthcare in correctional facilities, especially for juveniles.
- What can legislators and healthcare professionals do to ensure access to treatment, especially in low-income communities?
- There is a historical disconnect between healthcare professionals and the black community. A subgroup of blacks avoids testing because they think there is a conspiracy to infect them. Where does that fear come from? The medical community has a responsibility to address fear and to move things forward.

Has access to treatment worsened in the last few years? Town Hall participants commented:

- Are predominantly white HIV organizations receiving most of the money but not sharing it with minority groups that are disproportionately affected?
- Is the HIV prevention message racialized? Should it be?
- As pay-for-performance physician reimbursement becomes more common, physicians are less likely to see low-income black patients because they have more serious and difficult-to-treat health conditions.
- There is no funding to provide care and treatment after routine testing.
- Bring black professional community to look at disparities, insurance practices. Create consortium to influence policy.

Gloria Browne Marshall, Co-Chair of the AIDS Coordinating Committee's HIV in Prisons Subcommittee, introduced a draft Committee paper, "From Cell Block to Your Block: HIV/AIDS in Prisons and Communities," after which **Paul Butler**, Professor of Law at George Washington University and

moderator of the town hall session on HIV in Prisons, asked if HIV/AIDS truly is a problem in correctional facilities. Town Hall participants commented:

- What happens in jail will eventually make it out into the community.
- For some inmates, jail is actually a step up – they can get access to services, meals, training.
- Inmates are human beings and entitled to healthcare.
- Competing priorities can create “compassion fatigue.”
- There is a very high incarceration rate of juveniles.
- Correctional officials should keep released inmates on medication for 30 days until they can get into other treatment. Most people have a lot of trouble getting stabilized upon release.
- It is cost-effective to treat people in prison.
- Right to sexual healthcare, not just protection of public health.

Why not segregate HIV-positive prisoners? Town Hall participants commented:

- Would we end up with more segregated facilities than we can afford?
- Would there be quality of medical care? Would that create more discrimination from staff? Or would it reduce “hate crimes” in general prison population?
- Should we test staff also? Should HIV-positive staff be segregated? Should we prevent everyone with HIV from visiting?
- False negatives (occurring during first three months of infection, when there is very high infectivity) would create even greater transmission risk.
- Segregation improves quality of care – doctors are more experienced.
- Why limit segregation to HIV? What about Hepatitis?

Is mandatory testing a good idea? Town Hall participants commented:

- False sense of security if they test negative?
- No one ever regrets getting a test. It is getting a positive result that is the problem.
- People who get tested alter their behavior, at least for a while.
- Stigma affects people’s willingness to get services.
- HIV status can affect parole.
- Studies show that people’s willingness to engage in prevention, get care, depends on trust of physicians. Doesn’t make sense to coerce.
- Prisoners don’t get a lot of health information. Why do you think they would voluntarily get tested?

Town Hall participants’ comments on harm reduction:

- Mandatory condoms – does this condone illegal behavior?
- Does distributing condoms encourage sex? Why is it bad to encourage sex?
- Seems like prisoners would not want to stigmatize themselves by admitting they are having sex with men (or committing illegal acts).
- Want to punish prisoners in every way shape and form – denial of safe sex.

Robert Dinerstein, Professor of Law at American University, moderated the session on the Ryan White CARE Act.

- Why did Ryan White become the face of HIV? Because he was a white child, not a drug user, not black, not gay.
- 75% of funding must to medical services. But where should money go? Where the need is greatest. HIV is not solely a biomedical issue. What is the biggest barrier to getting care? Transportation, privacy, stigma.
- Artificial characterization of what is medical and non-medical.

- Medical-Legal Partnerships – doctors first recognized need for this.

What would you want to see in a CARE Act reauthorization bill? Town Hall participants commented:

- Housing is a big issue. But how do you get information out to Congress? How do you make them understand? They would say there's section 8 and HOPWA. What about people who are convicted felons? They are ineligible in some states.
- Congress makes distinctions between "good" poor and "bad" poor.
- Formula does not award appropriate funding per patient. Must be evidence based.
- ABA should be on HHS committee that reviews these proposals.
- ABA Government Affairs Office to meet with HHS staff.
- Send letters to staff of presidential candidates. Become one of their resource people who they can call in formulating policy. Especially important for direct service providers to do because they have first-hand have a lot of information.
- Why aren't more people up in arms about testing as an end in itself without any consideration of treatment?
- A test is not enough; it should not be an end in itself.
- Is there a connection between eliminating information and increasing testing rates?
- All counseling is not equal. General knowledge about HIV is relatively high. Other counseling is more important. Tailor counseling – some people need brochure, some people need video, some people need one-on-one. A lot of providers think counseling is too time consuming.
- No longer have to have written consent. Does that eliminate a component of informed consent?