



**GLOSSARY:**

**PWA = PERSON WITH AIDS**

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**Topics**

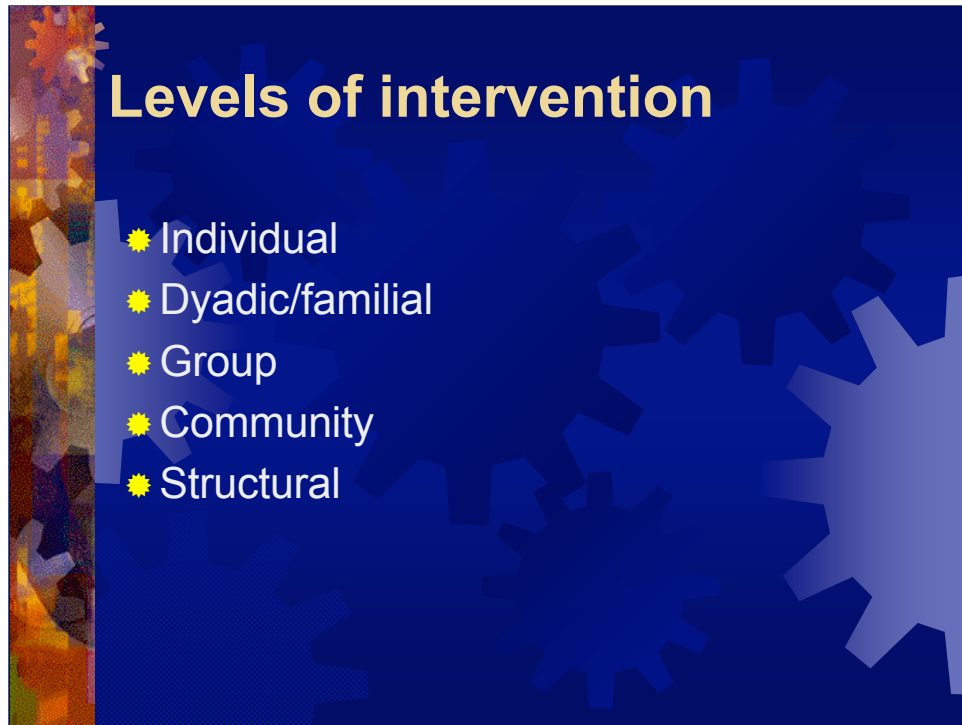
- **The state of HIV prevention research**
- **“What’s wrong with this picture?”**
- **The state of HIV prevention policy**
  - **CDC: AHP and Other Issues**
  - **Science conflicting with politics**

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## What is HIV Prevention?

- ✦ Any policy, strategy, program or action that prevents the transmission of HIV from an infected to an uninfected person ... or reduces the rate of HIV infection in a community or population ... or reduces the risk of HIV spread
- ✦ An action or program to change behaviors or policies to reduce HIV risk is often called an intervention



**GLOSSARY:**

**INDIVIDUAL** = COUNSELLING OR 1:1S

**DYADIC/FAMILIAL** = TWO'SOME

**COMMUNITY** = SOCIAL MARKETING, COMMUNITY MOBILIZATION

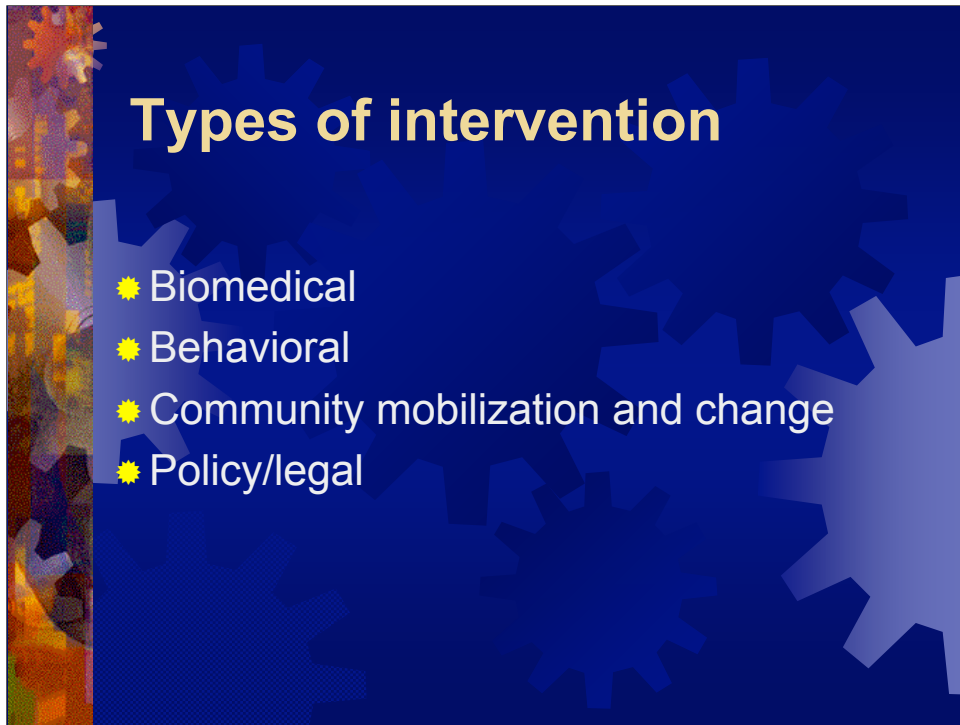
**STRUCTURAL** = POLICY, LAW ETC.

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### GLOSSARY:

**BIOMEDICAL** = CONDOMS / VACCINES / PROPHYLAXIS

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## Research: The Funding

- Most funding from NIH (biomedical through NIAID, behavioral via NIMH)
- Significant funding from CDC
- Small funding from states, foundations
- NIH funds mostly extramural research
- CDC mix of intramural & cooperative

### GLOSSARY:

**NIMH** = NATIONAL INSTITUTE OF MENTAL HEALTH

**EXTRAMURAL** = OFF-CAMPUS

**INTRAMURAL** = MORE IN-HOUSE , MAINTAINING DIRECT CONTROL

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## Research: The Players

- Network of established academic researchers and centers, e.g. Columbia, Yale, Emory, Medical College of Wisconsin, UCSF, UCLA
- Close ties to the government funders
- Few are persons of color (more women, gays)
- NIH funds mostly investigator-initiated proposals (RO1's)
- CDC often uses cooperative agreements
- Peer review panels key in decisions

### GLOSSARY:

#### **PEER REVIEW PANELS =**

THE GOVERNMENT CONVENES A PANEL TO REVIEW THE PROPOSALS FOR FUNDING AND SCORE THEM.

PEER REVIEW PANELS ARE SUPPOSED TO INSULATE THE WHOLE PROCESS FROM POLITICS BUT THIS DOES NOT HAPPEN.

THE PANEL IS POPULATED BY THE SAME SOCIAL NETWORKS AS IN THE POLITICAL ARENA – THIS MAKES IT VERY HARD FOR NEW RESEARCHERS TO ACHIEVE FUNDING.

**P.I.** = PRINCIPAL INVESTIGATOR – PERSON IN CHARGE OF THE RESEARCH AT A LOCAL LEVEL.

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## Research: Key Characteristics

- Overall, inordinately controlled by physicians and uses biomedical and clinical models of understanding
- Behavioral research mostly by psychologists or using individual paradigms, with some but limited awareness of social and cultural influences on human behavior
- Tends to focus on a limited intervention
- Usually short-term in delivery, follow-up

### EXPLANATIONS:

#### **BIOMEDICAL AND CLINICAL MODELS OF UNDERSTANDING -**

RESEARCH GENERALLY DOESN'T START WITH A SOCIAL OR CULTURAL MODEL THAT CONCERNS PEOPLES' BEHAVIOR.

#### **BEHAVIORAL RESEARCH MOSTLY BY PSYCHOLOGISTS OR USING INDIVIDUAL PARADIGMS -**

THIS MEANS THAT BEHAVIORAL RESEARCH OFTEN FOCUSES ON CHANGING THE INDIVIDUAL AND IS NOT VERY BROAD. RESEARCH IS CONDUCTED ON A 1:1 BASIS – IT DOES NOT REALLY LOOK AT SOCIAL AND CULTURAL FACTORS – JUST THE INDIVIDUAL.

#### **RESEARCH IS USUALLY VERY SHORT TERM -**

THIS MEANS THAT IT IS EASIER TO CONDUCT AND MUCH CHEAPER.

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## Research: More Characteristics

- “Endpoints” tend to be “soft,” i.e. measure self-reported behavior change, not whether HIV transmission has actually been reduced
- Try to emulate clinical drug trials in having randomization, control groups
- Little research is “operational” or “translational,” i.e. what happens when a researched intervention is put into wide practice and/or with different populations

**EXPLANATIONS/GLOSSARY:**

**ENDPOINTS –**

THIS IS WHAT YOU MEASURE IN A STUDY TO SEE IF SOMETHING HAS HAD AN EFFECT OR NOT.

**LITTLE RESEARCH IS TRANSLATIONAL –**

I.E. IT IS NOT TAKEN BEYOND THE ORIGINAL RESEARCH CONTEXT, FOR EXAMPLE INTO ANOTHER NEIGHBOURHOOD OR STATE.

**COMMENTS/QUESTIONS FROM PARTICIPANTS:**

COMMENT:

*I PARTICIPATED IN A RESEARCH STUDY AND CAN CONFIRM THAT IT USED*

*“SOFT” ENDPOINTS AS IT RELIED ON PEOPLE TELLING THE TRUTH ABOUT WHETHER THEY CAN CHANGED THEIR ATTITUDE TO USING CONDOMS OVER A 30 DAY PERIOD.*

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## Research: Some Findings

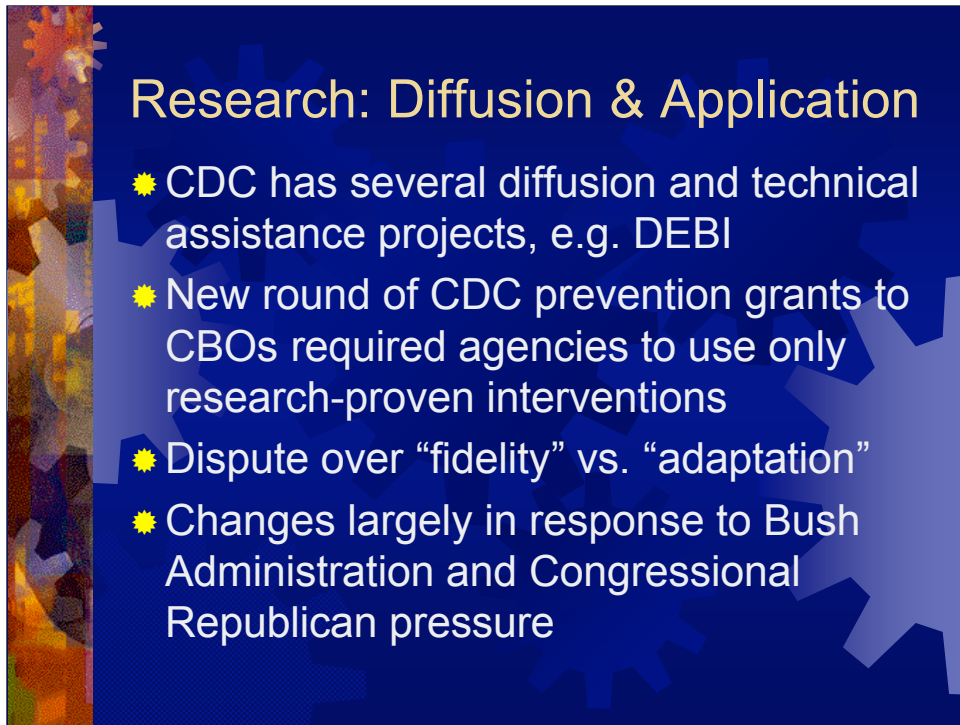
- Behavioral prevention interventions work, at least some of them among some groups! **CAN** work in any group.
- More effective ones tend to be longer and more comprehensive, include skills development, are culturally relevant, change social status. (Theory based ?)
- Effects are modest, e.g. a 25-40% risk reduction over relatively short time

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## Research: Diffusion & Application

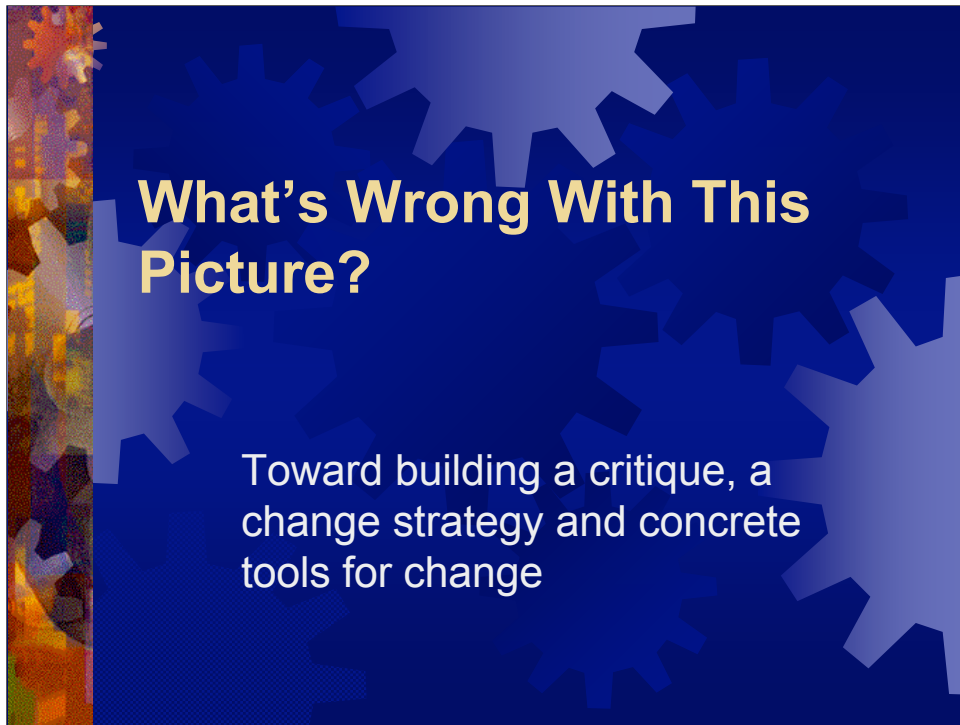
- CDC has several diffusion and technical assistance projects, e.g. DEBI
- New round of CDC prevention grants to CBOs required agencies to use only research-proven interventions
- Dispute over “fidelity” vs. “adaptation”
- Changes largely in response to Bush Administration and Congressional Republican pressure

### GLOSSARY :

**DEBI** = DIFFUSION OF EFFECTIVE BEHAVIORAL INTERVENTIONS

**TECHNICAL ASSISTANCE PROJECTS** = THESE PROJECTS TAKE THE RESEARCH AND PUT IT INTO ACTION.

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## The Paradigm

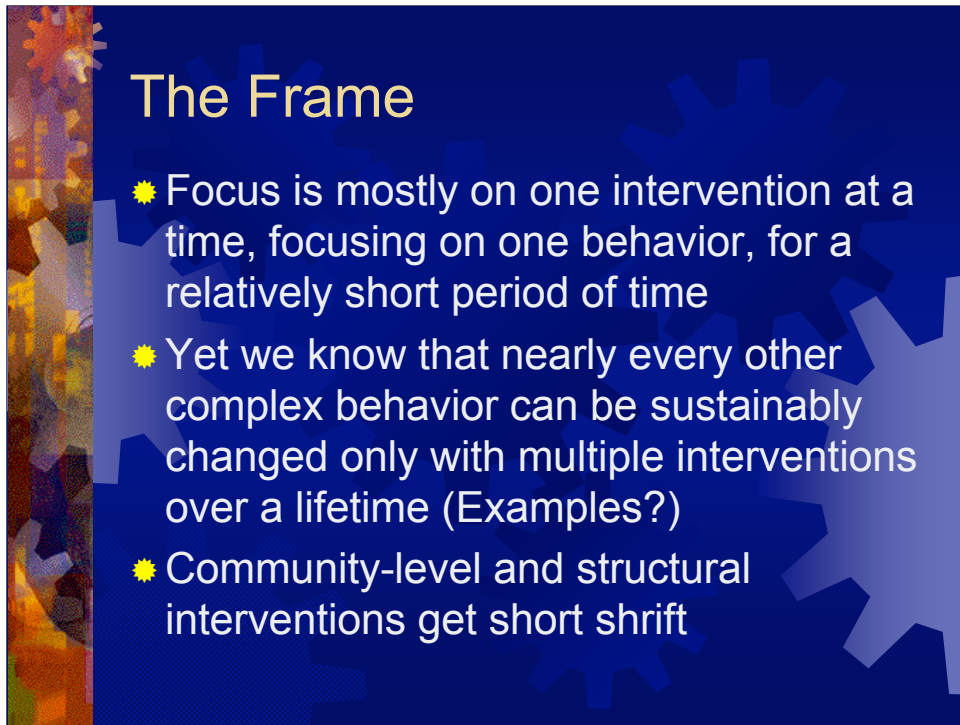
- ☀ The focus is on the individual, whereas our lives are social and cultural
- ☀ The individual must have the **power** to make changes, and that requires more than “attitude adjustment,” “overcoming knowledge deficits,” or even learning new skills.
- ☀ HIV risk does not exist in isolation from all other social burden, need, oppression
- ☀ How can we change the paradigm?

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## The Frame

- ☀ Focus is mostly on one intervention at a time, focusing on one behavior, for a relatively short period of time
- ☀ Yet we know that nearly every other complex behavior can be sustainably changed only with multiple interventions over a lifetime (Examples?)
- ☀ Community-level and structural interventions get short shrift

### EXPLANATIONS:

#### ***MULTIPLE INTERVENTIONS OVER A LIFETIME -***

FOR EXAMPLE WITH YOUR DIET – YOU NEED MORE THAN ONE COUNSELLING SESSION!

IT IS HARD AND EXPENSIVE TO RESEARCH BEHAVIOR

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## The Players & Populations

- Most behavioral prevention research not done in the populations most affected
- Particularly weak for transgenders, gay/bi men of color, HIV+ people, incarcerated and post-incarcerated, immigrants, people with combined risks
- Researchers and research institutions overwhelmingly white

### EXPLANATIONS:

MOST BEHAVIORAL PREVENTION RESEARCH NOT DONE IN POPULATIONS MOST AFFECTED – (SEE READING LIST – 'COMPENDIUM OF HIV INTERVENTIONS WITH EVIDENCE OF EFFECTIVENESS')

THIS IS DUE TO PREJUDICE, FEAR AND THE FACT THAT IT'S HARD TO DO RESEARCH WITH PEOPLE WHO ARE SUSPICIOUS OF RESEARCHERS.

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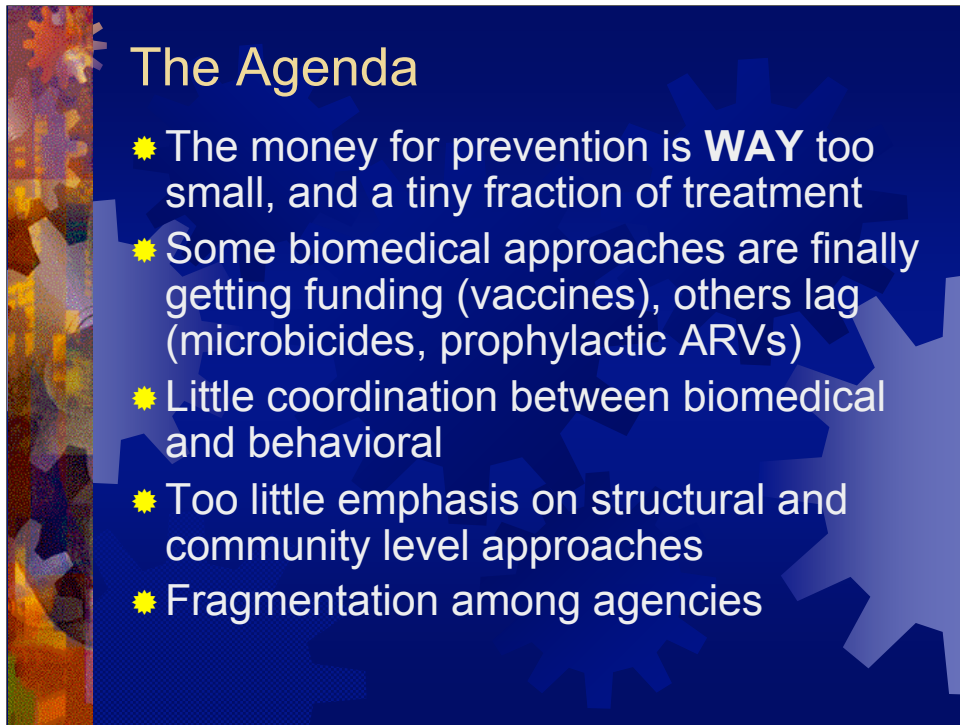
## The Process

- No significant community or “target population” input into framing the agenda, setting priorities, selection of research teams, oversight or telling the story afterward
- It is an “expert” controlled process
- There are occasional “consultations,” token reps on advisory boards, after-the-fact local CABs
- Of late, explicit political interference

### GLOSSARY:

**CONSULTATIONS** = THIS IS WHEN 15-20 PEOPLE ARE INVITED TO COME IN FOR PRESENTATIONS – IT IS THE GOVERNMENT VERSION OF COMMUNITY INPUT. GENERALLY THE DECISIONS HAVE ALREADY BEEN MADE.

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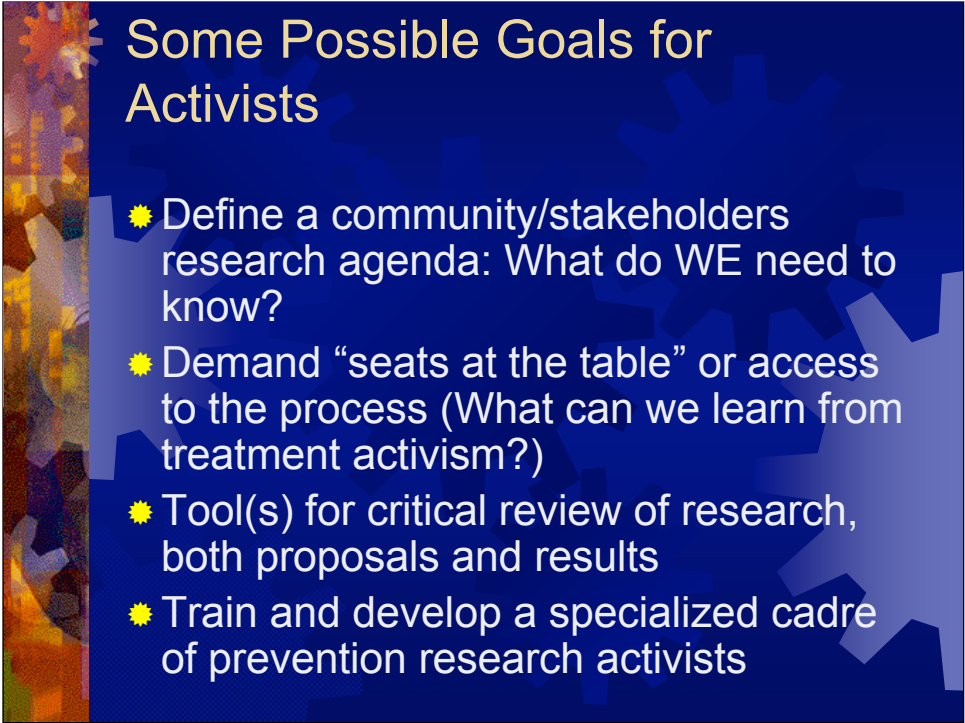
## The Agenda

- The money for prevention is **WAY** too small, and a tiny fraction of treatment
- Some biomedical approaches are finally getting funding (vaccines), others lag (microbicides, prophylactic ARVs)
- Little coordination between biomedical and behavioral
- Too little emphasis on structural and community level approaches
- Fragmentation among agencies

### EXPLANATIONS:

THERE IS A BIG POLITICAL INFLUENCE IN THE ALLOCATION OF FUNDING. PEOPLE HAVE TO BE VERY CAREFUL ABOUT WHAT WORDS THEY USE AND WHAT THINGS THEY MENTION ON THEIR APPLICATIONS OR THE APPLICATION WILL BE IMMEDIATELY DISCARDED.

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## Some Possible Goals for Activists

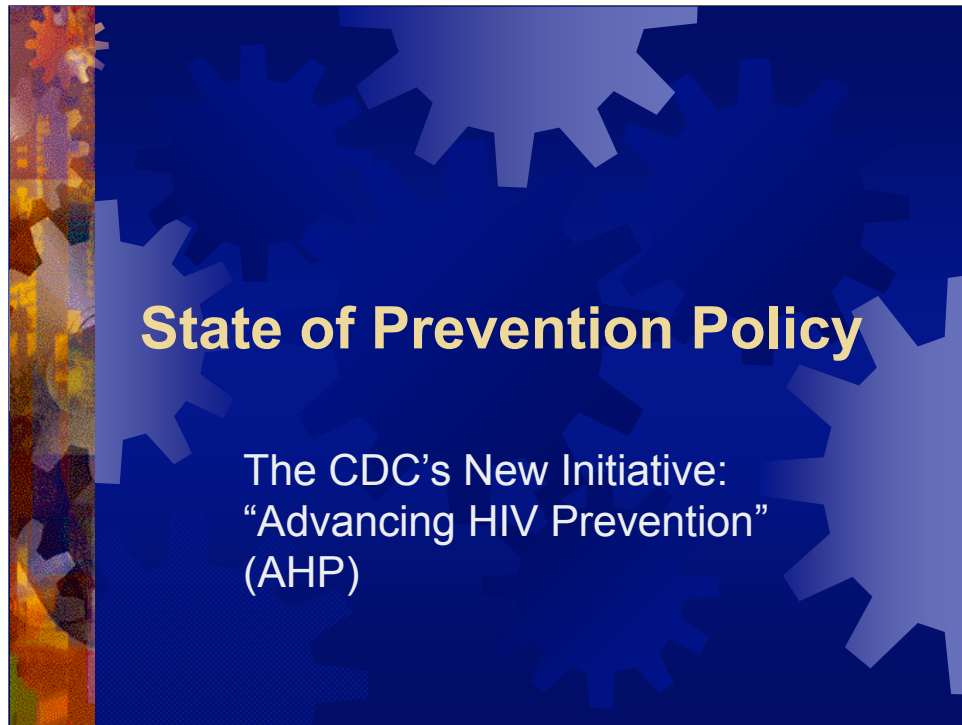
- ☀ Define a community/stakeholders research agenda: What do WE need to know?
- ☀ Demand “seats at the table” or access to the process (What can we learn from treatment activism?)
- ☀ Tool(s) for critical review of research, both proposals and results
- ☀ Train and develop a specialized cadre of prevention research activists

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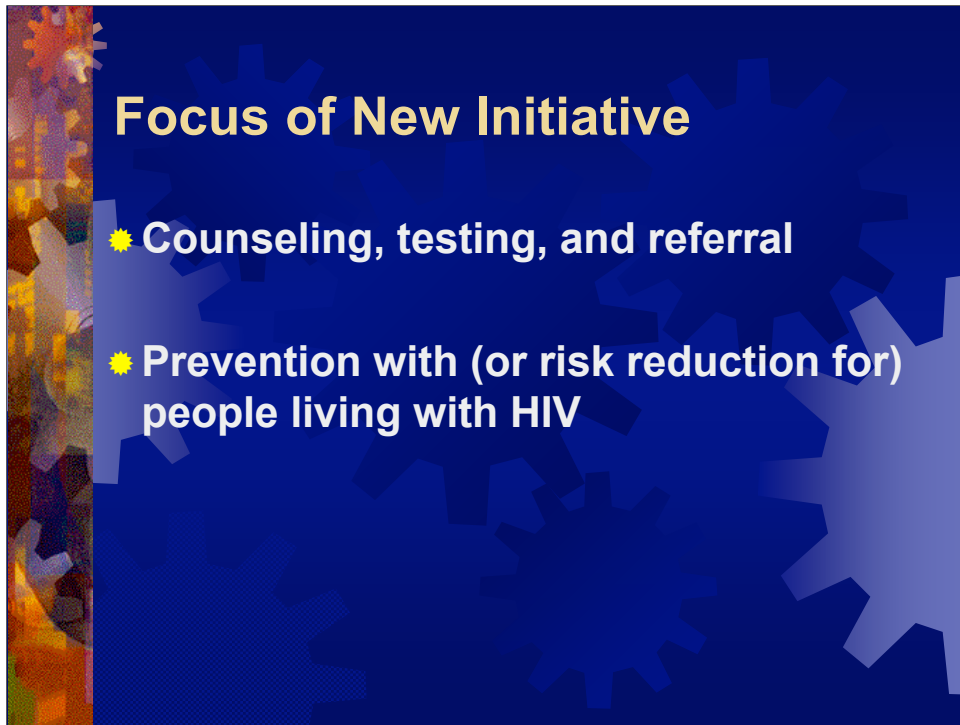
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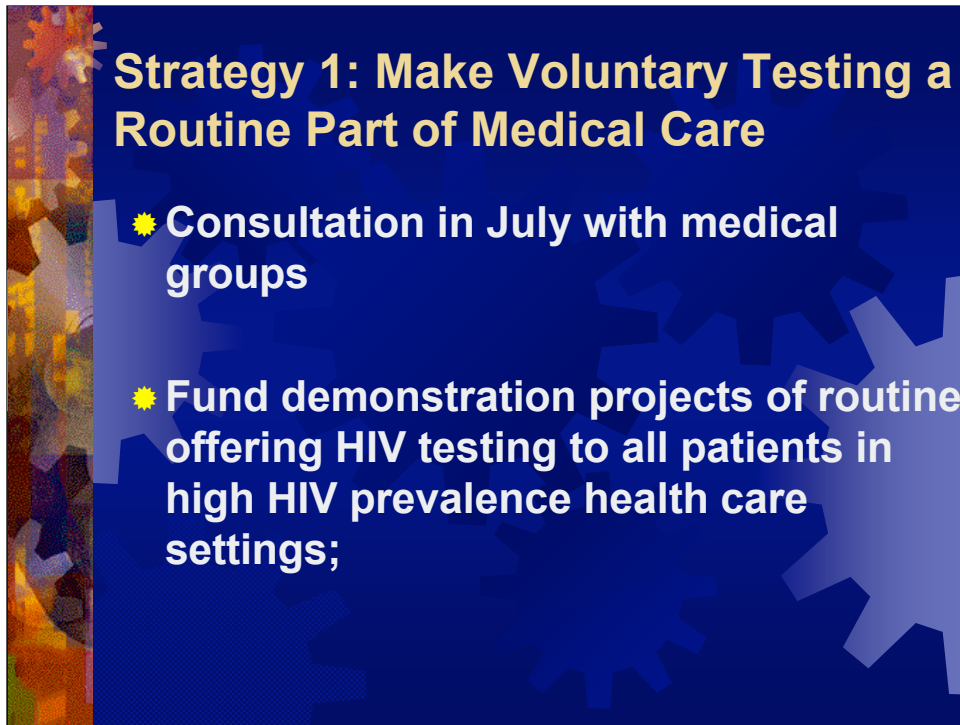
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**Strategy 1: Make Voluntary Testing a Routine Part of Medical Care**

- **Consultation in July with medical groups**
- **Fund demonstration projects of routine offering HIV testing to all patients in high HIV prevalence health care settings;**

**QUESTIONS/COMMENTS FROM PARTICIPANTS:**

QUESTION:

*'WHAT ABOUT THE PRIVACY OF RAPID TESTING?' 'THERE ARE LOTS OF ISSUES WITH RAPID TESTING – THEY DON'T TELL YOU TO BRING SOMEONE WITH YOU.....'*

QUESTION:

*'RAPID TESTING HAS CHANGED THE WHOLE SPECTRUM OF COUNSELLING ...PEOPLE ARE NOT TRAINED TO COUNSEL FOR RAPID TESTING...IT IS VERY DIFFERENT TO THE 2 WEEK WAIT FOR TEST RESULTS..'*

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## **Strategy 2: Implement New Models for Diagnosing HIV Infections**

- **Fund demonstration projects using the rapid HIV test to increase testing in high-HIV prevalence settings in short stay facilities (jails);**
- **Fund CBOs to pilot new models of CTR in nonmedical settings: social networks and rapid testing in nontraditional settings**

### **GLOSSARY:**

**CTR = COUNSELLING, TESTING AND REFERRAL**

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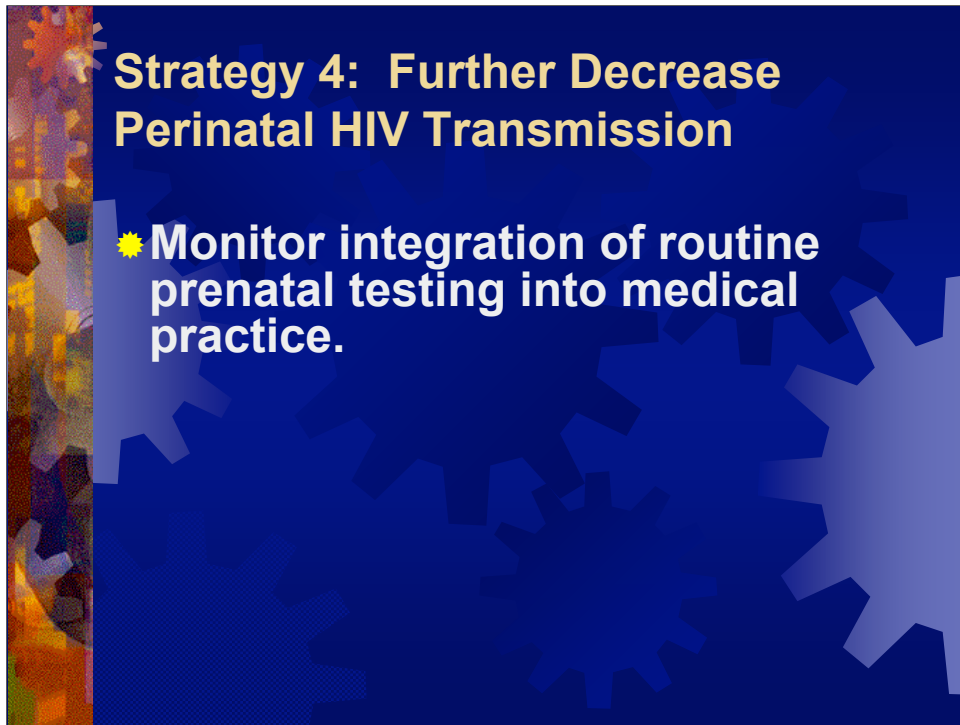
### **Strategy 3: Prevent New Infections by Working with Persons Diagnosed with HIV**

- *Publish Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection (CDC, HRSA, NIH, and IDSA)*
- **Fund demonstration projects to provide PCM for people with HIV who have ongoing high-risk behavior**
- **Fund demonstration projects of new models of PCRS**

**GLOSSARY:**

**PCM** = PREVENTION CARE MANAGEMENT

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**EXPLANATIONS:**

PERINATAL HIV TRANSMISSION REPRESENTS A TINY PROPORTION OF ALL HIV TRANSMISSIONS, IT'S ABOUT 0.33%. THE ISSUE OF PERINATAL TRANSMISSIONS IS ESSENTIALLY A POLITICAL TACTIC.

60% OF NEW INFECTIONS COME FROM PEOPLE WHO DON'T KNOW THEY ARE HIV POSITIVE – THEREFORE IT IS SO IMPORTANT THAT PEOPLE KNOW THEIR STATUS.

**QUESTIONS/COMMENTS FROM PARTICIPANTS:**

QUESTION:

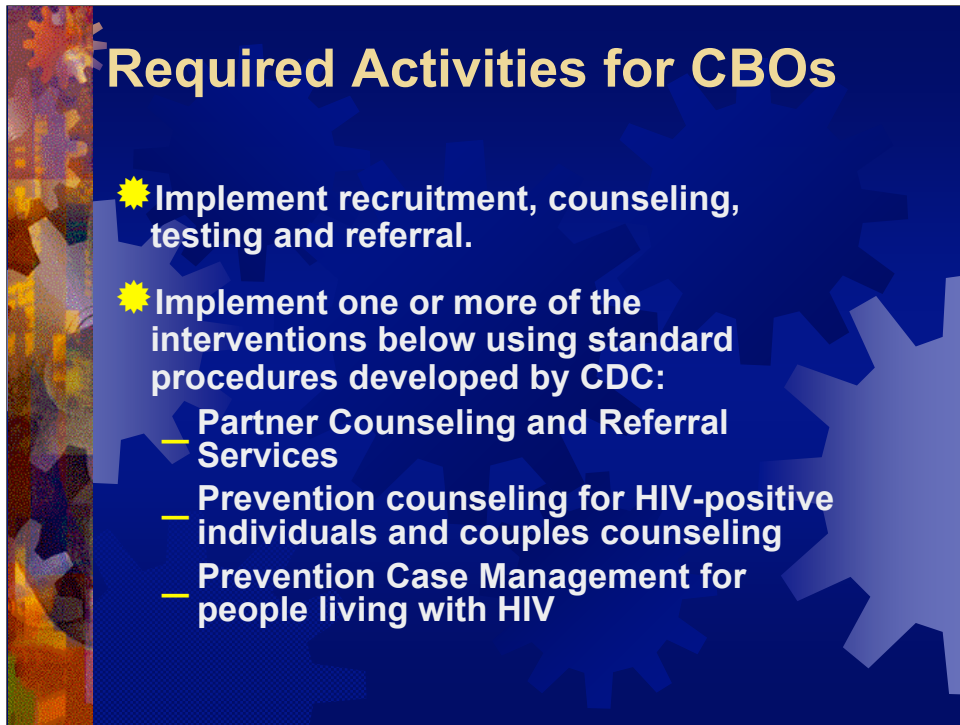
*'IS THERE A CHANGE IN BEHAVIOR WHEN PEOPLE FIND OUT THEIR STATUS?'*

ANSWER FROM WALT: YES – THE RISK FACTORS GO RIGHT DOWN, 1/3 BECOME ABSTINENT, SOME PEOPLE PICK ONLY POSITIVE PARTNERS, OTHERS USE CONDOMS MORE OFTEN.

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**QUESTIONS/COMMENTS FROM PARTICIPANTS:**

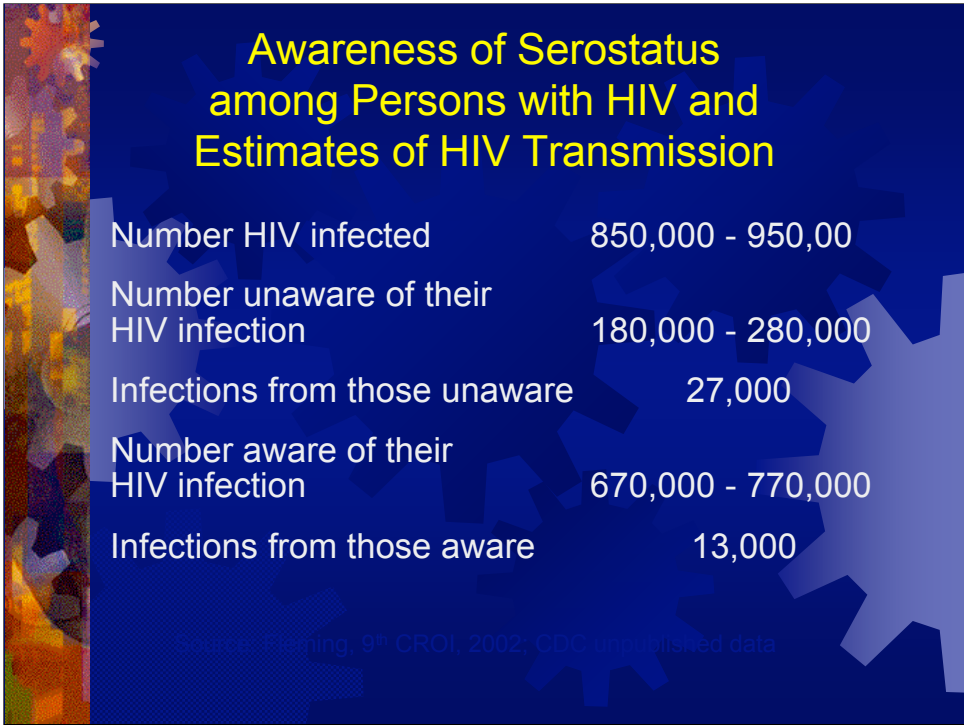
*COMMENT:*

*PARTICIPANT A IS INVOLVED WITH PCM BUT HAS FOUND THAT THERE ARE NO CLEAR-CUT GUIDELINES ABOUT WHO TO TARGET – PEOPLE WHO ARE HIV-POSITIVE OR NEGATIVE? PARTICIPANT A'S IMPRESSION IS THAT THE GUIDELINES ARE VERY CONFLICTING.*

*COMMENT:*

*PARTICIPANT B COMMENTED THAT IT WAS IMPORTANT TO IDENTIFY HIV-POSITIVE PEOPLE THROUGH TESTING BUT AT THE SAME TIME THE TREATMENT PROTOCOLS NEED TO BE EXPANDED AS THERE IS NOT THE MEDICAL PROVISION TO COPE WITH ALL THE POTENTIALLY NEWLY DIAGNOSED HIV-POSITIVE PEOPLE.*

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**EXPLANATIONS:**

25% OF PEOPLE THAT ARE AWARE THAT THEY ARE HIV-POSITIVE DO NOT ACCESS MEDICAL TREATMENT – EITHER BECAUSE THEY HAVE OTHER SEEMINGLY MORE PRESSING PROBLEMS, BECAUSE THEY ARE IN DENIAL OR BECAUSE THEY LITERALLY HAVE NO ACCESS TO MEDICAL TREATMENT.

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## **Why Work with People Living with HIV?**

- ☀ By reducing the risk behavior of one person living with HIV, we have the potential to prevent multiple infections.**
- ☀ By reducing the risk behavior of one person who is not infected with HIV, we have the potential to prevent one infection.**

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## Why Prevention with Positives

- ☀ **In a population where HIV prevalence is 20%, there is a 1 in 5 chance that an uninfected person will come into contact with a person with HIV**
- ☀ **However, there is always a chance a person with HIV may transmit to an uninfected person in a single sexual or needle sharing contact**

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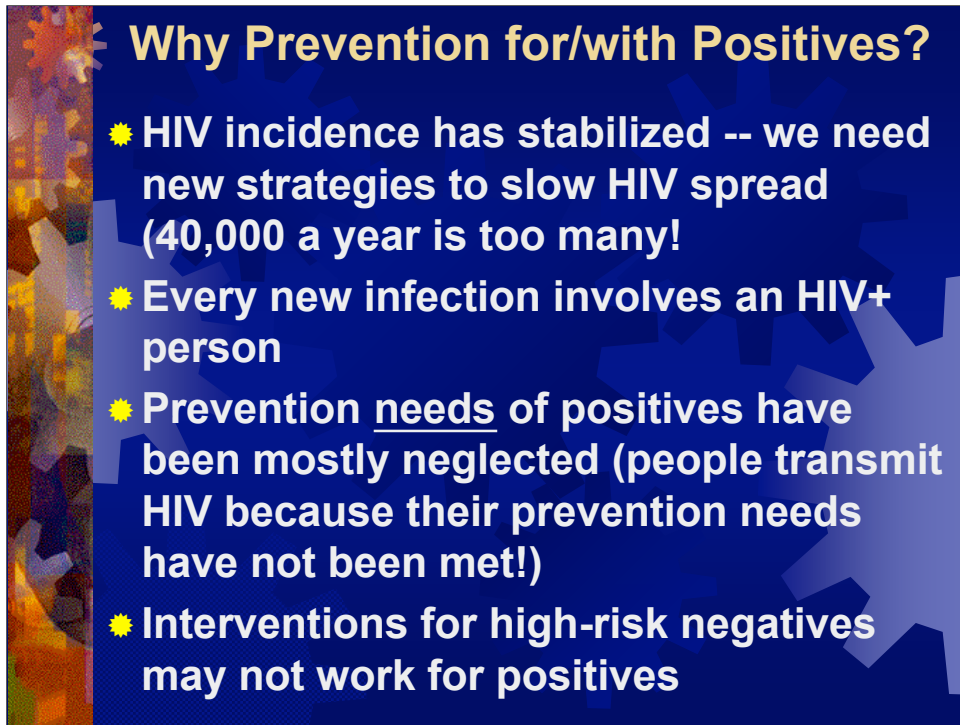
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## A slightly different take!

- Why “prevention with positives” and what it is in the words of a positive epidemiologist (next several slides)

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## **Why Prevention for/with Positives?**

- ☀ HIV incidence has stabilized -- we need new strategies to slow HIV spread (40,000 a year is too many!**
- ☀ Every new infection involves an HIV+ person**
- ☀ Prevention needs of positives have been mostly neglected (people transmit HIV because their prevention needs have not been met!)**
- ☀ Interventions for high-risk negatives may not work for positives**

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## **Integrate Treatment and Prevention?**

- **Because of treatment advances more people with HIV are living longer and better lives**
- **Treatment advances have also contributed to complacency and increased risk behavior in some high risk communities**
- **Proportion of new infections with drug-resistant virus is increasing**
- **Treatment settings may be best place to access HIV+ for prevention interventions**

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## Comparing "Natural History" Pre- And Post-HAART

"Untreated": true natural history

9 yrs (8-11 yrs) 1.5 yrs

HIV Infection      AIDS      Death

"Treated" history

> 11 yrs

> 6 yrs

HIV Infection      AIDS      Death

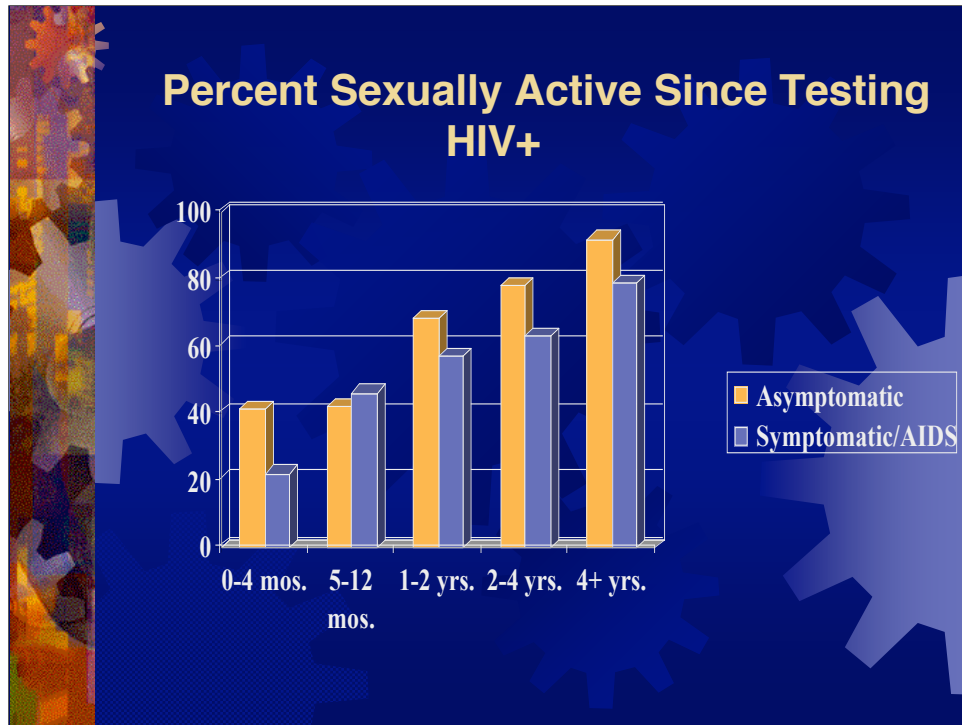
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**QUESTIONS/COMMENTS FROM PARTICIPANTS:**

QUESTION:

DOES THE CDC ACKNOWLEDGE THAT PEOPLE ON HIV DRUGS TRANSMIT THE VIRUS LESS DUE TO THE EFFECTIVENESS OF THE MEDICATION?

ANSWER – THERE IS NO SYSTEMATIC LARGE SCALE STUDY INTO THE TRANSMISSION OF HIV IF YOU ARE ON HIV-DRUGS. THERE WOULD BE MANY ETHICAL PROBLEMS IN CONDUCTING THIS TYPE OF RESEARCH – AS YOU WOULD HAVE TO SIT BACK AND WATCH THE TRANSMISSION OF HIV WHICH YOU COULD HAVE PREVENTED IN ORDER TO HAVE A MEANINGFUL TRIAL.

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## What is Prevention with Positives?

- \* A continuum ... or a rainbow
- \* Starts with **finding, reaching and engaging** HIV-positive persons who don't know it or are not in care and services
- \* **Links** them to HIV medical care, other needed clinical care, social services, social support, and prevention [the "BIG FIVE"]
- \* Provides a multiplex and lifelong range of **risk reduction interventions**
- \* Supports **maintenance**, in care ...adherence to regimens ... of behavioral and life changes ... of hope and wellness

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## **Mobilizing Positive Power in Finding, Reaching, Engaging Unaware +s**

### **Social Networks of Clients/Patients:**

**Oasis Clinic (L.A.) example – Over 5 years,  
200+ HIV+ patients have brought in 490+  
network contacts for testing and  
counseling: 37% tested positive, of whom  
100% got results and 92% entered care**

**Replication/adaptation study underway**

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## More Positive Power in Case Finding

- ☀ Interviews of persons new/recently infected ... to target prevention effort.  
Example: *Project Open Window, LA*:  
Identified 100 cases of seroconversion in two years: 73% associated with sex while high on alcohol/drugs (crystal meth in white/Latino; cocaine in AA/Latino); 60% in public sex environments

## Positive Power for Linking

- **BRIDGE Project (PHIPP/CA) ... 16 EIP clinics in CA; Peer outreach worker attached to clinic staff and trained in CTR and Treatment Education; 1) Try to find clinic patients who quite coming; 2) Present for + test results at community testing sites, 3) Help link to care, or stay in touch and educate/support until client ready**
- **Found and linked 50% of those lost**

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## **More Positive Power for Linking**

- ✦ **Positive Buddies**
- ✦ **Multi-service mobile vans**
- ✦ **Community delivery of positive test results**
- ✦ **Stipended peer community liaison workers, e.g. with syringe exchange, drug treatment centers, release-from-incarceration programs**

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## **What Positive People Want from Prevention Programs**

- ✦ **Sex-positive and love-positive messages and programs**
- ✦ **Not to be further stigmatized/blamed**
- ✦ **Differing programs for differing needs**
- ✦ **Social connection with other PLWHAs**
- ✦ **Wellness and wholeness orientation**
- ✦ **Positive people involved, employed, leading**

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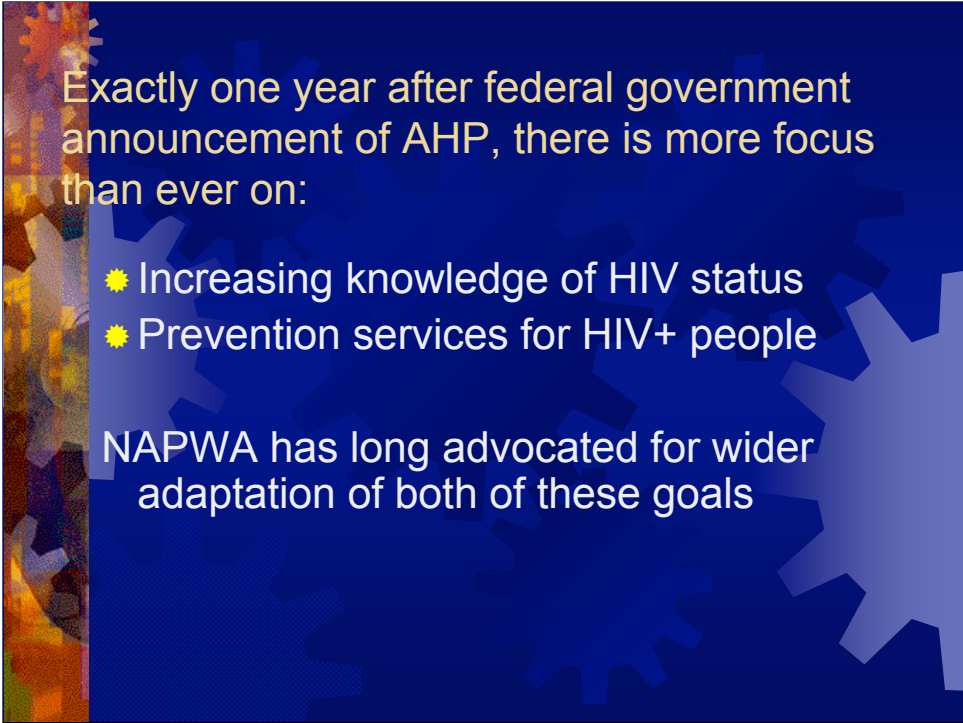
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## Expanding the Boundaries of Positive Prevention Programmes




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Exactly one year after federal government announcement of AHP, there is more focus than ever on:

- Increasing knowledge of HIV status
- Prevention services for HIV+ people

NAPWA has long advocated for wider adaptation of both of these goals



## But AHP has been flawed from the beginning

- No prior consultation/ secretive roll-out
- Positive people not involved
- Politically inspired
- Overly reliant on medical and individual level interventions
- Lacks sound scientific basis in many areas
- Displaces important intervention funding
- Increases stigma and blame
- Includes no plan for care and treatment
- Unlikely to be effective

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## Medicalizing/ Individualizing HIV Prevention

- Initial announcement, April 2003
- Testing
- “On-going case management”
- “Focused risk reduction counseling”
- “Medical interventions”
- “Support of other psychosocial stressors”
- Testing for pregnant women and newborns

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## Medicalizing/ Individualizing HIV Prevention

Ideology of individual responsibility

Ignoring social context of HIV risk

Treating people living with HIV solely as  
“vectors” of new infections

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The slide features a dark blue background with several light blue gears of various sizes. On the left side, there is a vertical strip with a colorful, abstract pattern of orange, yellow, and brown. The title 'Stigmatization' is written in a light yellow font at the top left. Below it, there are three bullet points, each starting with a yellow gear icon. The text is in white, with the third bullet point being italicized.

## Stigmatization

- No language of shared responsibility
- Background of criminalization, discrimination, blame
- “...Initiative has the potential to increase stigma and discrimination against HIV positive persons” - CDC



## Care and treatment

- ? How many new positives will the initiative identify?
- 500, 5,000, 50,000, 150,000 ?



## Care and treatment

- What are the ethics of promoting mass testing with no provision for care?
  - *No national plan for care and treatment*
  - *ADAP waiting lists*
  - *Flat funding for Ryan White*
  - *Medicaid/state level cuts*
  - *Medicare bill's impact on 50,000 HIV+ "dual eligibles"*

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## Is history repeating itself?

☀ 1985 CDC advice on prevention:

“Know your partner”

“Don’t have sex with people who have  
AIDS”

“Avoid the exchange of bodily fluids”



## Making AHP better!

- Demand new resources for prevention and care
- Embrace full range of prevention/ take a comprehensive approach
- Stand up for science
- Learn to use language of shared responsibility/ fight stigma
- National plan for care and treatment
- Reclaim the discussion of meeting the prevention needs of HIV+ people

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## Redefining the “problem”

900,000 HIV+ people

40,000 new infections annually

*Less than 5% annual transmission rate*

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## Redefining the “problem”

CDC estimates:

≈ 700,000 positive people know status

Only ≈ 16,000 transmissions from those  
aware of status

(2% transmission rate)



## Redefining the “problem”

CDC estimates

≈200,000 unaware of infection

≈24,000 transmissions from those  
unaware

(12% transmission rate)

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## Redefining the “problem”

Need to better understand what is behind these stats

- Health status, viral load, duration of infection
- Demographic, sociological, geographic
- Accurate risk profile (MSM, IDU, Het)
- Partner status (long term, serial, casual)
- “transactional” analysis of infection dynamic (intentionality, substance use, disclosure/ non-disclosure, social vulnerability, etc)

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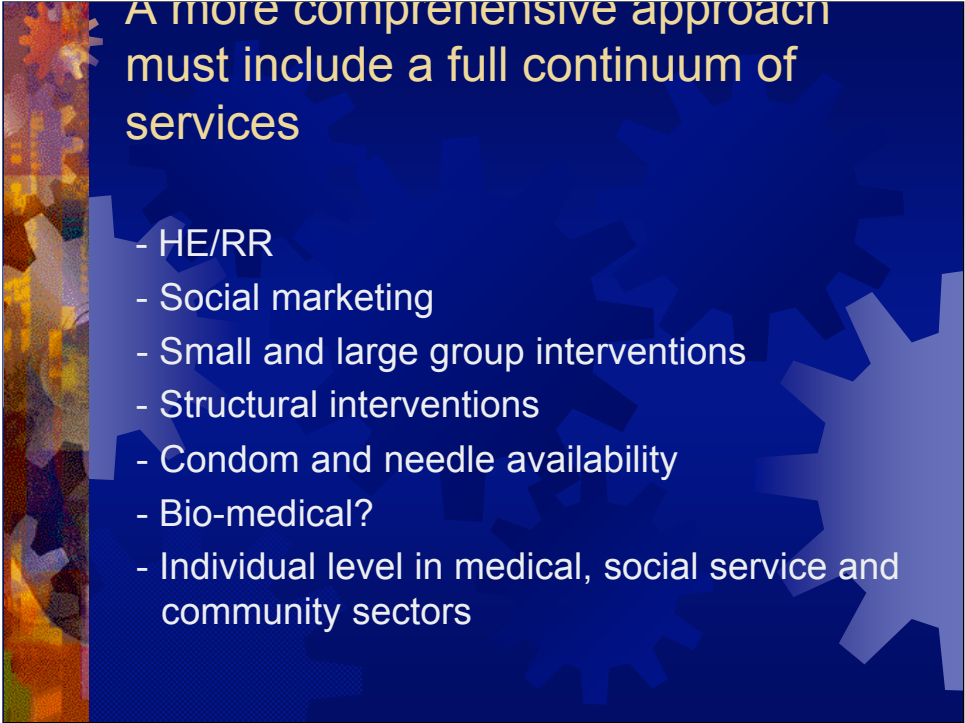
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## Toward a broader view of HIV Prevention for Positives

Meeting the prevention needs of positive  
people

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A more comprehensive approach  
must include a full continuum of  
services

- HE/RR
- Social marketing
- Small and large group interventions
- Structural interventions
- Condom and needle availability
- Bio-medical?
- Individual level in medical, social service and community sectors



## Elements of prevention

Expanding our definition of what prevention is to include:

- Health care
- Housing
- Substance abuse treatment
- Education and economic opportunities
- Mental health services/ self-esteem support
- Domestic violence prevention and services

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## Defining a positive sexuality

The sexuality of HIV positive people is assaulted on many levels

- *Guilt for becoming infected*
- *Post-diagnosis sexual shutdown*
- *Fear of infecting others*
- *Assuming responsibility*
- *Message of "toxicity"*
- *Criminalisation*
- *Demonisation (such as in "barebacking" debate)*
- *Fear of rejection*
- *Body image (lipo, wasting, etc)*
- *Sexual function impacted by disease & treatment*
- *PTS (pre and post diagnosis)*

based in experience of racism, homophobia, poverty, sexism, homelessness, incarceration, domestic violence, sexual & emotional abuse, addiction, dealing with complex system, HIV stigma, etc

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## Defining a positive sexuality

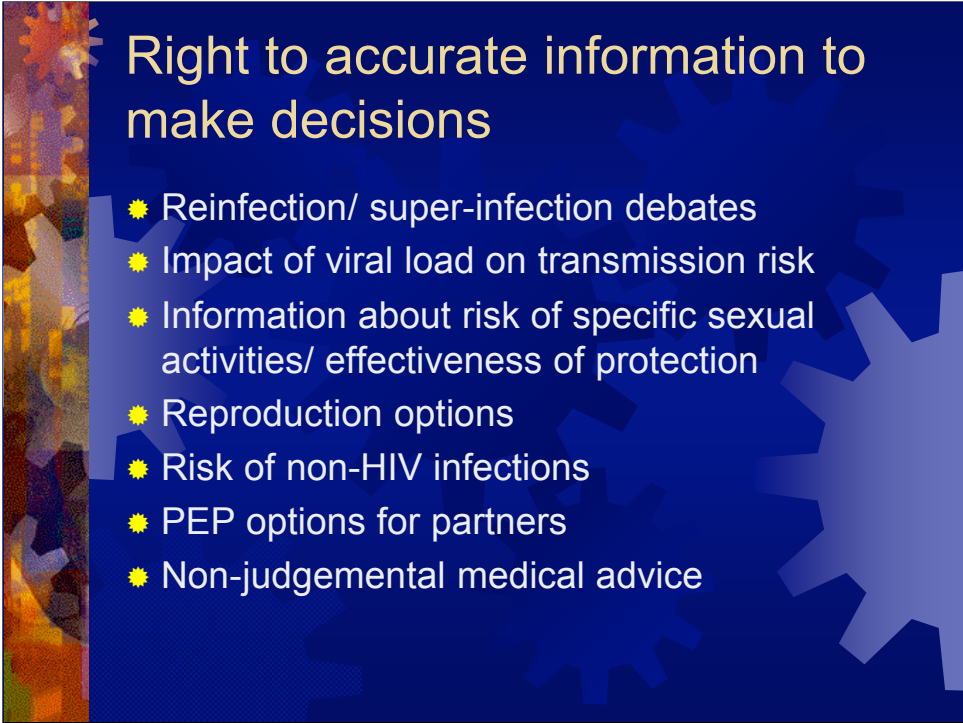
- Prevention programmes must develop and offer a positive view of HIV+ sexuality
- Embracing sexual intimacy as a right and an important part of health
- Helping people identify and achieve a sexual life that meets their needs/priorities while negotiating the complex choices

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## Right to accurate information to make decisions

- Reinfection/ super-infection debates
- Impact of viral load on transmission risk
- Information about risk of specific sexual activities/ effectiveness of protection
- Reproduction options
- Risk of non-HIV infections
- PEP options for partners
- Non-judgemental medical advice

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## Overcoming social isolation

- Near universality of social isolation among HIV+ people
- The demise of support groups, PWA coalitions etc in age of more successful treatment, epidemiologic change
- Need for meaningful social, emotional romantic and sexual opportunities
- Opportunity for dialogue and discussion among HIV+ people
- Creation of a more welcoming community/ overcoming stigma

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## Shared responsibility

- ☀ People living with HIV are willing to accept a special responsibility for avoiding transmission, but we need prevention programmes to communicate a message of responsibility to our partners as well



## Positive driven, positive delivered

- ✦ We are the experts in our lives and our needs
- ✦ Economic, organizational opportunities
- ✦ Credibility, authenticity will help produce success
- ✦ Supported by prevention/ behavioural expertise

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## Other CDC Policy Issues

- ✦ Capitulation to right-wing pressure from HHS and Congress
  - STOP AIDS/SF as case study
  - “Materials review”
  - Got worse, but didn’t start, with Repubs.
- ✦ Censorship/coercion/culling out of community-centric scientists & staff
- ✦ Declining partnerships with CBOs, community stakeholders
- ✦ Exaggerated focus on measurement

### EXPLANATIONS:

**“MATERIALS REVIEW”** – 1992 – CONGRESS PASSED A LAW SAYING THAT YOU CAN’T HAVE HIV PREVENTION MATERIALS THAT PROMOTE SEXUAL BEHAVIOR – NOW IN 2004 THE CDC HAVE RE-WRITTEN THE DETAILS OF THIS LAW AND IT IS EVEN STRICTER.

### QUESTIONS/COMMENTS:

QUESTION:

*WHAT ABOUT FUNDING FOR INITIATIVES WITH HIV-NEGATIVE PEOPLE WHO ARE AT A HIGH RISK OF BECOMING HIV-POSITIVE?*

*ANSWER: THE GOVERNMENT DOESN'T LIKE TO SEPARATE THOSE AT HIGH-RISK AND THOSE AT LOW-RISK – THEY WOULD PREFER TO SIMPLIFY THE MATTER AND SAY THAT EVERYONE IS AT RISK.*

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## Other legal and political challenges

- ☀ Needle and syringe exchanges are still substantially illegal, absent
- ☀ How can we end a sexually transmitted epidemic without talking frankly about sex? Or educating youth/students?
- ☀ HIV-specific criminalization is harmful
- ☀ Abstinence-only and distortion of “ABC”

### GLOSSARY:

**ABC** = ABSTINENCE, BE FAITHFUL, CONDOMS.

### QUESTIONS/COMMENTS FROM PARTICIPANTS:

#### QUESTION:

*‘LANGUAGE IS A BARRIER AS IT PREVENTS PEOPLE FROM TAKING ACTION...PEOPLE JUST TUNE OUT. ARE THERE ORGANIZATIONS WHO WORK TO MAKE JARGON AND SCIENCE MORE ACCESSIBLE?’*

*ANSWER: ‘THIS IS ONE OF THE GOALS OF CHAMP – TO DEFINE THINGS AND MAKE INFORMATION ACCESSIBLE TO PEOPLE WHO NEED IT’*

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## What would it take to change:

- Helms Amendment and other sex-negative, homophobic, transphobic policies written into law ?
- Encourage and fund syringe/needle exchanges?
- Replace abstinence-only funding and programs with comprehensive sex education and empowerment?
- Roll back “medicalization” or prevention in favor of “whole person” social/cultural strategy?

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