NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

NEW YORK CITY COUNCIL

COMMITTEE ON HEALTH AND

COMMITTEE ON WOMEN'S ISSUES

OVERSIGHT HEARING:

THE HIV/AIDS EPIDEMIC AMONG WOMEN IN NEW YORK CITY

LARAY BROWN,
SENIOR VICE PRESIDENT
CORPORATE PLANNING, COMMUNITY HEALTH & INTERGOVERNMENTAL RELATIONS

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

DECEMBER 13, 2007

Good afternoon Chairpersons Rivera and Sears, members of the Health and Women's Issues Committees and other distinguished members of the New York City Council. I am LaRay Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations at the New York City Health and Hospitals Corporation (HHC). Thank you for the opportunity to discuss how HHC serves New Yorkers City living with HIV/AIDS. Following my testimony, Dr. Tod Rothschild, Associate Director of OB/GYN at Queens Hospital Center, will discuss the care and services provided to women with HIV at HHC facilities.

HHC has been at the forefront of diagnosing and providing an array of services to persons with HIV/AIDS for more than a quarter of a century. Dedicated, comprehensive HIV/AIDS care is provided at State Designated AIDS Centers located within HHC's 11 acute care hospitals. HHC's six diagnostic and treatment centers also provide HIV primary care and other related services. Coler-Goldwater, one of HHC's long-term care facilities, provides specialized care to individuals with HIV who require ongoing medical and skilled nursing care. These sites currently serve approximately 19,000 patients with HIV and AIDS. In addition, through HHC's health plan, MetroPlus, we operate a Special Needs Plan (SNP) for people living with HIV/AIDS. With more than 1,350 members, the MetroPlus HIV SNP is the largest of the three in New York State.

I'd like to take a minute to talk about the results of HHC's HIV testing expansion initiative. HHC is committed to improving access to HIV testing so that people are able to learn of their HIV infection earlier in the course of the disease and can be linked to life-prolonging treatment. As you may know, we held a press conference at Gouverneur Health Care Services on the Lower East Side two weeks ago with Speaker Christine Quinn and Council Members Robert Jackson and Alan Gerson to announce that HHC facilities tested nearly 134,000 patients during Fiscal Year 2007 – a 116 percent increase over the 62,023 tested only two years earlier, before our hospitals and health centers began to expand the use of rapid HIV tests and make HIV testing part of routine medical care for patients 13 and above. Of the 134,000 patients tested this year, 51% were Hispanic, 40% were Black, 3% were White, 4% were noted as 'Other' and 2% were Asian. 1,630 patients tested positive for HIV; for just over half of these patients, it was the first time they had heard they were HIV positive. Of the patients who tested HIV positive during the last fiscal year, 48% were female. Our clinics and hospitals often provide the first and only medical contact some previously undiagnosed patients have.

With the financial support HHC has received from the City Council, as well as the New York City Department of Health and Mental Hygiene (DOHMH) and

the U.S. Health Resources Services Administration (HRSA), HHC readily offers HIV testing to patients in every emergency room and in many inpatient units and clinics across our system. By expanding testing and making it available as a routine medical service, we can help overcome the stigma and barriers associated with HIV and AIDS and reach more New Yorkers who may be HIV positive but do not know it. Routinizing HIV testing, and making results available in less than an hour, offers patients a critical opportunity to know their HIV status so they can protect themselves and others. For FY 2008, we are committed to further expansion of our testing program and expect to reach 150,000 patients.

Within HHC, there are a number of facilities with special programs dedicated to the health needs of women with HIV that illustrate both the unique issues faced by women with HIV as well as some of the creative programs we operate. Many of these specialized programs are grant funded. Without these grant funds, HHC would not be able to maintain the critical enabling and educational programs that are absolutely essential to early engagement and retention in care.

At Jacobi Medical Center and North Central Bronx Hospital a Family Service Program provides support groups for adolescent girls and wraps entire families into the care process. The program recognizes that if a single family

member is infected then an entire family is impacted. It provides the support needed to ensure that the patient may continue successfully in care and that the support needs of the patient's family are also addressed.

Lincoln Medical and Mental Health Center's HIV program sees patients and their affected household members who come from diverse ethnic backgrounds and cultures. Lincoln's staff have specialized training to assist these patients. In a joint project between HHC and DOHMH, Lincoln runs a treatment adherence program to help patients take their medications regularly. Lincoln's staff visits the patient's home and observes the patients taking their HIV medication. Lincoln's Bronx Family and Adolescent Children's Consortium Program (providing care for HIV positive children and affected family members) is supported in part by a sub-contract from Montefiore Hospital. Montefiore is the lead agency of this Ryan White Part D consortium which includes Lincoln.

Both Bellevue Hospital and Harlem Hospital run a Transitions Program for older children who were infected perinatally. These programs work with adolescent patients as they 'age' into adult services and teach them to use self-care management techniques that are appropriate for their young adult status. Bellevue is also part of a consortium led by the AIDS Service Center, a Manhattan

Community Based Organization, which provides services to women, youth and families. This is supported by funding from the Ryan White Part D program.

In Queens, Elmhurst Hospital also has a Ryan White Part D Program for women and children where social workers work closely with parents and children in families affected by HIV. A special aspect of this program is the Family Matters Program Partnership with the AIDS Center of Queens (ACQC), which focuses on individual and group counseling for infected parents to help them improve their parenting skills and more importantly, provide the mental and emotional support their children need. At both Elmhurst and Queens Hospital Center, the Ryan White Part D Program also provides counseling support groups for women and adolescents.

Both Woodhull Hospital and Cumberland Diagnostic and Treatment Center (D&TC) participate in the New York State Department of Health's AIDS Institute's Project WAVE to increase community awareness about access to care, prevention and testing. Both also participate in the Brooklyn Prenatal Care Consortium, a community development project in which community based organizations, hospitals, clinics and faith-based organizations work collaboratively to serve pregnant women in North-Central Brooklyn. In addition, Cumberland

D&TC offers special prevention services to educate African-American and Hispanic women of childbearing age, including their sexual partners, about HIV risk behavior, prevention, and transmission.

Harlem Hospital has a Mom-Baby clinic where services are co-located for both adult and child patients making it easier – and therefore more likely - for patients to obtain life extending care. Funding for this program is provided by the New York State's AIDS Institute.

I mentioned the HIV SNP, our managed care plan operated by HHC's MetroPlus Health Plan. Women living with HIV have an increased incidence of cervical cancer and cervical dysplasia. One of the unique services offered to members in our SNP is intensive staff outreach and education that encourages female members to receive annual gynecologic examinations so that these health conditions can be detected early. Women who have not had their annual visits are educated through mailings and telephone contacts on the importance of cervical cancer screening. Moreover, female members who are not actively engaged in care also are targeted in community canvassing efforts if more conventional outreach activities are unsuccessful. The SNP helps ensure patients obtain care by

scheduling members' gynecology appointments and arranging for transportation to the medical visit if required.

To give you an example of some of the challenges of working with pregnant, HIV-positive women I'd like to describe one case: a woman came into care and through our routine HIV screening, was determined to be HIV positive. She was counseled about the availability, desirability and benefits to herself and her unborn child of taking antiretroviral treatment during pregnancy. Although she continued to receive prenatal care, she decided not to initiate treatment for her HIV infection despite repeated counseling throughout most of her pregnancy. Late in pregnancy, she agreed to initiate a course of HIV medications and her care continued. Nevertheless, her child was born HIV-infected. This woman subsequently came into care again for a later pregnancy and this time, chose to take HIV medications immediately - from her first prenatal visit. Between 2003 and 2006, out of approximately 300-400 HIV-positive women giving birth each year, 47 children were born to HIV-positive women in New York State. As Dr. Rothschild will note, only a very small number of the infants born to positive mothers actually are truly infected themselves; this one case illustrates the tremendous importance and impact of ongoing care for both mother and child.

This concludes my written testimony. I would now like to turn to Dr. Tod Rothschild, Associate Director of OB/GYN services at Queens Hospital Center. We would be happy to answer any questions you have at the conclusion of his presentation.

THE HIV/AIDS EPIDEMIC AMONG WOMEN IN NEW YORK CITY

Oversight Hearing of the New York City Council Health and Women's Issues Committees

Tod J Rothschild, MD, Associate Director OBS/GYN Queens Hospital Center (QHC), Assistant Professor OB/GYN Mt. Sinai School of Medicine, Physician Education Officer QHC

December 13, 2007

Seeking and remaining in HIV care can be difficult for women

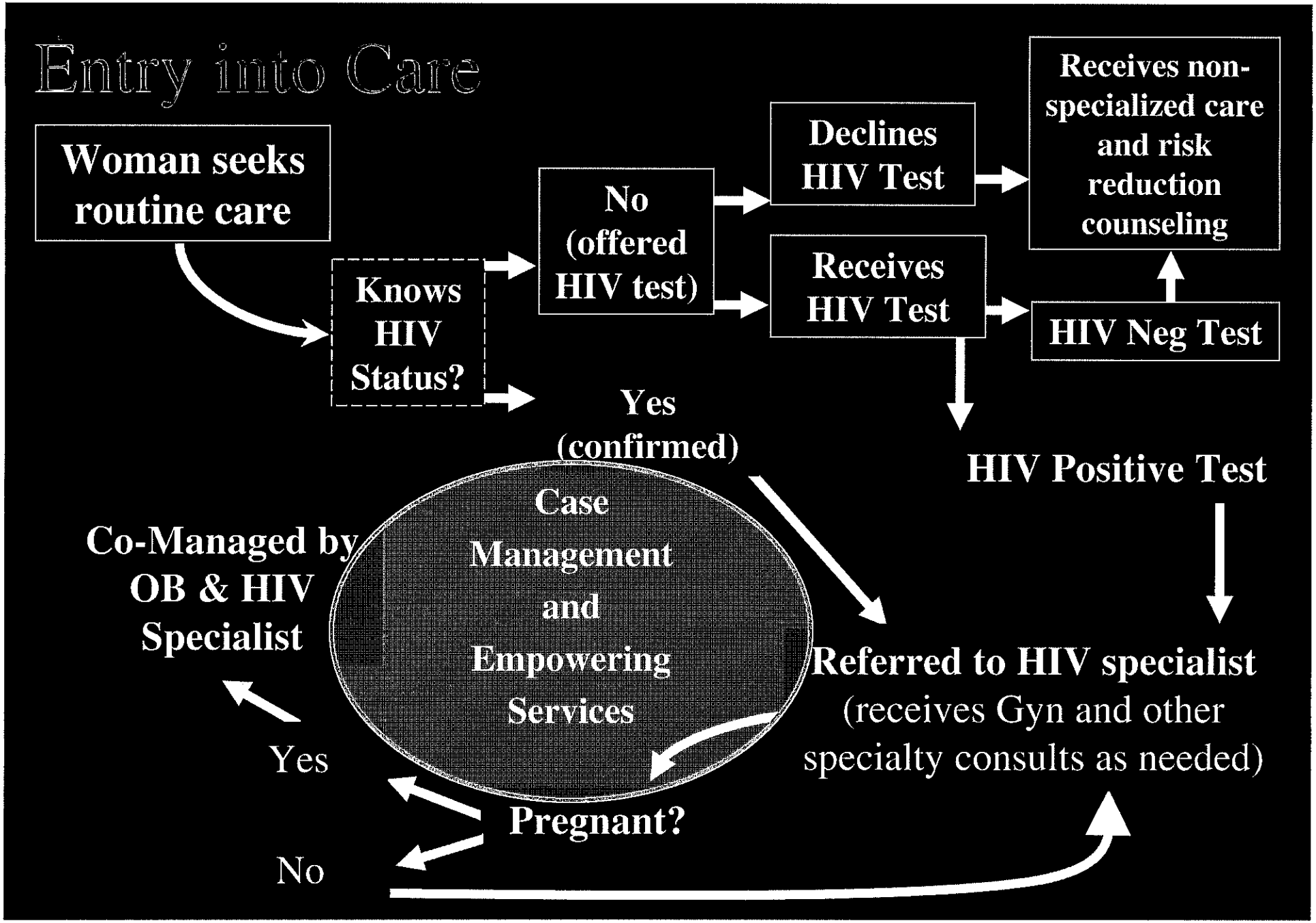
- General Issues
  - Primary care giver for children and other adults
  - Alcohol and other drug dependencies
  - Mental illness
  - Homelessness
- HIV-related issues
  - HIV stigma
  - Complex treatment regimens, some requiring frequent medical visits
  - Period of, or ongoing, severe illnesses and/or chronic suboptimal health

Services for HIV Positive Women at HHC Facilities

- Comprehensive services for HIV-positive women at all HHC facilities
  - HIV Primary Care
  - GYN Services
  - Mental Health
  - Treatment Adherence
  - Case Management
  - Individual Counseling
  - Support and Health Education Groups

- Specialty services offered at many of HHCs Acute Care facilities include
  - Ophthalmology
  - Dental
  - Hepatitis C Services

- Many facilities have co-located these services with one another to provide a seamless continuum of care


Entry into Care
Woman seeks routine care
Knows HIV Status?
No (offered HIV test)
Declines HIV Test
Receives non-specialized care and risk reduction counseling
Receives HIV Test
HIV Neg Test
Yes (confirmed)
HIV Positive Test
Case Management and Empowering Services
Co-Managed by OB & HIV Specialist
Referred to HIV specialist (receives Gyn and other specialty consults as needed)
Yes
Pregnant?
No

Pregnancy and HIV

- Pediatric AIDS Clinical Trials Group (PACTG) protocol 076 demonstrated that a three-part regimen of **zidovudine** (ZDV) administered during pregnancy, labor and to the newborn, could reduce the risk of perinatal transmission by nearly 70 percent

MMWR Morb Mortal Wkly Rep 1994; 43(RR-11):1.

Reducing perinatal transmission

- Adherence to long-term treatment plans
  - Viral load >1000 (**12 fold increase likelihood of transmission to child)**
- Lactation Counseling
- Elective Cesarean (reduce 5 fold infections)
  - Cesarean delivery performed prior to labor would also prevent maternal-fetal microtransfusions that have been shown to occur during uterine contractions
  - With detectable viral load
  - American College of Obstetrics and Gynecologists (ACOG) issued an opinion that elective cesarean delivery should be discussed and recommended for all HIV-infected pregnant women with viral loads above 1,000 copies/mL

Care and treatment of pregnant women

- Early identification: routine HIV testing in 1st and 3rd trimester
  - If patient tests HIV-positive: immediate consultation with HIV specialist to begin/alter antiretrovirals
  - Actively link HIV-positive patients to case management and supportive services
- Rapid HIV testing during delivery for patients with unknown HIV status
- Infants born to HIV-positive mothers are co-managed between Pediatrics and HIV

Comprehensive HIV care

- ***Inter-Disciplinary Teams***
  - Obstetrician
  - HIV Counselor
  - Immunologist
  - Nurse
  - Perinatologist
  - Neonatologist
  - Social Worker
- ***Communication and Coordination***
  - Team meetings
  - Case conferences
  - Detailed medical records
  - Immunology records/results

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

Testimony

of

Monica Sweeney, M.D., M.P.H.
Assistant Commissioner for the Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene

before the

New York City Council Committees on Health and Women's Issues

regarding

The HIV/AIDS Epidemic among Women in NYC

December 13, 2007

City Hall
New York City

Good afternoon Chairpersons Rivera and Sears, and members of the Health and Women's Issues Committees, I am Dr. Monica Sweeney, Assistant Commissioner for the Bureau of HIV/AIDS at the Department of Health and Mental Hygiene (DOHMH). On behalf of the Department, I would like to thank you for this opportunity to discuss the HIV/AIDS epidemic among women in New York City.

Today I will identify and assess the extent of the epidemic, describe DOHMH programs and initiatives, and identify some of the key challenges that we face in addressing the epidemic among women.

The HIV/AIDS Epidemic Among Women in New York City

The number of newly diagnosed HIV and AIDS cases and HIV-related deaths among women is declining. The Department's data reveal the number of females diagnosed with HIV declined from 1,912 to 1,016 between 2001 and 2006, and the death rate among females with HIV/AIDS has declined over each of the past six years, from 35.4 per 1,000 in 2001 to 22.1 per 1,000 in 2006.The number of AIDS cases from intravenous drug use among women has decreased dramatically from a high of 1,742 cases in 1994 to 143 cases in 2006, which we believe is in significant part a direct result of the City's commitment to funding and promoting needle exchange programs. In addition, perinatal HIV transmissions have been nearly eliminated because of success in identifying and treating pregnant HIV-infected women. The number of HIV-infected infants born each year in New York City decreased from a high of 334 HIV-infected infants born in 1990 to 6 born in 2006.

However, New York City remains the epi-center of the HIV/AIDS epidemic; with a case rate more than triple the national average and 45 times the Healthy People 2010 target. The decreases in new HIV diagnoses experienced in NYC have leveled off in recent years, and new information suggests that HIV diagnoses among young women has begun to rise again. In 2006, HIV non-AIDS diagnoses among females 13–29 years increased 6% from the previous year to 242 new cases, after declining 46% from 2001 to 2005 (426 to 228 cases). This increase mirrors increases in HIV diagnoses we have seen among men in the same age group in recent years.

Females now represent 27% of all new HIV diagnoses. The vast majority of these cases with a known transmission risk are from heterosexual contact (92%). There are more than 30,000 HIV-infected women in New York City– 0.7% of all females. Females comprise an increasing proportion of AIDS cases and now account for approximately one-third of all new AIDS cases in this City.

One significant finding that the Department has highlighted is the disparities between HIV/AIDS rates among black and Latina New Yorkers, as compared to New Yorkers of other race and ethnicity groups. These racial and ethnic disparities are even more pronounced among women than among men. In 2006, among adult New Yorkers a black woman was nearly 20 times as likely, and a Latino woman almost 9 times as likely as a white woman to be diagnosed with HIV; black and Latino women comprised 94% of

the HIV diagnoses among adult and adolescent females; and a black woman was nearly 14 times as likely, and a Latino woman almost 7 times as likely, as a white woman to die from AIDS.

Women in the correctional system are particularly likely to be to HIV infected. A recent serosurvey among female admissions to New York City jails in 2006 showed 1 in 10 female inmates are infected with HIV– twice the prevalence of males admitted. Among females diagnosed with HIV in 2006, at least 5% had a history of incarceration.

I would also like to point out, as the Department discussed in testimony earlier this year that older women make up an increasing proportion of those living with HIV/AIDS in New York City. They are disproportionately diagnosed with HIV late in the course of infection; among new HIV diagnoses in women in 2006, 39% of women age 50 and older were diagnosed when they already had symptoms of AIDS, compared with only 20% of women younger than 50. Almost one-third of women living with HIV/AIDS were aged 50 years or older at the end of 2006, compared with 17% at the end of 2001.

DOHMH Initiatives

As you know, in 2004 the Department launched Take Care New York, a health policy for the City that prioritizes actions to help individuals, health care providers, communities, and the City as a whole improve health. The policy promotes actions we can all take to keep healthy, and knowing one's HIV status is one of the Take Care New York health priorities. The expansion of rapid HIV testing has the potential to greatly increase the number of people who know their current HIV status, enable them to benefit from improvements in medical treatment, and take steps to prevent the spread of infection to others. Accordingly, DOHMH strongly encourages health care providers to routinely offer HIV testing to all patients, male and female ages 18-64.

Routinization of testing is critical to addressing the epidemic among women in New York City. Too many women are victims of risk-based testing. Women, and black and Latino women in particular, do not perceive themselves to be at risk for HIV/AIDS, and too often neither do their providers. The Department partners with the Health and Hospitals Corporation and community based providers to expand rapid and routine testing throughout the City to men and women, and also funds several testing programs focused specifically on women. All DOHMH STD clinics offer HIV tests, and the Department's promotion of routine testing also extends to correctional settings. In the Rose M. Singer jail facility, the City's female-only facility, all newly incarcerated women are offered a rapid HIV test at the time of admission. Between 2004 and 2007 8,500 women have been tested for HIV in City jails, which is approximately 21% of all admissions during the 4 year period.

Prevention through the promotion of condom use is also a key priority for the Department. DOHMH has significantly increased condom distribution in the City since the launch of the NYC Condom in February 2007, with male condom distribution

increasing from 250,000 per month several years ago to an average of more than 3 million condoms per month now. In addition, the Department targets women through the female condom initiative. More than 300 organizations participate in the Department's Female Condom Project, and since January 2007, DOHMH has distributed 558,000 female condoms throughout the City. During 2007, the Condoms and Materials Distribution Unit conducted 10 Female Condom Train-the-Trainer Trainings, reaching 118 individuals representing ninety-eight programs/organizations. The Department has a Condom Specialist in each of the District Public Health Offices, and that individual is responsible for coordinating with organizations and businesses in diverse New York City communities in order to promote and expand male and female condom use.

DOHMH also established a new unit in 2006, the Field Services Unit (FSU), to provide direct assistance to HIV-infected persons in high prevalence areas – the South Bronx, Harlem, and Central Brooklyn. DOHMH public health advisors work at 8 large clinical facilities. They help men and women testing positive for HIV notify their sex and needle sharing partners of their potential HIV-exposure and offer assistance linking to and staying in care. During the FSU's first year of operation, 637 women were offered assistance, 464 met with a public health advisor, 350 accepted help with linkage to care and 290 kept an appointment within 90 days of their interview. 150 sexual and needle sharing partners were notified of their potential HIV exposure. Of the 104 notified partners who were not already diagnosed with HIV, 66 accepted testing and 6 were identified as newly HIV positive. All partners are counseled, as appropriate for their current status, on how to either prevent transmitting or acquiring HIV.

In addition to the initiatives I just described, the Department's HIV prevention contract portfolio, funded through the Centers for Disease Control and Prevention, has 12 contracts with programs that target services to female New Yorkers. These programs include community-level and peer-led skill building interventions, as well as HIV Co-factor screenings to identify women who are at risk for HIV. The Department also administers several City Council contracts funding community and faith-based organizations that specifically target women with services including peer training and education, pre and post-test counseling, community roundtable presentations, supportive services for women with substance abuse disorders, and supportive services for immigrant HIV infected women and their families.

Federal treatment programs, including Ryan White and the Federal Housing Opportunities for People with AIDS (HOPWA) program, offer services to NYC residents in more than 16 categories, including mental health, housing placement and assistance, treatment adherence, access to care/maintenance in care, outreach and early intervention services, food and nutrition, and substance abuse services. Most of the HOPWA and Ryan White programs target and treat male and female PLWHA, however a portion of the HOPWA grant funds women with mental illness and women with children; and there are 8 Ryan White programs in the DOHMH portfolio that devote 80% or more of their resources to serving women with HIV and AIDS.

In addition, the Department works closely with the New York City Human Resources Administration's HIV/AIDS Services Administration (HASA) who facilitate access to financial benefits and social services needed by medically eligible individuals and their families. Services and benefits include direct linkages to Cash Assistance, Medicaid, Medical Assistance, Food Stamps, voluntary referral for Employment and Training Services and Substance Abuse, Home Care, and Homemaking; case management; and emergency and non-emergency housing services and placements.

As of the last reporting period in October 2007, 35.8% of the 31,195 medically eligible individuals were female adults. Some of the services utilized by women, particularly female heads of households are:

- Guardianship and permanency planning in the event that the head of household dies or becomes too incapacitated to care for her children;
- Child care for women who are in an employment activity, employed, or attending school;
- Discharge planning in conjunction with the Administration for Children's Services if a child or children have been removed from the home and are being returned;
- A pregnancy allowance of $50 a month for up to five months;
- Homemaking services for when a parent or primary caretaker is temporarily absent from the home or is incapable of caring for a minor child. These services include childcare, home management, household chores, and limited personal care services for children; and
- Referrals to the Office of Domestic Violence for safety-related and/or counseling assistance.

Challenges

Despite our efforts and those of our partner agencies and organizations in the promotion of testing, educating, and linking patients to life-saving treatment, many challenges to addressing the HIV/AIDS epidemic in women remain. The success the Department has had in controlling the spread of HIV/AIDS is dependent on the infrastructure that has been built in conjunction with our partners at the federal, state and local levels. When incidence of disease declines, we are lulled into a sense of complacency, and neglect the modest investment that needs to be maintained to prevent future epidemics – epidemics that will cost lives and money. The maintenance of funding, technical rigor, and good management are critical to controlling this and future epidemics.

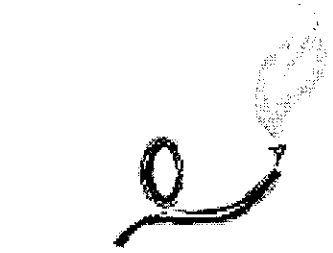
Negotiating safe sex is an important barrier to women protecting themselves against HIV/AIDS. Cultural attitudes, stigma and fear of domestic violence are often cited by women as reasons for not practicing safe sex. Women must become more empowered to safely and comfortably negotiate for safer sexual activity with their partners. Accordingly, there is a need to continue and expand the female condom distribution program. This program is expensive, as female condoms cost $1 each,

however the Department continues to invest in their promotion because maintaining the variety of safer sex options, and encouraging female empowerment are critical to preventing the spread of HIV among women in NYC.

Finally, as noted earlier, routinization of testing is critical to reaching all women, and in particular those women that do not perceive themselves to be at risk. However New York State law currently requires a burdensome consent process that is a clear barrier to providers offering testing and that we believe stands in the way of getting as many people tested as possible, and getting them into appropriate care. The Department has been active in promoting legislation to change these requirements, however the law remains.

Thank you for your interest in this issue, I am happy to answer any questions you have at this time.

###



Testimony before
The Council of the City of New York
Committee on Health and
Committee on Women's Issues
on The HIV/AIDS Epidemic Among Women in NYC

Patricia
Center for Women and HIV Advocacy

December 13, 2007

My name is Patricia, I am a 52 Year-old African-American woman living with HIV. I have two sons, one sister, and three brothers. I was raised in a large and extended family in a small town in New Jersey, where we grew our own food and vegetables. My parents have been married for 54 years. My grandfather made all of my toys and everyone in town came to my Grandmother's house for dinner on Sundays. That is the kind of place it was. I consider myself to be a woman of faith, a prayer warrior. Praying keeps me grounded and speaks to my inner man, while faith sustains me daily and provides me with the strength to climb life's mountains. Although there are many challenges living with HIV, being positive has given me a desire to live each day to the fullest and not take anything for granted.

When I was first diagnosed with HIV, I was very angry. I went from shock to denial, and then prepared myself mentally and spiritually for death. I could not tell my family, and having very little knowledge about the disease itself, I thought death was my only option. One day as I stood in my bathroom brushing my teeth and having a pity party, I looked up and into the mirror that I've managed to avoid for some time. To my surprise, it was not the face of death looking back at me; it was a beautiful black woman, a woman of strength and courage, who made a decision to live and not die. That's when I decided to do something. I got involved in a medication adherence support group, then eventually joining a clinical trails community advisory board.

After a while, my desire to affect change at a greater level grew more intense. I started coming to advocacy trainings at the HIV Law Project. It was here that I first heard the terms "empowerment" and "public policy". The Law TAP program here taught me to tap into my strengths and realize that collectively we can make a difference. Getting involved in advocacy allows me to use the skills I've acquired from life experiences. It gives me a sense of worth, and a belief that my voice matters. This is why I am sharing my story today.

I've lived in New York City for the past twenty years, currently in the East Flatbush section of Brooklyn. All the neighbors in my building are friendly and we watch out for each other. In the past two years, I've noticed an increase of young people hanging out on street corners in my neighborhood, engaging in risky behaviors such as smoking weed (blunts), drinking, and being disrespectful to themselves and others. Sex with multiple partners is now apparently the "in" thing to do. As someone who has spent 15 years of my life shooting heroin and cocaine, going in and out of prisons, I know what that is like.

Many of us find it difficult to talk about sex because unfortunately we live in a society that portrays sex in a negative light. I grew up in a family that didn't talk about sex, and I had to learn about it out on the streets. My mother couldn't even explain to me what was happening when I first started menstruating, I thought I had cut myself. She told me to ask my brother to read the instructions on the tampon box and to show me how to use it.

In other societies people are taught to love and respect their bodies, but here we are taught that our bodies are something to be exploited and abused. I believe that if we begin to talk to our children at an early age about sex and begin to instill the idea that our bodies are our temples and made wonderfully and beautifully, then we can at least create a sense of pride in our bodies and ourselves. Then and only then will we begin to want to make healthy, conscious decisions about when, how, and with whom we choose to share our temple.

The most troubling aspect of HIV is not only the alarming rate of infection among our youths, but also the fact that it is preventable. Knowledge is power! Providing comprehensive, age appropriate sex education gives our youth a more leveled playing field than "abstinence-only" programs. These programs are limited in their views and do not provide the information necessary to make healthy and informed choices.

As a parent and concerned member of my community, I believe we have a moral obligation to our children, because they are our future. Our house is on fire and the kids are still in it! The safety of our children is at stake. Tomorrow will be too late.

Testimony before
The Council of the City of New York
Committee on Health and
Committee on Women's Issues
on The HIV/AIDS Epidemic Among Women in NYC

Alison Yager
Staff Attorney, HIV Law Project
Project Manager, Center for Women and HIV Advocacy

December 13, 2007

Speaker Quinn and Members and Staff of the Committee on Health and the Committee on Women's Issues:

On behalf of the HIV Law Project, I appreciate the invitation to testify before you today about the issues which we see facing HIV positive women in New York City. The HIV Law Project was founded in 1989 in response to the growing need for legal and advocacy services for low-income people living with HIV/AIDS in New York City.[1] In addition to our policy advocacy and impact work, we have handled nearly 20,000 individual legal cases for our clients. Over 92% of our clients are people of color, approximately 34.5% are women, and 75.6% are new or recent immigrants. The overwhelming majority of our clients receives public assistance and depends on Medicaid or ADAP to obtain access to HIV primary care. Most come from New York City's poorest communities, and frequently have few educational, familial and community resources at their disposal.

A Silent Epidemic of Women

We applaud your efforts to learn more about HIV among women in New York City, as HIV is becoming a silent epidemic among women of color and immigrant women. In 2005, 25% of the reported AIDS cases were among women, with 80% of those cases resulting from heterosexual transmission.[2] In New York State (NYS), a staggering 35% of people living with AIDS are women. Incredibly, the rate of infection among African American women is 27 times higher than among white women. On a national level, while African American women comprise only 12% of the population, they account for 66% of all U.S. AIDS cases.[3]

The trend is even more alarming among girls and young women. Females under 25 years of age accounted for 38% of new reported HIV/AIDS cases nationwide in 2001-04. In NYS during those years, females under 19 years of age accounted for 42% of new cases among teens, and 38% among youths 20-24. Girls 13-19 make up 22% of all female HIV/AIDS cases (boys comprise only 13% of all male cases), and 72% of all new HIV/AIDS diagnoses among girls 13-19 years is among girls of color.

While HIV rates among foreign-born populations on a national level cannot be obtained from the Centers for Disease Control, country of origin data published by the Massachusetts Department of Public Health show that among non-US born people, the rates of HIV are nearly equally distributed among males and females, with females comprising 45% of the cases.[4] In Massachusetts, women account for 38% of the non-US born people living with HIV/AIDS. That data also shows, consistent with national data

---

1. Additional information can be found on our website www.hivlawproject.org
2. Centers for Disease Control and Prevention, *HIV/AIDS and Women*, June 2007. Available at http://www.cdc.gov/hiv/topics/women/overview_partner.htm
3. Kaiser Family Foundation, *HIV/AIDS Policy Factsheet: Women and HIV/AIDS in the United States*, July 2007. Available at http://www.kff.org/hivaids/upload/6092-04.
4. Mass. Dept. of Health HIV/AIDS Surveillance Data, 1990-2000.

on race and ethnicity, the largest proportion of non-US born people living with HIV/AIDS is Black (59%) and the next largest proportion is Hispanic (23%).

Gender as a Major Risk Factor of HIV Infection

HIV risk for women is not all about behavior – the promiscuous versus the cautious, the good girls versus the bad. By virtue of their biology, women are categorically at a higher risk for HIV infection than men. The male-to-female transmission rate of HIV is estimated to be at least two times higher than female-to-male. The presence of sexually transmitted diseases further increases the risk of HIV infection for females by at least two to five times. Adolescent females, because of their immature biological development, are also more susceptible to HIV infection than older women.

Biology, however, is not the only reason gender plays a significant role as a risk factor for HIV infection. Social and economic inequality and violence against women dramatically influence the landscape in which women negotiate their lives and make individual decisions. Women often lack the power or ability to negotiate sexual relationships with their partners. Younger women often lack access to sexual health information and resources to make informed decisions. Women lack female controlled prevention methods. Women as a class, especially women of color, experience higher rates of poverty and less access to community resources such as health care services. Sexual abuse histories are strongly linked to HIV risk, as are histories of domestic violence and/or rape.

Immigration Status as a Barrier to Care for HIV Positive Women and Girls

Though New York does not report HIV/AIDS surveillance data by country of origin, it is widely accepted based on service experience that HIV is a growing epidemic among immigrant communities. And, as reflected in the HIV Law Project's legal docket, increasing numbers of women with HIV/AIDS in New York City are low-income immigrants. These women often lack access to all sorts of services, including legal assistance, comprehensive health services, and peer education and support.

Undocumented immigrants who cannot afford private health insurance are ineligible for Medicaid, and must rely on ADAP, the federal AIDS Drug Assistance Program, which only covers care and medications that specifically treat HIV infection. Further, applicants to ADAP often face long processing delays. While those well enough to work could theoretically benefit from employer-sponsored group health benefits, they cannot seek legal employment without first obtaining proper immigration status and employment authorization documentation. As most undocumented immigrants have no avenue to obtain a green card, they are typically trapped in low wage jobs which require long hours worked in unsafe working conditions, and consequently live in substandard housing rife with health hazards, with insufficient money to purchase healthy food, and no access to comprehensive health care.

To the extent that HIV positive immigrant women do have access to healthcare, they must also confront a dire lack of translation services, and culturally sensitive educational and support services. When care cannot be provided in their native language, women are often left with unanswered questions about their condition and their treatment. In many cases, this means that the misinformation or lack of information about HIV that these women brought with them from their home countries is not timely countered with accurate information. Further, knowing the stigma surrounding HIV in their own culture and community, many women conceal their diagnosis even from those people closest to them. As a result, family members are precluded from acting as interpreters when the patient is unwilling to share her medical condition with those who might act as her cultural bridge. Lacking medical and support services in her own language, HIV positive immigrant women often remain isolated and afraid, and devastated by news that they feel they cannot share. The isolation experienced by HIV positive immigrant women is exacerbated by the shortage of culturally sensitive and language appropriate peer educator and peer support services, which would allow women to connect with others in their situation and community.

Additionally, HIV positive immigrant women lack access to critical legal services. Many undocumented women are unaware of special visas for which they may be eligible, as, for example, victims of trafficking, or witnesses to a crime, and are similarly unaware of the Violence Against Women Act (VAWA), which provides an immigration remedy to immigrant victims of domestic violence, and their children. Further, many HIV positive immigrant women are unfamiliar with their rights as tenants, as employees, as applicants for or recipients of public assistance, and as mothers of school-aged children.

At the extreme margins are battered HIV positive immigrant women. They face a similar lack of culturally sensitive services, and the hurdles they must overcome to leave their batterer are monumental. A mistrust or fear of the police leave many women conflicted about calling on law enforcement for assistance. Fear of their abuser revealing their status often keeps HIV positive, immigrant women with a spouse or partner. Moreover, the fear of extreme poverty which so many abused women must confront is all the more terrifying to a woman who lacks the immigration status to work legally, and who has intensive, and expensive medical needs. Further, once they enter the legal system, these women typically face a lack of translation services at the courthouse, and again find themselves forced to rely on friends or family as interpreter. More extensive services for these women are desperately needed.

Having acknowledged that the numbers of HIV positive women in New York City continue to skyrocket, and having assessed the myriad challenges faced by these women, I could not conclude without emphasizing the need for revitalized prevention efforts. Our experience reveals that contrary to popular belief, many immigrants diagnosed with HIV are infected and diagnosed in this country. Prevention efforts must be supported in every corner of the city, and again these must be culturally sensitive, and language appropriate. While services are critical to those who are infected, only a renewed focus on prevention will stem the rising numbers of HIV positive women.

PLANNED PARENTHOOD OF NEW YORK CITY
EXECUTIVE OFFICE | MARGARET SANGER SQUARE | 26 BLEECKER STREET | NEW YORK | NEW YORK 10012-2413
WWW.PPNYC.ORG | P: 212.274.7200 | F: 212.274.7276

FOR THE RECORD

Testimony before
The New York City Council Committee on Health/Women's Issues
HIV/AIDS Epidemic Among Women in New York City

Daphne Hazel
Planned Parenthood of New York City
December 13, 2007

Good afternoon. My name is Daphne Hazel. I am the Associate Vice President of Project Street Beat at Planned Parenthood of New York City ("PPNYC"). I would like to thank Committee Chairs Joel Rivera and Helen Sears and the entire committees of Health and Women's Issues for holding this hearing to allow for public comments concerning the HIV/AIDS epidemic among women in New York City.

Planned Parenthood has been a leader in reproductive health care for over 90 years. Now, as one of New York's oldest community-based safety-net providers, Planned Parenthood provides reproductive health care, education and advocacy throughout New York City. We are committed to ensuring access to reproductive health care to those who are most in need -- persons for who age or income are obstacles to high quality care. In 2006, at our three centers in the Bronx, Brooklyn and Manhattan, we provided reproductive health care and family planning services to more than 45,000 New Yorkers, which translates into more than 80,000 visits. In addition to the health care clients we serve at our centers, we reached 60,000 plus people through our community outreach and education programs and Project Street Beat. Our clients come from all five boroughs. The majority of our clients are at or below the poverty level, more than half use public insurance to pay for their care, and over two-thirds of our clients are women of color.

I oversee Project Street Beat, Planned Parenthood of New York City's unique HIV prevention and access to care-program. We have three locations in the Bronx, Brooklyn and Harlem. We serve teens, women, and men who live and work on New York City's streets. Traveling to neighborhoods in our minivans and mobile medical unit funded generously by the City Council a few years ago, our street-staff connect with the people who are at highest risk for HIV/AIDS, including substance users, commercial sex workers, homeless people and at-risk youth. Since 1988, Project Street Beat has provided education, medical services, and case management to nearly 100,000 people at risk for or infected with HIV/AIDS. We also provide weekly support groups for youth, for HIV+ individuals, and for people experiencing substance addiction; all part of our efforts to help individuals make behavioral changes that will reduce the transmission of HIV.

Because Project Street Beat staff work on the streets, we can reach our clients where they are. After our HIV prevention staff build trust with a client, we can provide other types of assistance, helping people access regular medical services and office-based counseling. In this way, Project Street Beat helps clients move from a focus on day-to-day survival on the street to pursuit of strategies that will help them maintain safer, healthier lifestyles.

In addition, Planned Parenthood helps providers of reproductive and sexual health care to integrate accessible, client-centered HIV prevention, education, and testing services into their full range of services via its HIV Integration Project, which is funded by CDC. The HIV Integration Project has two components: training and technical assistance. Planned Parenthood's health centers provide HIV counseling and encourage all clients to test for HIV; it is anticipated by the end of 2007, we will have provided 16,000 HIV tests in our health centers.

Based on our experience providing reproductive health care and HIV/AIDS outreach and education to thousands of New Yorkers, Planned Parenthood can provide insight into the HIV/AIDS crisis and its effect on women. I would like to share with you today, some of our experiences with current HIV/AIDS intervention methods and their effects on women.
Current HIV/AIDS Intervention Programs:

Project Street Beat receives funding from the NYC Department of Health and Mental Hygiene, NYS Departments of Health- AIDS Institute and Centers for Disease Control and Prevention for HIV/AIDS intervention programs for women. With this funding, we offer two programs: Safety Counts and SISTA. Safety Counts helps clients reduce high-risk substance use-- including intravenous drug users-- and sexual behaviors. Based on the "stages of change" behavioral model, the curriculum's seven sessions include structured and unstructured psycho-educational activities in group and individual settings. At a minimum, each Safety Counts cycle includes:
* Two group workshops that focus on identifying each client's HIV risk and current stage of change, share risk-reduction success stories, help clients set personal goals, and identify steps toward reducing HIV risk.
* One individual counseling session to discuss the risk reduction goal, assess clients' needs, and provide referrals to counseling/ testing and medical and social services, as indicated.
* Two social events that allow clients to receive positive reinforcement from each other.
* Two supportive follow-up contacts that focus on imparting knowledge about HIV infection and transmission. Clients learn about and receive condoms and bleach kits, discuss safer sex techniques, and receive voluntary substance abuse counseling.

The SISTA (Sisters Informing Sisters about Topics on AIDS) project is a social skills training intervention for HIV-positive and high-risk African American women, designed to reduce risky sexual behaviors. The curriculum is based on the Social Learning Theory of Gender and Power. Its five regular and two booster sessions are gender-related and culturally sensitive, and use methods such as behavioral skills practice, group discussion, lectures, role-play, an educational video and take-home exercises. Core elements include:
* Educating participants about condoms through hands-on exercises that emphasize gender and ethnic pride to encourage participants to reduce HIV risk behaviors
* Viewing a culturally-specific video about responsibility for sexual decision-making
* Learning sexual assertiveness and communication skills

Planned Parenthood is proud of the work that it has been able to do to address the HIV/AIDS problem in New York City. Nevertheless, there is still a ways to go to fully and effectively addressing the problem of HIV/AIDS among women. Two major issues that still need to be addressed are: 1) insufficient funding for HIV/AIDS intervention programs specifically designed for women and; 2) the ineffectiveness of current intervention programs for women.

Insufficient funding for women:
There is insufficient funding for HIV/AIDS intervention programs for women. Most of the current funding is geared towards the prevention of HIV/AIDS among men who have sex with other men. While the HIV/AIDS epidemic among men is important, recent figures show that new HIV/AIDS cases among women, specifically African-American and Latina women have skyrocketed.

Current interventions for women are ineffective:
Women face a number of barriers to treatment that are largely ignored by current HIV/AIDS intervention programs. Those barriers include: 1) lack of childcare assistance; 2) lack of incentives for attendance; 3) lack of mental health treatment; and 4) failure to address cultural differences.

Lack of childcare assistance

Many programs, including the 2 we use - Safety Counts and SISTA -- require women to attend multiple workshops over a number of weeks making attendance extremely difficult if not impossible for those women who cannot arrange for childcare during the weekly workshop.

Lack of incentives for participation
Another problem that we face is attendance at the workshops. Faced with a whole host of daily problems and issues, the workshops are often the first to drop off the radar for our clients. Providing some sort of incentive would go along way to encourage women to make attendance at workshops a priority in their lives.

Lack of mental health counseling
Many of the current intervention programs fail to address mental health needs of the women. Many of the women in our programs face a myriad of mental health issues in addition to their addiction. There may be domestic violence, physical or sexual abuse or other mental health issues that should be addressed along with that addiction. In order to be successful, programs need to take the whole client into account.

Cultural competency and health literacy issues
Lastly, the workshop materials for the current HIV/AIDS intervention programs fail to sufficiently address the diversity of backgrounds, life experiences and health literacy that women bring to workshops. This barrier impacts our clients' ability to access vital information. We are hopeful moving forward that the continued development of best practice models for the dissemination of health information to diverse communities will strengthen our work and our outcomes.

As a safety net provider committed to improving the health of all New Yorkers, we are encouraged by the City's commitment to addressing the HIV/AIDS epidemic. I recently attended a meeting in the Bronx regarding the borough wide initiative to get all residents tested within the next 3 years - indeed, it is an ambitious and laudable goal that we look forward to being a part of. If we are going to make any strides in reducing the rates of HIV in New York, it will take this type of focused thinking and commitment. And, throughout this proves we need to keep in mind the unique needs of different constituencies, including women. That's why we are grateful to the City Council today for focusing the conversation on these important issues and allowing us to testify. We look forward to continuing to work with the Council and our various partners throughout the City to promote the health and well-being of New York's women, men and families.

Thank you again. I'm happy to answer any questions.

FOR THE RECORD

Remarks Of Daniel Tietz, Executive Director
AIDS Community Research Initiative of America

THE HIV/AIDS EPIDEMIC AMONG WOMEN IN NYC

New York City Council
Health & Women's Issues Committees

Thursday, December 13, 2007

Good afternoon.

It was just about a year and a half ago that ACRIA released the findings of its seminal *Research on Older Adults and HIV,* or ROAH, study. Almost a third of people with HIV in New York City are over the age of 50, and this group is growing both in number and as a segment of the entire HIV-positive population.

The City Council Committees on Health and on Aging, chaired by Councilmembers Joel Rivera and Maria del Carmen Arroyo, convened a joint hearing to investigate the special needs of people with HIV as they aged, what services were available to them, and what steps were being taken to prevent further spread of the disease among older adults.

What emerged from that hearing was a picture of a healthcare and social services system that was unprepared to deal with the complex needs of people trying to manage their HIV disease while dealing with the common ailments of aging. The picture was colored by the ongoing stigma of AIDS-phobia, combined with the pervasiveness of ageism. There were agencies that provided services to people with HIV, and there were others that served aging and elderly clients, but no combined or complementary efforts to address HIV issues among the baby boomers and their older brothers and sisters.

The two City Council Committees took decisive action, convening a workgroup of service providers who worked with older adults and those who worked with people with HIV, together with the New York City Department of Health and Mental Hygiene and Department for the Aging, to design a comprehensive HIV education and prevention program aimed at destigmatizing HIV and bringing it into the mainstream of services for the aging. The result is the New York City Council Older Adults HIV Initiative, a multiple-agency program that brings HIV education and prevention information into senior centers, NORCs, and other venues used by middle-aged and older adults. Thanks to the enthusiastic support and energetic efforts on the Initiative's behalf, the program received $1 million in funding for FY2008--$640,000 in City money, and a $360,000 match from the State, enabling the program to reach sites in all five boroughs and in all 51 Council Districts.

So, what does all this have to do with HIV among New York City's women, which is after all why we're here?

For one thing, for the past several years women's numbers have been increasing as a percentage of the total HIV-infected population. Also, medical breakthroughs have meant that increasing numbers of people with the virus are living longer . . . and getting older. And we know that women in general have longer life expectancies than men, and there's no reason to believe that the same isn't true when both have HIV. The inescapable conclusion is that the greater our success on the medical front and the longer people with HIV live the larger will be the proportion of older people with HIV who are women.

And there's more to it than that. As in younger HIV-positive age groups, women and men have differing needs. Even after their children are grown, women tend to continue to be caregivers—to their life partners and very often to their grandchildren, to friends and extended family. The physical changes that come with aging are often very different; severe osteoporosis, for example, is more prevalent among women than among men, and there is evidence that HIV exacerbates this condition in both sexes.

And there are sex-specific issues in HIV prevention. For the most part, people tend to choose their sexual partners from among those close to them in age. As the HIV-positive population ages, older HIV-negative people are thus more likely to engage in sexual activity with someone who has the virus. Not only are women more vulnerable to infection than men during heterosexual intercourse, there are other, physical, factors that put post-menopausal women at greater risk.

The New York City Council last year took a bold step in following the leadership of the Health and Aging Committees and underwriting the Older Adults HIV Initiative. Obviously, the challenges presented by an aging HIV-positive population cannot be overcome in a single year, and it will be necessary for HIV education and prevention services aimed at older adults to continue. Equally clear is that what we do for our senior population will have to be refined in the light of what we learn as we go along, and to address issues specific to various parts of that population.

As you look at issues specific to women with HIV in New York City, please remember the growing number of those women who are entering the "older adults" category, and their HIV-negative sisters who are at risk of joining them.

CONTACT
c/o Desiree Flores
Program Officer, Health
Ms. Foundation for Women
(212) 709-4413
dflores@ms.foundation.org

Change to CDC Policy Could Save Thousands of Women's Lives

The National Women and AIDS Collective (NWAC), the first policy coalition led by and for women living with and affected by HIV/AIDS, contends that serious flaws in the CDC's HIV surveillance system are fueling the AIDS epidemic among women in the United States. The system, established in the early 1980s to track newly diagnosed HIV cases, paints an outdated, inaccurate picture of the epidemic and misinforms funding prescriptions for HIV/AIDS prevention and intervention nationwide. **The bottom line: women are falling through the cracks.**

Meanwhile, women have come to represent a growing number of new HIV/AIDS cases, more than tripling from 8% in 1985 to 27% in 2005. And women of color have been especially hard hit: In 2004, HIV infection was the leading cause of death for African American women aged 25–34 years.

Women's Data and Women's Lives

In reality, most women contract HIV heterosexually when they believe they are in a monogamous relationship. But if a newly-diagnosed woman can't identify her male partner's HIV status or "high-risk" behavior (e.g. male to male sexual contact or injection drug use), and other means of transmission are ruled out, the CDC surveillance system automatically places her in a generic category labeled "no identified risk" (NIR). As a result, her case and the thousands of others like hers have no real chance of informing funding prescriptions for prevention and testing efforts nationwide or influencing public perceptions of the epidemic and the greater public health response. In fact, women are reportedly being denied HIV testing at federally funded sites because they do not fit into the CDC's high-risk categories. It is estimated that 47-60% of all women testing HIV positive in the US are classified as NIR.

Most significantly, the CDC surveillance system fails to collect comprehensive data on environmental and socioeconomic factors that are known to fuel the virus—even when behaviors are normative. Research shows that women, low-income people and people of color remain at disproportionate risk of HIV/AIDS even when they aren't engaging in high-risk behavior like injection drug use or sex work. As such, a system predicated on behavioral risk that excludes the socioeconomic realities and networks of people's lives falls far short of addressing the prevention needs of low-income women and women of color.

RECOMMENDATIONS TO THE CDC

- **Revise current transmission categories to accurately capture HIV incidence and prevalence data on women** and enable health practitioners and advocates to address the quickening impact of the AIDS epidemic on women nationwide.
- **Capture data on comprehensive socioeconomic and environmental determinants of health known to fuel the virus among women and people of color.** This would require a necessary departure from an exclusively risk-based assessment of newly reported HIV cases.
- **Increase surveillance funding.**
- **Include NWAC in current and future working groups** to address the above issues and ensure that the leadership and perspectives of women living with and affected by HIV play a central role in decision-making processes concerning data collection and the concomitant, dramatic rise in HIV/AIDS cases among women, particularly low-income women and women of color.

Overview of HIV/AIDS & the Impact on Women

Nancy Genova, MPA

November 15, 2

Overview of HIV/AIDS

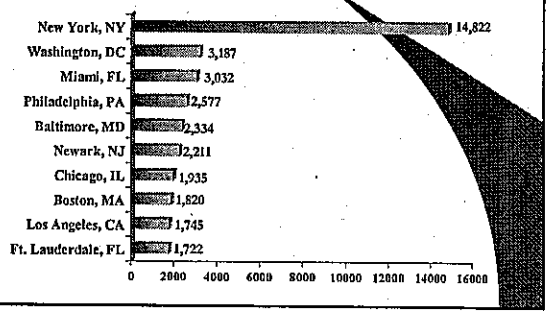
Worldwide:

- Over 4 million people are living with HIV/AI[illegible]nd 74 percent of these infected people live in sub-Saha[illegible]frica.
- Over 19 million women are living with HIV/AIDS.
- There are 14,000 new infections every day (95 perce[illegible] developing countries). *HIV/AIDS is a "disease of youn[illegible] people" with half of the 5 million new infections each ye[illegible] occurring among people ages 15 to 24.*
- The UN estimates that, currently, there are 14 million AIDS orphans and that by 2010 there will be 25 million.

United States

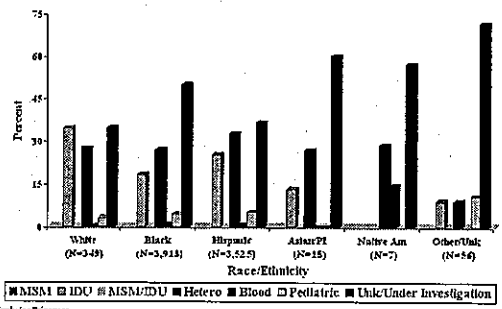
- An estimated one million people are curr[illegible]tly living with HIV in the United States, with approximate[illegible]40,000 new infections occurring each year.
- 70 percent of these new infections occur in men [illegible] percent occur in women.
- By race, 54 percent of the new infections in the Unit[illegible] States occur among African Americans, and 64 perce[illegible] the new infections in women occur in African America[illegible] women.
- *75 percent of the new infections in women are heterosexually transmitted.*
- Half of all new infections in the United States occur in people 25 years of age or younger.

Women estimated living with AIDS: top 10 metropolitan areas, 2001



Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category

Bronx, New York City



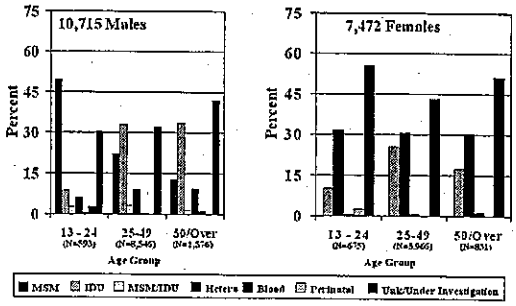
* Excludes Prisoners

** There were no Multi-Race cases.

NYSDOH/BHAE

Persons* Living with HIV/AIDS by Gender, Transmission Category and Age at Diagnosis

Bronx, New York City



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

NYSDOH/BHAE

Persons Living with HIV and AIDS and Cumulative AIDS Cases*
Bronx, New York City

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Kingsbridge-Riverdale	156	298	692
Northeast Bronx	519	823	1,818
Fordham-Bronx Park	1,251	2,090	4,706
Pelham-Throgs Neck	1,056	1,801	4,235
Crotona-Tremont	1,419	2,375	5,663
High Bridge-Morisania	1,437	2,557	6,138
Hunts Point – Mott Haven	922	1,614	3,930
Unknown	360	327	920
TOTAL	7,120	11,885	28,102

*Excludes prisoners

METROPOLITAN

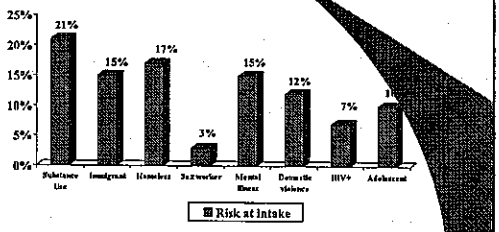
Bronx Community Action for Prenatal Care Initiative

- Known as Bronx-CAPC
- Goal of the Program: reduction of [illegible] Perinatal Transmission, infant mortality and low birthweight
- CDC Funded
- Managed by the AIDS Institute

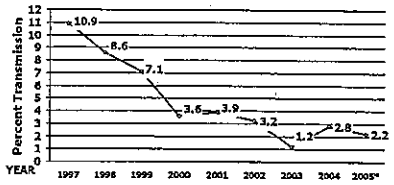
Comprehensive Model

- The basic elements of the comprehensive model:
  - Local planning
  - Recruitment / referrals from the hotline
  - Direct outreach by specially trained outreach workers
  - Referrals from agencies servicing high-risk women

Risk Factors of Women Enrolled in Bronx CAPC 2006 N=361



Mother-to-Child HIV Transmission Rate by Year of Birth, NYS 1997-2005*



Bronx CAPC Findings

- 20 newly identified HIV+ women in 3 of our prenatal clinics/ January-June 2006
- Identified because they were pregnant
- 12 Hispanic
- 5 African American
- 2 Caribbean
- 1 African

From the following zip codes

- 10472/ 3
- 10454/ 2
- 10457/ 2
- 10462/ 2
- 10468/ 2
- 10029/ 2
- 10460, 66, 67 = 1 in each zip code
- 10451, 52, 58, = 1 in each zip code
- 10473/ 1

Bronx CAPC Findings

- May 07 **23 yr old**, 10451 @ AKAHP
- June 07 **15yr old**, 10457, @ MLK, **15 yr old**, 10457, @ Taft H.S., **16 yr old**, [illegible] @ AECOM
- August 07 **24 yr old**, 10456, @ BLHC WHC
- September 07 **17 yr old**, 10458, @ BLHC WHC, **19 yr old**, 10459, @ UHP

Plan of Action

- We informed our workgroups of our findings
- We partnered with a local college to [illegible] demographic study
- This included focus groups
- They prepared a community assessment to [illegible]
- The recommendations were presented to our Steering Committee

Plan of Action Cont;

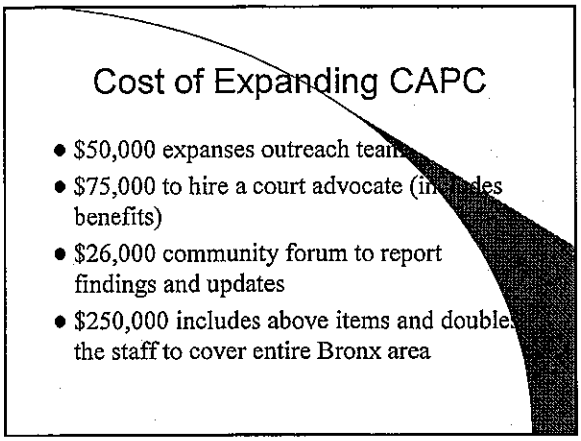
- We shared the information with a consulting firm
- They also have given us recommendations on interventions and what outcome measures to use to help us collect data
- We began the interventions this Spring
- Meet with local legislatures and discuss our findings, request expanded funding

Cost Effectiveness

- For AIDS infected child the cost is : $12, 315 X 42(2004 NYS) = $620,600.00 annually
- $620,600.00 x 27years, the longest living individual with HIV Perinatal Transmission
- In order to medicate them the cost would be $16 million!!!!!
- Prevention the best tactic to use!!

Cost Containment

- Federal spending on HIV/AIDS patient care; $10.8 billion
- Medicaid = $2.2 billion
- Medicare = $1.7 billion
- Ryan White = $1.6 billion
- Per month expenditures = $1,359


Cost of Expanding CAPC
• $50,000 expanses outreach team
• $75,000 to hire a court advocate (includes benefits)
• $26,000 community forum to report findings and updates
• $250,000 includes above items and doubles the staff to cover entire Bronx area

HIV/AIDS Statistics
Queens, NY

- Queens comprise 16% of b new HIV diagnoses
- In Queens, HIV/AIDS primarily affects people in their 30's and 40's.
- Western Queens has the 2nd highest number of new HIV diagnoses of all Queens (37.7).
- HIV prevalence is highest in Jamaica Queens, ***Western Queens***, and Rockaway.
- Latinos account for 36% (second largest) proportion of new HIV diagnoses in Queens.
- Women account for 23% of new HIV diagnoses in Queens
  88% of new HIV diagnoses in females are due to heterosexual sex.
- The foreign born account for 43% of new diagnoses in Queens.
- **South America accounts for 30% of new HIV diagnoses among the foreign born.**
- **Central America accounts for 19% of the foreign born.**

Good afternoon. My name is Nathaly Rubio-Torio; I am the Executive Director and Co-Founder of Voces Latinas.

Voces Latinas is a non profit organization in Woodside Queens. Since 2003, we have been bringing the immigrant community HIV /AIDS prevention information through community forums, conferences, educational workshops and advocacy training. Our mission is to reduce the HIV transmission rate among immigrant Latinas by empowering and providing education, training, mental health resources and advocacy services to those infected by HIV, those at risk for HIV, and those serving the Latino community.

The women we serve at **Voces Latinas** are Latinas in monogamous relationships, housewives, mothers, grandmothers, and a large part of our workforce. Many of them are the backbone of our families.

Immigrant Latinas are at even greater risk for HIV for obvious reasons, such as not speaking the language, immigration, etc. These women leave their families, their support system, and many leave their careers, their independence, and a sense of who they are when they decide to come to this country. They experience loneliness, financial hardship, depression, a sense of vulnerability, and are forced to depend on others. Theses series of events sets up the perfect storm for our women acquiring HIV: they begin feeling down, sad and are unaware of the signs of depression, something very common among Latinas, but are unable to identify the symptoms. This depression puts them in vulnerable positions and at high risk where they can experience situations such as domestic violence, and substance abuse, or a partner begins to experience alcoholism and abusive behavior against her, and infects her with HIV and she never even knows it, neither does her partner. She begins to isolate herself even more because culturally, she is not taught to seek services such as mental health counseling, or she fears the repercussions of immigration. This can go on for years, and never receive any treatment or support and she eventually comes to accept that this is the way her life is meant to be. Her children, family back home, and others depend on her yet she, without knowing, is letting her health go.

This situation is very familiar to Voces Latinas. We understand the concerns of immigrant Latinas and understand the many variables they have to encounter in their daily lives before even thinking about getting tested for HIV. We connect immigrant Latinas with resources such as legal assistance, housing, mental health, etc. because we understand that in order to be able to really hear the prevention messages about HIV/AIDS, their immediate needs have to be addressed first since these are what concerns them most. We also understand the various factors that place immigrant Latinas at higher risk, such as depression, alcoholism, domestic violence, low self esteem. .Our women are survivors and we recognize strength in each and every one of them and we tap into this strength via our support groups, educational workshops, and leadership training.

We ask that you not forget the **immigrant Latina** when reading the HIV statistics among Latinos. Their needs and priorities are very unique and if we are going to do prevention

work in this population, we need to have a solid understanding and ways of addressing the other factors that place immigrant Latinas at high risk for HIV/AIDS.

Thank you for your time.

Hello my name is Janet Rivera. I am a Voces Latinas peer educator. I was diagnosed HIV positive 20 years ago.

Ladies and Gentlemen,

With much honor and humbleness in my heart, I appreciate the opportunity and privilege to bring you a message on behalf of the immigrant Latina living with and at high risk for HIV/AIDS. I represent the immigrant Latinas' hope of a changed future of "life." New York represents liberty, strength and opportunity. As a woman who was abused physically, mentally, the Statue of Liberty represents a free and empowered strong woman, who lives within me.

On behalf of immigrant Latinas, I ask you to protect us so that we can once again be the woman that transmits strength, morals, principles and a base of sacrifice and work.

I've been in New York for 20 years living in fear about my immigrant status. My dreams of freedom turned into a chain of sexual abuse, alcohol, depression and HIV/AIDS. Two years ago I found Voces Latinas. They taught me that being an HIV positive immigrant Latina, I still have rights and that, YES, I can have my dreams of liberty.

Abuse still exists in 2007. HIV does exist in 2007 and the fear of asking for help for the immigrant woman does exist.

It's with your wisdom and within your hearts that I humbly ask you for help to be able to achieve what the Statue of Liberty represents to all immigrant women.

Thank you for your time.

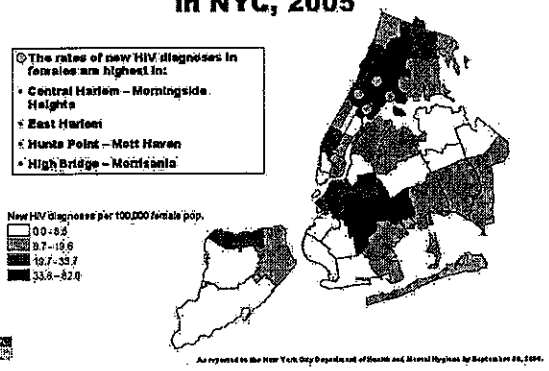
MEDICAL TREATMENT, EARLY DIAGNOSIS AND RESEARCH PARTICIPATION FOR WOMEN

Delivette Castor Ph.D.
The Aaron Diamond AIDS Research Center (ADARC), Rockefeller University, NY, NY

Women comprise nearly fifty percent of HIV / AIDS cases globally. It is estimated that nearly one woman is infected with HIV every 20 seconds around the world. The impact of HIV / AIDS in women internationally and domestically is nuanced for many reasons ranging from biological to socio-cultural. According to the Center for Disease Control and Prevention (CDC) data, AIDS diagnoses among women in 2005, increased more than three and a half times the number of diagnosed AIDS cases in 1985. New York City alone accounts for nearly 15% of national HIV / AIDS cases. Therefore it is not surprising that the patterns of HIV / AIDS locally resemble the national trends, and that local rates tend to be higher.

In 2006, women comprised nearly 27% of HIV diagnoses in NYC, and among those diagnoses, women were 25% of the people who were concurrently diagnosed with AIDS. Women also make up 30.3% of people living with HIV / AIDS and 31.2% of AIDS deaths last year. As of 2005, the median age of HIV diagnosis and death for women was 39 and 47 years, respectively. The AIDS mortality rate is 13% higher in NYC women compared to men. Heterosexual sex was the transmission route for nearly 65% of HIV diagnoses in women, supplanting Injection Drug Use (IDU) as the primary risk factor for HIV in NYC women. The Bronx and Brooklyn had the highest number of female HIV diagnoses by borough of residence in 2006. However, data at the neighborhood level provides a different view of "less risky" boroughs like Manhattan. The figure below my DOHMH of HIV diagnoses in 2005, shows that two of the neighborhoods with the highest number of HIV diagnoses are neighborhoods of color in Manhattan, East and Central Harlem.

HIV Diagnoses per 100,000 Females in NYC, 2005



Minority women

Among all NYC women diagnosed with HIV in 2006, black and Hispanic women comprise 65.1 % and 28.9 % of all HIV cases respectively. Similarly, black and Hispanic women comprised 65% and 28% of AIDS death during this year. Black women make up 36% of all HIV diagnoses among blacks. This is disproportionately higher than all other female groups in NYC. Nearly 60% of HIV diagnoses among black women were within the age groups 20-39 years, and the highest mortality is among 40-49 year olds, 40% of AIDS deaths. The pattern is similar for Hispanic women in the city, 55% of HIV diagnoses were among women 20-39, and 40% of death occurred in those 40-49 years.

Although the rate of HIV transmission from the mother to the child has decreased tremendously after the introduction of antiretroviral therapy to treat pregnant women, there are still incidents of HIV transmission from mother to child in NYC, and the demographic trend reflects the demographics of HIV infected women in NYC. To date, 58% and 35% of children infected with HIV in NYC were black or Hispanic respectively.

Immigrant women

Currently, nearly 40% of NYC's population are foreign-born. In 2004, NYCDOHMH reported that 23.1% of all HIV diagnoses were among foreign-born individuals. The specific area of birth was unknown for nearly 34% of individuals. The northeast Bronx, High Bridge, East Flatbush had some of the highest percentage of HIV diagnoses who were foreign-Born, and were also some of the highest prevalence of HIV diagnoses in the city. More than 55% of new HIV diagnoses in West Queens were foreign-born, marking the highest percentage of foreign-born HIV infections by neighborhood in NYC. Where data were available, the Caribbean represented the highest percentage of HIV diagnoses among foreign-born individuals, followed by Africa. These data were not broken down by gender of transmission and risk, which would provide a clearer picture of what is happening in these groups.

Treatment and care access and outcomes

HIV infected women overall, minority in women in particular, and immigrant women who tend to be predominantly minority, often have added difficulties accessing health care. For these and possibly biological reasons that are not entirely understood, women fare worse than men in HIV disease outcomes. It is therefore imperative to not only get women access to care, but to gain an understanding of factors that put women uniquely at risk of HIV infection, and to understand their disease process, and treatment outcomes. A key component of this is participation in research studies, both to understand the causes of infection and disease, and to understand ways to treat.

Research Participation

Merely 12% of participants in research on potential HIV treatments are women. In other studies of the epidemiology of HIV, women typically comprise less than 30% of the participants. In part because of historical reasons, and largely because of less access to adequate health care, our understanding of HIV symptoms, disease and treatment outcomes are based largely on studies of men. The Aaron Diamond AIDS Research Center, has been involved in identifying HIV infection during the acute stage. Our current understanding of HIV, suggest that diagnosis during this stage of HIV may be important in avoiding further transmission of HIV, and may influence the outcomes of HIV in the individual. However, women are typically not included in these studies for a variety of reasons that revolve around social, behavioral, and economic reasons. Additionally, this may also be due to unrecognized symptoms in the woman, or her health care provider, if she has one. Therefore, we advocate for more routine testing for women to determine their HIV status, to identify the barriers to women participating in HIV research, to communicate to women at risk for HIV and their health care providers, the importance of recognizing the early signs and symptoms of HIV.

Testimony for
New York City Council Health Committee & Women's Issues Committee
On
The HIV/AIDS Epidemic Among Women in NYC
December 13th, 2007

Submitted by the Women's HIV Collaborative of New York.
By Claire Simon
Interim Executive Director

Good afternoon, Chair Rivera, Chair Sears and members of the Health and Women's Issues Committees. Thank you for the opportunity to testify, my name is Claire Simon and I am the Interim Executive Director for the WHCNY.

The Collaborative was formed in April 2000 in response to the need for a sustainable and broad based advocacy network focused on women and HIV. We are a collaboration of individuals, HIV+ women, and organizations committed to addressing the multiple needs of women infected and affected by HIV.

The Collaborative is angered, disheartened, but not surprised, by the increasing rates of HIV infection in young women and women of color. Why should there be shock when New York City has been the epicenter of the AIDS epidemic for women since the very beginning? African American and Hispanic women together represent 86 percent of the 53,500 women who have been diagnosed with HIV and AIDS in New York. In New York, females now account for 48 percent of new HIV infections among teens ages 13-19, and 43 percent of new infections among young adults, ages 20 to 24. An increasing number of HIV/AIDS cases are also being seen in women over 50 years of age.!

We are not surprised that AIDS is still, in 2007, one of the top killers of Black women between the ages of 25-34. Why would there be alarm when efforts to teach HIV and AIDS prevention have been thwarted for the last 10 years? It cannot be ignored that some of the new infections that we are now seeing among 20 and 30 year-olds were likely in New York City Public Schools a decade or less ago.

We are facing an ever expanding epidemic - one that is affecting young people in their prime and the very women who are the ones who hold families and communities together. We are also seeing newly diagnosed women and girls have a concurrent diagnosis of HIV and AIDS. This is what the new HIV data is telling us, and we have plans to address this.

With generous funding from the City Council this fiscal year, **the Collaborative has embarked on a Women and Girls HIV/AIDS Visibility Plan** to analyze, explore and address the impact the epidemic is having on women and girls in New York City. **The Collaborative Monthly Roundtables** reach 500-750 borough-wide – the roundtables highlight issues that are relevant and pressing to our constituents, women and the HIV Community.

In the upcoming months the Collaborative **will conduct a community mapping project** to identify those areas in New York City where women are most highly impacted by the HIV/AIDS epidemic and assess how high HIV incidence rates correlate with other significant co-factors such as poverty, gender based violence, and lack of access to health care. In the last few years there have been several reports on women and HIV/AIDS and its' impact included is our March 2005 report *Service Access, Stigma & Advocacy: The Experiences of Women Living with HIV and AIDS* showed that New York City has such fragmented services for women, especially those at risk from **heterosexual contact or those who are newly infected, it is as if there are no visible AIDS services at all. And we know that is not true.** But what is true is that coordination of HIV services for women, who are infected, especially newly infected, are fragmented. The community mapping project aims to address this issue.

The Visibility Plan includes working with our members, constituents and particularly the NYC Department of Health and Mental Hygiene, Women and HIV/AIDS Unit and the HIV Prevention Planning Group **to determine mechanisms for improving prevention and care coordination for women and girls HIV programming, for ensuring that all participating City Agencies who serve women are moving in the same direction.** The Women and HIV/AIDS Unit is severely underfunded and has not been able to adequately provide technical assistance to women focuses HIV/AIDS organizations. [Note; benefit of TA to assure the life of organizations] Neither have they been able to promote cross collaboration and information across City agencies

In addition, the Collaborative's work with DOHMH, will include **addressing the high rates of newly diagnosed women and girls whose risk category is not reported (NRR) in the data.** The current HIV surveillance system, established in the 1980s to track newly diagnosed HIV cases, paints and outdated, inaccurate picture of the epidemic and misinforms funding prescriptions for HIV/AIDS prevention nationwide and evermore so in New York City.

In reality, most women contract HIV heterosexually when they believe they are in a monogamous relationship. But if a newly-diagnosed woman can't identify her male partner's HIV status or "high-risk" behavior (e.g. male to male sexual contact or injection drug use), and other means of transmission are ruled out, the CDC surveillance system automatically places her in a generic category labeled "no identified risk" (NIR) or "no reported risk" (NRR). As a result, her case and the thousands of others like hers have no real chance of informing funding prescriptions for prevention and testing efforts nationwide or influencing public perceptions of the epidemic and the greater public health response. **In fact, women are reportedly being denied HIV testing at federally funded sites because they do not fit into the CDC's high-risk categories. It is estimated that 47-60% of all women testing HIV positive in the US are classified as NIR.**

To meaningfully address HIV and AIDS among young women and communities of color, we will need to develop new access points and strategies in addition to supporting the current ones that we know work. Women's susceptibility to HIV/AIDS is substantially higher than men's both biologically and due to their lack of economic and social power, especially in situations where women cannot control sexual encounters on insist that their partners use condoms. The Collaborative is the co-convener of the New York Microbicides Working Group along with the Women's Institute at the Gay Men's Health Crisis and Housing Works – our current agenda includes garnering support to pass the resolution of the Microbicides Development Act (MDA) introduced in the House (H.R. 1420) –and the Senate (S.823). **Microbicides are a topical product that women and men can use to prevent the transmission of HIV/AIDS and other sexually transmitted diseases.** The MDA will help ensure that the US government's commitment to microbicide research and development is increased substantially.

In New York City, we must invest in targeted prevention and education for women, especially young women of color, starting in our public schools.

With this new epidemic in mind, we submit to you the following recommendations:

The Collaborative recommends convening a task force of a broad base of stakeholders to research, assess and develop recommendations to address the "no reported risk" data for New York City – in particular for women and girls

Secondly, the Collaborative recommends the development of a mechanism for improving service coordination for women and HIV programming as well as to foster information sharing and cross-collaboration that can address the need for comprehensive, "women-focused care" programs.

Thirdly, the Collaborative recommends that a hearing be held to look at the impact and issues faced by young women and girls who are HIV+ and newly diagnosed. The issues that they face brings on a new set of challenges as it relates to cultural issues, employment health care, violence, and access to services.

As HIV escalates among women of color in the city, fewer federal dollars are coming to the City to support primary prevention and supportive services. The City must provide additional resources for a broader array of primary and secondary prevention, education, support service and counseling programs/initiatives for women.

Visibility is the context in which the history and the issues of women and HIV in New York City have to be viewed. As I mentioned, research conducted by the Collaborative has revealed that there is a general lack of a visible and coordinated system of care for women with HIV that addresses their needs holistically. The City should invest in a mechanism for improving service coordination and cross collaboration building on it's existing infrastructure.

On behalf of the Collaborative, I thank you for this opportunity to testify and for your support of the Women and Girls Visibility Plan. We appreciate your leadership in holding this hearing, and look forward to working with the City Council in designing solutions to address the diverse needs of women and girls living with HIV and AIDS.

Women's HIV Collaborative of New York
2007-2008 NEW YORK CITY FUNDING PRIORITIES
THE NEW YORK CITY WOMEN AND GIRLS HIV/AIDS VISIBILITY PLAN

The Women's HIV Collaborative of New York calls on the City Council to invest in a **Women and Girls HIV/AIDS Visibility Plan** to recognize, explore and address the impact the epidemic is having on women and girls in this City, and to determine mechanisms for improving prevention and care coordination for women's HIV programming, and for ensuring that all participating city Agencies who serve women are in compliance.

The Collaborative was formed in April 2000 to respond to the need for a sustainable and broad-based network focused on mitigating the impact the epidemic was having on women, and to demand timely, gender-specific information, research, resources and policies. We are a collaboration of individuals, women living with, and affected by, HIV and AIDS and organizations committed to addressing the multiple needs of women infected and affected by HIV. With strategic alliances among a number of organizations serving women with HIV, and with formal and informal links to a network of HIV/AIDS and other agencies, this structure has positioned the Collaborative as a "hub" among local providers, officials and social service agencies in their needs for training, education, research and documentation to improve services to women with HIV city-wide.

We call on the New York City Council to respond to the emergency of HIV/AIDS among women and girls of color in this City and the deplorable response to this trend.

- Young Black and Latina women (ages 13-24) comprise over 80% of the total new HIV infections in NYC.
- Of all women living with AIDS in NYC, women of color comprise 89%.
- In New York City, it is estimated that by the year 2010, women will account for 50% of all AIDS cases.

We see that the systems or networks that should exist to stem the spread of HIV infections among women and girls in high incidence communities remain poorly resourced and fragmented by service "silos." The health of this segment of women in New York does not appear to be a priority on New York City's health agenda. We recognize that structural issues that disproportionately impact women – such as poverty, gender-based violence, lack of access to healthcare, histories of incarceration and substance use - fuel the HIV and AIDS epidemics.

It is to this end that the Collaborative calls on the City Council to invest in a **Women and Girls HIV/AIDS Visibility Plan** to recognize, explore and address the impact the epidemic is having on women and girls in this City, and to determine mechanisms for improving prevention and care coordination for women's HIV programming, and for ensuring that all participating City Agencies who serve women are in compliance.

For more info, please contact us by phone 212.367.1012.

- PLEASE TURN OVER -

THE WOMEN AND GIRLS HIV/AIDS VISIBILITY PLAN

PRIORITY 1: Support the Women's HIV Collaborative of New York for the Women and Girls HIV/AIDS Visibility Initiative (Visibility Initiative) which will provide policy and program advice, and technical assistance through research, analysis and community education, to bring end-user best-practices to bear upon women's HIV/AIDS prevention, treatment and services needs and policies in NYC. The goals of the Visibility Initiative are to research and document the disparities that exist for women living with HIV/AIDS in New York City, publish and distribute the findings, and develop timely and vital resources to women living with or at-risk for HIV/AIDS in NYC. The Visibility Initiative will promote cross-collaboration and information sharing amongst women-focused HIV/AIDS community-based organizations and government agencies, in an effort to improve HIV prevention and care coordination for women's programming. We will accomplish this via the following initiatives:

1) Monthly community roundtables - Over the next year, we request support for an ongoing series of monthly community roundtable presentations to reach 750-1000 people borough-wide. The roundtables highlight issues that are relevant and pressing to our constituents - the women and HIV community. Transcripts, meeting summaries and community calendars are direct outputs from the roundtables, and are forwarded to a number of different networks, reaching up to 5,000 individuals.
2) Community mapping project and meta-analysis – We will conduct a community mapping project of those areas in NYC where women are most highly impacted by the HIV/AIDS epidemic, and how high HIV incidence rates correlate with other significant co-factors such as poverty, gender-based violence, and lack of access to health care. We will also conduct a meta-analysis of various women and HIV/AIDS reports that have emerged over the last two years in New York.
3) Social marketing community forum and campaign launch - support a community forum to identify successful elements of previous social marketing campaigns and to help inform the launch (in year 2) of a major, targeted social marketing campaign to address the climbing rates of HIV infection among women.

A second year goal of this initiative is to develop a comprehensive New York City Women and HIV Benefits Manual (Handbook), which lists resources and information relevant for clients and providers to help better navigate the system of HIV prevention and care in New York City. The manual will be distributed via mail and email and will reach over 5,000 individuals and agencies.

PRIORITY 2: Support and build the capacity of the Department of Health and Mental Hygiene, Women and HIV/AIDS Unit, to provide technical assistance to women-focused HIV/AIDS organizations, and to determine strategies to promote cross collaboration and information sharing across City agencies. Support this agency's capacity to 1) Provide technical assistance to organizations that serve women and girls living with and at risk for HIV, in an effort to expand outreach, education and prevention, and to improve coordination and delivery of services, and 2) Conduct a needs assessment/gaps analysis to identify City agencies' roles and activities concerning women and girls affected by HIV, and determine and promote mechanisms for improving cross collaboration and information-sharing across agencies.

PRIORITY 3: We urge the City Council to pass a resolution supporting the Microbicides Development Act (MDA) introduced in both the House (H.R. 1420) and Senate (S.823). Women's susceptibility to HIV/AIDS is substantially higher than men's both biologically and due to their lack of economic and social power, especially in situations where women cannot control sexual encounters or insist their partners use condoms. Microbicides are a topical product that women and men could use to prevent the transmission of HIV/AIDS and other sexually transmitted diseases. The Microbicides Development Act will help ensure that the US government's commitment to microbicide research and development is increased substantially.

For more info, please contact us by phone 212.367.1012.

NYAC • 231 West 29th Street • Suite 1002 • New York, New York 10001
Tel: (212) 629-3075 • Fax: (212) 629-8403 • Web: www.nyaidscoalition.org

NYAC
New York AIDS Coalition
Educate
Advocate
Mobilize

Oversight - The HIV/AIDS Epidemic among Women in NYC

Testimony of Marie Saint Cyr, Executive Director

My name is Marie Saint Cyr, I am Executive Director of the New York AIDS Coalition (NYAC). NYAC is a coalition of over 160 HIV/AIDS organization across New York State, with the overwhelming majority of our member organizations residing in NYC. Since its inception in 1988, NYAC has been New York's only statewide coalition that has assumed a leadership role in managing and representing tens of thousands of people living with HIV and AIDS. At a time when there are competing interests and political and social biases, NYAC has been a beacon that has consistently spoken with a clear and focused voice on the issues that effect the well being, rights and entitlements of those impacted by the AIDS epidemic.

I would first like to thank the Committee on Health and Committee on Women's Issues for jointly holding this hearing on the HIV/AIDS epidemic among women in New York City. I have been very focused on the lives of women living with HIV for a long time. I was previously the Director of the Haitian Coalition on AIDS in New York City and developed the first program for women, called the Women and AIDS Resource Network in Brooklyn. I was also formerly Executive Director of Iris House, the first and only comprehensive program for women living with HIV and AIDS and their families. For me, addressing the needs of women living with HIV has been a lifelong crusade.

The intersection of HIV/AIDS and women is highly complex. No one single factor is responsible for the rising number of women who are infected, and routinely become infected with HIV. I want to bring to you first a few statistics. In 1985, approximately 7% of HIV/AIDS infections were among women.[1] But that has clearly changed. As of June of 2006, in New York City fully 30% of all persons living with HIV were women. In addition, among women living with HIV, 58% were black and 31% were Hispanic. In the first six months of 2006, black and Hispanic women constituted 94%

[1] http://www.thebody.com/content/whatis/art6129.html

of all new HIV infections among women.[2] This is an alarming number and a grave issue for women of color.

While epidemiology data from the City Health Department reports a large number of female infections labeled as "unknown" transmission risk, nationally, high risk heterosexual contact is the source of 80% of HIV infections among women.[3] I have every reason to believe that it is very similar in New York City. HIV has migrated across the city from its early attack on the gay community and has now expanded include heterosexual, minority women. While gay men account for 29% of those living with HIV/AIDS, HIV has expanded to heterosexual minority women and people over 50.

HIV has become one of the biggest killers of women in the United States. According to the U.S. Centers for Disease Control and Prevention (CDC), HIV is the leading cause of death for black women between 25-34 years old, and the third leading cause of death for black women 35-44 years old.[4]

I could spend a few minutes telling you about the tragic stories of so many women, and you could be mulling over questions like why would a woman with a master degree married to a doctor who should know better get an STD and remain silent about it. You could equally wonder why another woman's daughter has an STD and we had to move her to a secret shelter. We can spend the day seeking blame and responsibility and still after a day not come up with a single strategy that could have prevented either case. HIV prevention is personal and complex for those women, but it is also political and social in its profound (core) elements.

The key pressing questions are (1) why do women continue to become infected with HIV and what can we do to prevent new infections and (2) what can we do to help those who are already infected? The key to finding the answer to both of these questions also means looking a little deeper into the lives of women. To address the HIV prevention and care and treatment needs of this epidemic, sound public policies must also begin to take a solid look at the lives that many women lead and the situations that put them at risk. Issues of poverty, disenfranchisement, abuse from their sexual

---

[2] New York City Department of Health and Mental Hygiene, *HIV Epidemiology & Field Services Semi Annual Report,* Vol. 2, No. 1, April 2007. <http://www.nyc.gov/html/doh/downloads/pdf/dires/dires-2007-report-semi1.pdf>

[3] U.S. Centers for Disease Control and Prevention, *HIV/AIDS Among Women,* June 2007. http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm

[4] U.S. Centers for Disease Control and Prevention, *HIV/AIDS Among Women,* June 2007. http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm

partners, poor self-esteem, and lack of access to services focused on women and their unique needs all contribute to this growing problem.

Socioeconomic factors contribute to the challenges that we face in addressing the needs of women with HIV. According to the Bureau of Labor Statistics, women still earn significantly less than men, an average of $600 a week compared to $743 a week for men.[5] Not surprising, women were more likely to be living in poverty than men, with almost 13% of women living in poverty, compared to 10% for men, and 26% of single family female head of households were living in poverty.[6] The income disparity continues into old age. The golden years are not always that golden for women: for individuals over 65, 12.4% of women are living in poverty, compared to 7.0% for men. All of these factors help to contribute to the challenges ahead of us. Poverty leads to so many other variables that contribute to this disease, such as lack of access to quality health care, exchange of sex for drugs or money, and high levels of substance use, which can all contribute to an increase in the risk for contracting HIV. The feminization of poverty has a direct relationship to the number of women who are now finding themselves infected.

With fully 80% of all infections due to unprotected heterosexual sex, new prevention messages must focus on addressing the issue of women's vulnerabilities and their risks. For some women, there is a lack of recognition of their sexual partner's risk factors, such as drug activity, unprotected sex with multiple partners, or other men who also have sex with men. In a 2003 study of HIV-infected individuals, 34% of black men who have sex with men, 26% of Hispanic men who have sex with men, and 13% of white men who have sex with men also reported having sex with women.[7] However, many women in this study did not know of their partner's bisexual activity. Lack of knowledge of HIV, lower perception of risk, drug or alcohol use, and different interpretations of safe sex may contribute to HIV infections.

The power dynamics in many relationships does play a role in increasing a woman's vulnerability and risk of HIV infection. Some women, out of fear of abuse or abandonment, may not be able to insist that their lover or husband wear a condom. This fear is real - one in six American women are victims

[5] U.S. Bureau of Labor Statistics, *Women in the Workforce: A Databook,* September 2007, p. 2.
[6] U.S. Census Bureau, *Men and Women in the United States, March 2002,* March 2003
[7] U.S. Centers for Disease Control and Prevention, *HIV/AIDS Among Women,* June 2007. http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm

of sexual assault, and one in 33 men. In 2005 there were an estimated 191,670 victims of rape, attempted rape or sexual assault nationwide.[8]

Today, while there are many HIV/AIDS organizations in the City, there still are very few that focus solely on the comprehensive needs of women. The view that HIV was solely a gay white man or intravenous drug user's disease lingered for quite a long time, despite mounting data that women were increasingly becoming infected. The failure to develop organizations focus on the needs of women of color also reflects women's limited financial resources. It is not insignificant that in New York City, the epicenter of the women's HIV crisis, it took years before Iris House, one of the first supportive services nonprofit organizations designated specifically for women with HIV/AIDS, was created in Harlem.

For many women, their first priority is not themselves; in many households women are also expected to be the primary caretaker for infants and children. This raises risks that in many instances HIV-infected women will not seek proper, regular medical care. Adhering to HIV treatment regimens requires that individuals take HIV medications precisely as prescribed; most medications must be taken on a strict daily routine. Effective treatment also means seeing an HIV primary care doctor on a regular basis in order to monitor and evaluate their ongoing health. This becomes difficult for women in abusive relationships, in shelters, with young children to care for, and other factors that can interfere with treatment.

My years of experience allows me to say that to address HIV among women and vulnerable populations, we must also reveal and accept that other conditions are more explicitly involved. The factors that result in the conditions that govern many poor people's lives must be addressed to make a significant difference. We are at a level where we see token differences, so we parade a single hero who has emerged as if to say I challenge every women because look at "Brenda" she did it.

To look at a single success story often means looking at the environment in which that individual lived. One success often means that we addressed the issue of financial instability and their associated risks, that we removed someone from the housing site where drugs flourished, that we supported someone with counseling and home visits to retain them in care when they would be discouraged, and we taught them to be their own advocate. Think, in those instances, how many institutional issues had

[8] U.S. Department of Justice, Bureau of Justice Statistics, *Criminal Victimization, 2005*, NCJ 214644, September 2006. < http://www.ojp.usdoj.gov/bjs/cvictgen.htm>

to be addressed and structural issues had to be remedied. Those who are in the trenches doing the work to assist many PLWHAs, rise above it all, only to be threatened with curtailment and cost containment measures in scarce times. This is more compounded for those whose status with immigration lingers, and there is a lack of political will in Washington to make a difference.

It was not that far ago, in October 2004, that Vice Presidential candidate Dick Cheney during a debate with Senator John Edwards responded to a question that he was "not aware" HIV/AIDS disproportionately affects African-American women. Thankfully, there has been increased awareness since then, but we still have a long way to go.

We cannot continue one more hearing, one more band aid and one more hero, the fact is that we have thousands of heroines and heroes waiting to be rescued from system failure, social biases and discrimination, lack of health care access and community deprivation.

helping many, one by one
AIDS Service Center NYC
41 East 11th Street, New York, NY 10003
(212) 645-0875 fax: 645-0705 www.ascnyc.org

NEW YORK CITY COUNCIL
COMMITTEE ON HEALTH
COMMITTEE ON WOMEN'S ISSUES

HEARING: HIV/AIDS EPIDEMIC AMONG WOMEN IN NYC

Diane Williams, ASC Peer Educator

Thank you for this opportunity to underscore the acute need among women of color in New York City for services that address women's unique needs and improve their access to HIV testing, medical care, mental health, substance abuse, recovery and support services.

HIV prevention, treatment and care services for women of color must address issues that affect women's lives: parenting and care-giving, power dynamics in intimate relationships, female sexuality, domestic violence, childhood sexual abuse, trauma, self-esteem issues, gender-based roles and expectations, and disclosure in the context of the family unit and women's central role within it.

My story of finding hope and help at AIDS Service Center illustrates one agency's efforts to create programs designed by and for women living with HIV/AIDS.

When I found out I was HIV positive in 1999, my whole life stopped. I was infected by love, not by drugs. I'd been planning to marry the man I loved. I wasn't in a high-risk category, so I didn't see any need for condoms. After learning I was HIV positive, my spirit was broken. I was totally destroyed inside, and preparing for the worst.

Then a friend told me about AIDS Service Center NYC. "You don't have to suffer anymore," she said, "ASC will love you until you can love yourself again." So I came to ASC and joined ASC's peer education training program. ASC embraced me with love and warmth. For the first time, I didn't feel ashamed of having HIV.

ASC's peer trainings put my skills to use and returned my self-worth. Before my diagnosis, I'd been in the workforce for years, helping other people as a substance abuse counselor. Now, with ASC's support, I was helping myself. After getting trained at ASC, I became an ASC Peer Educator and facilitated HIV prevention presentations in at-risk communities citywide. My presentations were more than just words on paper. I spoke with conviction, because the information was so personal. When I'm talking about HIV prevention and see the "light bulb" go on in someone's head, it's payday for me. I am blessed and hope to be a positive example for others.

Today, I am a woman who's gotten her self-confidence and self-worth back. ASC provided safety, warmth, and security when I really needed it. ASC gave me the tools to help myself. Along with the

peer trainings, I got individual therapy that helped me see my personal strengths and learn to put my own health first. ASC also came with me to my doctor's appointments, to offer support during some scary times so I never felt alone.

At ASC, "helping many, one by one" is more than just a slogan. Today, I embrace the goodness in my life, but when the next storm comes, I know I can count on ASC. I also know that I can apply the skills I've learned to help other men and women prevent HIV, or if infected, get the tailored help they need.

Here are other statistics about the disproportionate burden faced by women in New York City who are living with HIV/AIDS:

Impact of HIV on Women of Color in NYC: NYC's communities of color are disproportionately burdened by the HIV epidemic. As reported by DOHMH, HIV infection rates in NYC are 6 times higher among non-Hispanic blacks and 2.5 times higher among Hispanics, compared with non-Hispanic whites.[1,2]

Black and Hispanic women comprise only 49% of NYC's female population,[3] yet they constitute 92.9% of women diagnosed with HIV; 90% of HIV-related deaths; and 89.7% of women living with HIV/AIDS in NYC.[4] AIDS mortality is 7 times higher for Black women than white women,[5] suggesting the urgency of early diagnoses and improved access to care.

There is a great need for targeted services to women, given the epidemic's growing impact and evolving transmission patterns. Early in the epidemic, 10% of New Yorkers with HIV were women; today, 1 in 3 is a woman.[6] Initially, most women were infected by injection drug use; today, most women are infected by an HIV-positive man.[7] In 2005, of the 1,042 women in NYC diagnosed with HIV, transmission risks were: injection drug use (IDU) history (6.7%), heterosexual transmission (52.6%), and unknown/under investigation (39.4%).[8] In NYC, 1 in every 14 Black men between ages 40 and 54 is living with HIV or AIDS, nearly 7 times the rate of other New Yorkers[9]—a fact with ominous implications, since heterosexual transmission is the #1 HIV risk factor for women.

Impact of Trauma on Women: A growing body of evidence, including a recent study by CDC researchers,[10] confirms ASC's strong anecdotal experience that among women there is a strong association between childhood sexual abuse (and other adverse childhood experiences) and a substantially increased risk of abusing drugs or alcohol, engaging in high-risk sexual activities, and becoming infected with an STD (including HIV). Women who report early and chronic sexual abuse have a 7-fold increase in HIV-related risk behaviors and markers of risk compared with women without abuse histories.[11] While it is estimated that 20%–25% of women in the U.S. have histories of sexual abuse, in ASC's client population, we have found the incidence to exceed 70%.

Needs of Reentry & Ex-Offender Women: Female ex-offenders are at exceedingly elevated risk for substance abuse, HIV, and hepatitis C, and sorely need services to alleviate the demanding process of reentering the community after their release from custody. For most of these women, health care concerns and recovery may take a lower priority than the search for jobs and housing and the process of rebuilding their lives.

Child Care & Employment Training Assistance for Women: In *We Speak: New York City Women Living with HIV/AIDS Speak About Their Needs* (prepared in 2006 for the United Way of NYC), Black and Latina women with HIV/AIDS comprised 100% of the study's participants. Among these women, the need for childcare support and other gender-specific services was raised in the context of meeting the "complexity of needs in the lives of HIV-positive women."[12]

Almost half of the women participating in the study wanted educational and employment services but were not receiving them.[13] The report also argues for the importance of service providers having "the human and financial resources to equip and empower HIV-positive women to transform their lives in the midst of the poverty in which they live. With a variety of support systems, it is hoped that poor sero-positive women increasingly can become more self-sufficient and advocates of change in their own lives, families, and communities."[14]

In conclusion, I'd like to describe a program for women that is peer driven and addresses recovery support and access to care in the context of women's lives, called **HERS @ ASC -- Honoring Everywoman's Right to Safety.** This program provides a continuum of much-needed peer education, HIV testing, medical care, and mental health services that:

- Increase the proportion of African American and Latina women in Manhattan who know their HIV status.
- Improve women's access to medical and mental health care, substance abuse services, housing placement assistance, and other needed services.
- Increase women's knowledge about HIV transmission
- Reduce infection, re-infection, and transmission of HIV, STIs, and hepatitis C among women of color in Manhattan.
- Address emotional issues underlying risk behaviors (e.g., childhood sexual abuse, trauma, domestic violence, depression, etc.) to promote sustained behavior change towards recovery and prevention of HIV and STIs.

Here are quotes from some of the women I've met and work with at AIDS Service Center NYC:

- "If I could save just one person from HIV/AIDS, I'd make my mark in life. ASC has given me the tools, the education, and the confidence to do it." —Yvonne, ASC Peer Educator
- "Mental health counseling helps me stay clean and maintain my health as a person living with HIV. The counseling is part of my foundation." —Carolyn, ASC client
- "ASC let me know that just because you have HIV doesn't mean you can't do everything you wanted to in life. ASC gives that type of support to people, and I give that same message to others." —Lillian, ASC Peer Educator

AIDS SERVICE CENTER NYC

Serving Manhattan, Brooklyn and the Bronx, ASC is a multiservice community organization that serves economically disenfranchised men and women facing addiction, poverty, mental illness, homelessness and domestic violence, alongside a range of other health issues such as HIV/AIDS, TB, and Hepatitis C. ASC fulfills its mission of *helping many, one by one* by promoting empowerment, well-being, and stability for persons living with and at risk for HIV/AIDS through dynamic programs that help people to reduce risk; embrace well-being; stabilize and improve their daily living situations; overcome despair; and access health care, housing, and jobs.

In 2006, ASC provided care to 1,565 clients at its three sites and reached 18,499 New York City residents through 2,820 peer education and community outreach initiatives. 89% of ASC clients people of color (57% African-American, 29% Latino/a, 3% Asian/Native American); 38% are women, 78% are active or recovering substance users, 74% are homeless or in need of housing assistance, 21% are LGBT, 50% reside in Manhattan, 26% in the Bronx, and 19% in Brooklyn. All ASC services are free, confidential, and available in English, Spanish, French, and Haitian Creole, and include:

- Peer Training Initiative, which annually trains over 350 people living with and at risk for HIV/AIDS to be HIV prevention and harm reduction Peer Educators.
- HIV counseling & testing yielding a 2.5% seropositivity rate.
- Basic needs program that provides over 12,000 meals, clothes and a food pantry for 1,400 individuals and families annually.
- Housing placement assistance for nearly 100 individuals and families annually.
- Comprehensive care coordination for 500 people living with HIV per year, including medical, housing, substance abuse treatment, translation assistance, mental health services, entitlements advocacy, and childcare aid.
- Specialized services that address the specific needs of women with HIV/AIDS.
- 24 Weekly support groups, recreational activities, and workshops.

Through pioneering peer education programs, and a comprehensive range of innovative services, AIDS Service Center NYC (ASC) helps New York City's most vulnerable individuals and families maintain the best possible quality of life and health in the face of HIV/AIDS. ASC fulfills its mission of "helping many, one by one" by building community, connection and stability for the thousands of New Yorkers we serve each year. In 2006, ASC provided care to 1,565 clients at its three sites and reached 18,499 New York City residents through 2,820 peer education and community outreach initiatives.

[1] Karpati A, Kerker B, Mostashari F, Singh T, Hajat A, Thorpe L, Bassett M, Henning K, Frieden T. *Health Disparities in New York City*, New York: NYCDOHMH.
[2] Reuters News Article, "HIV Rate in New York City Men Higher Than Thought," by Deborah Mitchell, February 10, 2004.
[3] Kerker BD, Kim M, Mostashari FM, Thorpe L, Frieden TR. *Women at Risk: The Health of Women in New York City.* NYCDOHMH, 2005.
[4] HIV Epidemiology Program, NYCDOHMH, *NYC HIV/AIDS Annual Surveillance Statistics, 2005* (Generated 12/4/06), Table 1.2.2. (Females).
[5] Kerker BD, Kim M, Mostashari FM, Thorpe L, Frieden TR. *Women at Risk: The Health of Women in New York City.* NYCDOHMH, 2005.
[6] Health Bulletin: Women and HIV/AIDS, NYCDOHMH News—Vol. 3, Number 11, Dec./Jan. 2004-2005.
[7] Health Bulletin: Women and HIV/AIDS, NYCDOHMH News—Vol. 3, Number 11, Dec/Jan 2004-2005.
[8] NYCDOHMH, HIV Epidemiology Program Semiannual Report, October 2006.
[9] NYCDOHMH, Office of Communications, Press Release, "New York City Department of Health and Mental Hygiene Presents New HIV/AIDS Data at International Conference in Thailand," Monday, July 12, 2004.
[10] "Adverse Childhood Experiences and Sexual Risk Behaviors in Women: A Retrospective Cohort Study," *Susan D. Hillis, Robert F. Anda, Vincent J. Felitti and Polly A. Marchbanks,* Family Planning Perspectives: Volume 33, Issue 5, September/October 2001.
[11] The Body: The Complete HIV/AIDS Resource (April 25, 2002), citing *Does a History of Trauma Contribute to HIV Risk for Women of Color? Implications for Prevention and Policy*, published in American Journal of Public Health. http://www.thebody.com/cdc/news_updates_archive/apr25_02/women_aids.html
[12] *We Speak: New York City Women Living with HIV/AIDS Speak About Their Needs (Executive Summary),* a report prepared for the United Way of NYC by The Women of Color Policy Network, Wagner School of Public Service, New York University, June 2006, page 6.
[13] *We Speak: New York City Women Living with HIV/AIDS Speak About Their Needs (Executive Summary),* a report prepared for the United Way of NYC by The Women of Color Policy Network, Wagner School of Public Service, New York University, June 2006, page 6.
[14] *We Speak: New York City Women Living with HIV/AIDS Speak About Their Needs (Executive Summary),* a report prepared for the United Way of NYC by The Women of Color Policy Network, Wagner School of Public Service, New York University, June 2006, page 12.

FOR THE RECORD

Testimony on Women and HIV/AIDS in New York City
New York City Council
Joint Health & Women's Committee Hearing

Delivered by
Kimberleigh J. Smith, MPA
Director, Women's Institute
Gay Men's Health Crisis

December 13, 2007

Good Afternoon. My name is Kimberleigh Smith, and I am the Director of the Women's Institute at Gay Men's Health Crisis. I want to extend my appreciation to the New York City Council's Committees on Health and Women's Issues for the opportunity to speak here today.

In my brief time, I'd like to share with you a bit about the Women's Institute and its perspective on this epidemic as it impacts women and propose a few strategies in which you, as our city's decision makers, can employ to lead a more strategic approach to women and HIV ultimately improving health outcomes.

Women's Institute

The Women's Institute carries much of the gender-specific prevention programming for GMHC and in this way contributes to a coordinated system of care for the nearly 3,000 women who seek GMHC's direct services annually. While the Women's Institute just celebrated its third anniversary, GMHC has been providing women-specific services and programming since the early 90s and the proportion of female clients at GMHC continues to grow. In the last fiscal year, we experienced a 37% increase in women seeking direct services from the year prior. Our reach to HIV-negative/at-risk women has nearly quadrupled.

Our core programming includes prevention for women at-risk as well as those who are newly diagnosed, services for women who identify as lesbian, a thriving program that reaches young women in schools, community-based and group-home settings, and a robust Peer Leadership Initiative.

One of the greatest successes of the Women's Institute is its women-specific testing days, organized in conjunction with GMHC's David Geffen Center. PHEs provide the outreach for these events and more than

200 women have been tested in total resulting in an 8% to 13% positivity rate, compared with the typical NYC-wide rate of approximately 1% - 2%.

Finally, the WI increases AIDS awareness through social marketing campaigns, our latest being *HIV-We're Not Taking it Lying Down* which was up for eight weeks on urban panels outside of subway stations in Central Brooklyn and Central Harlem. We are grateful for support from the New York City Council to conduct these campaigns.

The Case

As you know, we are in the midst of an unrelenting epidemic with HIV and AIDS in the U.S. In upcoming weeks the CDC will release new statistics demonstrating that the number of Americans who are infected with HIV and AIDS each year is 50% higher than previous calculations. While we've seen some small successes in the number of new infections among women, New York City remains at the epicenter of the HIV epidemic so this statistical increase demands special attention and immediate action. Furthermore, HIV is not equally spread out among populations. The disparities continue to be alarming.

In the last 26 years, AIDS diagnoses in NYC women have also climbed from 11% to 32%. Women of color, especially African-American women, are disproportionately affected. From January to June 2006 in New York City, African-American and Latina women accounted for almost 94% of HIV diagnoses among women, 90% of new AIDS diagnoses among women; 90% of women living with HIV/AIDS and 89% of all AIDS deaths among women.[1] Approximately two-thirds of all women report that exposure occurred through heterosexual sexual contact.[2]

Co-infection of either sexual partner with an STI can increase the rated of HIV transmission dramatically. Of serious concern, HSV-2 (Herpes Simplex Virus 2), the most prevalent STI in the U.S. and worldwide, is particularly significant in communities of color. Over 60% of African-American women in New York are infected with the virus and HSV-2 doubles the risk for HIV transmission.[3] Women infected with Chlamydia are up to five times more likely to become infected with HIV, if exposed. Women are three times as likely as

---

[1] Ibid.
[2] Ibid.
[3] Corey L, Wald A, et al,"The Effects of Herpes Simplex Virus-2 in HIV-1 Acquisition and Transmission: A Review of Two Overlapping Epidemics." *Journal of Acquired Immune Deficiency Syndrome*, 2004 April. 15:35 (5): 435-45 as referenced in New York State Department of Health AIDS Institute Division of HIV Prevention RFA, January 2007.

men to be diagnosed with Chlamydia, and the rate of reported Chlamydia among African-American women was more than 7.5 times that of white women. [4]

Affecting a Greater Impact

We've learned that we must be more strategic in our approach to preventing HIV among women in New York City if we're serious about really slowing down this epidemic. In order to do this, the Women's Institute at GMHC proposes the following strategies:

NUMBER ONE: SUPPORT WITH RESOURCES COORDINATESDAND INTEGRATED SYSTEMS OF CARE FOR WOMEN

Women's Institute joins the Women's HIV Collaborative of New York in its push for coordinated care for women, for co-located primary medical care services, mental health, substance use and supportive services that are women-focused and reach women across their life-span. The research is there. Coordinated care predicts access to, and maintenance of, care for women and people living with AIDS.

NUMBER TWO: AUGMENT EFFORTS TO DO COMMUNITY AND POPULATION-LEVEL INITIATIVES FOR WOMEN

It is becoming increasingly documented that racial disparities cannot be explained simply by traditional measures of socioeconomic difference, and it cannot be explained by individual-level determinants of sexual behavior, but rather reflects deeper group-level social and environment factors for which race is a marker.

As a result, many women of color in New York City and in the US are at higher risk in contracting HIV than their white counterparts, despite comparable risk behaviors. An individual black female, for example, is likely to be at higher risk for acquiring an STD or HIV simply because she is likely to choose sex partners within her racial group and the entire population of blacks has a higher prevalence of STDs and HIV; in fact, her risk of acquiring an STD is far higher than a white woman with exactly the same risk behavior."[5] This notion suggests the need for population-level interventions. We specifically are promoting a city-wide women-specific HIV testing, STI screening and women's wellness initiative complemented by a mass media and strategic social marketing about sexual health, healthy relationships and community health. Behavioral-level change alone will not continue to resonate with women in these communities.

---

[4] New York State Department of Health AIDS Institute Division of HIV Prevention, Communities of Color Initiative, Request for Applications, January 2007.
[5] Ibid.

NEXT: SUPPORT THE MICROBICIDES DEVELOPMENT ACT

A female-controlled prevention product offers us great hope for impacting the epidemic among women. Microbicides are a class of product currently under development that women could apply topically to prevent transmission of HIV and other infections. Microbicides could come in a variety of forms, including gels, creams or rings that would release the drug slowly over days or weeks.

You can support the NYC Resolution No. 839, introduced last spring by Councilmember Rosie Mendez, and push for the Microbicides Development Act in Congress. Right now, barely three percent of the U.S. budget for HIV and AIDS research – three cents for every dollar – is spent on development of microbicides. Sign on, if you haven't already, and support the MDA. Pressure our Congress to get this important bill passed.

FOURTH: UPDATE SURVEILLANCE SYSTEMS

The HIV-surveillance system as it is currently designed is flawed and might be a key reason why women are unaware of - or choose not to believe - their own risk for HIV infection and may ultimately be fueling the growing crisis of HIV and AIDS among American women.

Women who are unable to identify the HIV-positive status or risk behavior of their male partner get automatically categorized in to a "no-identified risk" category. The current system focuses primarily on risk behaviors and does not take in to consideration contributing environmental and socioeconomic factors that go beyond gender, race and ethnicity classifications.

Long a topic of our city's Prevention Planning Group; the "no-identified risk category" movement is gaining national momentum. Let's work together to improve our surveillance locally and advocate to the CDC to do the same.

FINALLY, WE MUST INTEGRATE BEHAVIORAL-LEVEL AND STRUCTURAL-LEVEL INTERVENTIONS IN OUR PREVENTION APPROACHES FOR WOMEN

There is a general and growing consensus that in order for effective behavioral prevention strategies to reach the maximum number of individuals, they should be integrated into the widest range of existing

education and health care services and that more efforts are needed to overcome the societal and policy barriers that keep effective community interventions from being implemented and scaled up. These approaches are needed for women, as well.

The vast majority of behavioral and social interventions focus on individuals without taking into account the larger social and cultural contexts that, at times, can promote risk behavior or that can serve as barriers to accessing effective prevention strategies. It remains to be seen whether the effects of these behavioral interventions alone are sustainable for the long term. Studies suggest they are not. To enhance opportunities for long –term sustainability, intervention activities cannot be aimed solely at changing individual behavior; they must work also to change the structural features of a community – such as its programs, practices, and laws or policies that place certain groups of people at increased risk of becoming infected, including women.

For instance, poverty and gender inequality are two core structural factors that shape risk to HIV and AIDS for women, yet there are very few integrated HIV and economic interventions in the U.S. at this time and very few domestic economic programs that integrate health concerns into them. Similarly, there's been considerable work about how gender roles shape sexual negotiations and HIV and AIDS risk. However, sexual negotiations are not simply about gender roles, but are structurally and institutionally reinforced through broader relations of inequality and privilege.

The City Council can command and allocate more resources to design these interventions, supporting participatory research and innovative pilot programming within our community-based organizations. With that, I will end. I'm happy to answer any questions you might have.

Thank you for your time.

Respectfully,

Kimberleigh J. Smith, MPA
Director, Women's Institute
GMHC
212-367-1360
kimberleighs@gmhc.org