30 FOR 30 CAMPAIGN

BRIEFING PAPER

Structural and Personal Violence: Connected Drivers of Women's HIV Acquisition and Compromisers of Health Outcomes for Women Living with HIV

Advocacy • Equity • Action

Introduction

The connection between women's lifetime experience of intimate partner violence (IPV) and relative risk of HIV is well documented. Overall, an estimated 36% of women in the U.S. have experienced IPV, but the percentage rises to 55% among women living with HIV.[3] Developers of social policy and programming in this area often approach the topic from the perspective of individual or community, rather than systemic, interventions. The White House Interagency Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-related Health Disparities reported in 2013 on the need to promote "economic security for survivors of violence living with HIV/AIDS" and to determine "resiliency-related factors that contribute to women and girls overcoming HIV-related stigma and the consequences of violence."[4]

These approaches are important, but they do not begin to address the pre-existing structural realities that condition women's intimate partner violence (IPV) and HIV risk. In its conclusion, the Interagency Working Group report acknowledges the need for further focus on "structural factors that contribute to violence and HIV risk."

This briefing paper summarizes a few of the structural factors that put women living in poverty, regardless of their individual behaviors, at increased risk of HIV and IPV. It also identifies factors that exacerbate these risks among women in key populations, those recognized as "groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response."[5] Among these are sex workers, women who use drugs, transgender women, Black women, young women and girls, prisoners and undocumented women.

There is not space here to discuss impacts on each of these groups in any meaningful depth. This paper, instead, is intended to generate discussion of how the structural violence inflicted on each of these populations (whether by the absence or the presence of specific factors) effectively traps many women in settings and life situations that heighten

The 30 for 30 Campaign is dedicated to ensuring that the unique needs of women living with and affected by HIV, including transgender women, are addressed in the national HIV response. We are especially committed to illuminating and eliminating the gaps in prevention and care services for Black and Latina women who currently make up over 80% of the epidemic among women but only 12% and 14% of the U.S. female population respectively.[1]

The Campaign is concerned with the current state of HIV prevention and care for women as studies continue to show that women, especially women of color, have consistently poorer health outcomes despite there being no significant clinical difference in treating men or women living with HIV.[2]

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their risk of interpersonal violence and HIV. The term "structural violence" refers here to the "systematic ways in which social structures harm or otherwise disadvantage individuals."[6] It is sometimes referred to as institutional violence since social institutions (such as governmental agencies, law enforcement, courts, etc.) can create circumstances that result in structural violence. Additionally, racism, sexism, classism, and HIV stigma are often at work undergirding structural violence. The term used here, however, encompasses both structural and institutional violence. Examples and forms of structural violence cited below are just illustrative examples and do not capture fully the wide variety of structural violence that occurs.

Structural Violence Impacts HIV Among Women

The absence of essential services is a form of structural violence. Some forms of structural violence are engendered by social structures or institutions that "harm people by preventing them from meeting their basic needs."[7] They take the form of the absence of essential structures or services, as well as the existence of those that are harmful. Food insecurity, for example, is a form of structural violence that is avoided when social systems ensure universal access to nutritious foods. The absence of supports and services needed to reduce HIV transmission in high-prevalence settings is a form of structural violence, as is the absence of services enabling women living with HIV and women in danger of IPV to keep themselves and their families healthy and safe.

Nineteen U.S. states,[8] most of them in the Deep South, for example, have not expanded Medicaid. Absent this expansion, more than a third of all uninsured women fall into an insurance coverage gap. Over half (52%) of all Americans caught in this gap are women. Most of them are women of color (29% Black and 23% Latina). While 9.5 million previously uninsured women (ages 18–64) have gained coverage through Obamacare, another 2.9 million remain excluded due to states' failure to expand Medicaid. Another four million women are barred from access to either Medicaid or Obamacare because they are undocumented immigrants.[10] Combined, this leaves a total of almost 7 million women in the U.S. without health insurance and unable to access essential prevention and care services. This is structural violence.

Uninsured women living with or at high risk of HIV face compounded violence by the lack of access to

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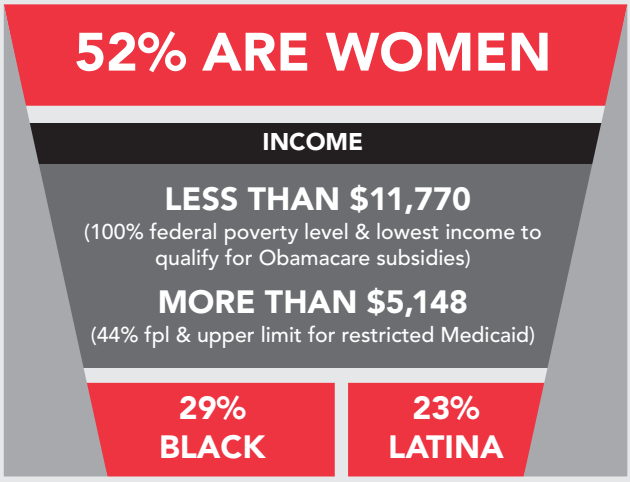
health care, generally, and the dearth of accessible HIV prevention, testing, treatment and care, in particular. Comparing the states without Medicaid expansion and the states with high HIV prevalence exposes this. Ten of the 19 states that have not expanded Medicaid are in the Deep South.[11] This region, home to 28% of the U.S. population,[12] accounts for half of all new HIV diagnoses. Of the women diagnosed,[13] 69% are Black[14] and their death rate is higher than that their male counterparts.[15]

Late diagnosis of HIV is a compelling indicator of this. At diagnosis, a person's level of HIV-related illness is described on a scale of 1–3. Stage 3 is AIDS, the result of approximately ten years of unchecked damage to the immune system. Nationally, nearly one-quarter of women and men with HIV received stage three diagnoses in 2012.[16] But in Louisiana between 2008 and 2012, the rate of late diagnosis rose to a full 33% among women being tested for HIV for the first time.[17]

Americans Caught in the Coverage Gap in States without Medicaid Expansion

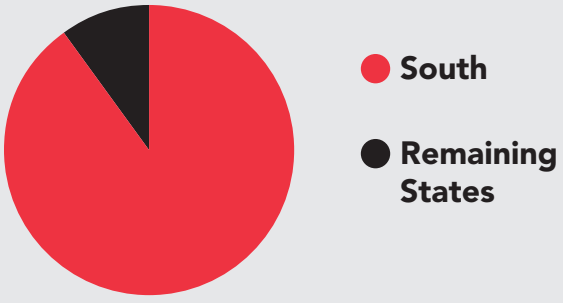


While more men than women are diagnosed with HIV in the U.S., women living with HIV are more likely than their male counterparts to be non-White (usually Black), caring for minor children and low-income. In 2014, 70% of men diagnosed with HIV were men of color and 40% were Black. Among women diagnosed, however, 82% were women of color and 65% were Black.[18] Most of these women (76%) are also caring for minor children at home, compared to 34% of their male counterparts.[19] And women living with HIV and highly vulnerable to HIV are significantly more likely to be poorer than their male counterparts — an important difference in terms of degree to which structural violence affects women's HIV risk and health outcomes.

Structural Violence Acutely Impacts Vulnerable Communities

Southern women[20] — especially women of color: The U.S. South has the highest rate of new HIV diagnoses as well as highest prevalence living with HIV.[21] Despite accounting for only 37% of the U.S. population, nearly half of all people living with HIV live in Southern states.[22] One study found that in nine Deep South states nearly a third of individuals living with HIV were women, suggesting that women are more heavily impacted by HIV in the South than most other parts of the U.S.[23] This study also found a lower five 5 year survival rate among women diagnosed with AIDS than among men and as HIV heavily and disproportionately impacts Black women in the South[24] — this further suggests Black women are highly vulnerable in this region. The disproportionate effect of HIV on Southern women must in part reflect the unique level of the role of structural violence in the South. Lack of access to health insurance remains highest in Southern states, which make up the vast majority of states refusing to expand Medicaid and the greatest number of individuals without health insurance due to the coverage gap. Additionally, the political climate in the South is having catastrophic impacts on women's ability to access existing institutions key to providing sexual and reproductive health care.

Geographic Distribution of People in the Coverage Gap



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For example, nearly one-fifth of the nation's second most populous state, Texas, is uninsured and thus 5 million Texans are unable to access affordable health care. The state's failure to expand Medicaid, in particular, has profoundly impacted the ability of 766,000 to access care. Many of those unable to access care are women (55%) and people of color (67%).[25] Moreover, the Texas state legislature enacted laws aimed at closing family planning clinics which are well documented as the usual source of health care for women[26] and often their source of HIV testing and linkages to care. While the U.S. Supreme Court in 2016 found unconstitutional the Texas law that resulted in shuttering 82 family planning clinics,[27] these closures have nevertheless destroyed or severely limited women's access to health care. Such actions inevitably perpetuated the already higher rates of later HIV diagnosis among women and hindered access to care for women living with HIV in Texas. Rebuilding access to the health care infrastructure that was dismantled by the Texas law, now overturned by the Supreme Court, will take time and meanwhile the health of millions of Texas women will suffer.

Residents of U.S. Southern states also experience profound structural violence through its deficits in their public educational institutions. Specifically, the South has maintained a resistance to implementing comprehensive, medically accurate sex and sexuality education — a public health intervention proven to improve sexual health knowledge and agency. Six Southern states do not mandate HIV education at all. Of those Southern states that do mandate it, only North Carolina requires that it be medically accurate.[28] Over half of Southern states do not require inclusion of the role of condoms in the HIV education taught in their schools. While many Southern schools keep their youth in the dark about their sexual health by withholding medically accurate, real world sex education (including information on condoms), the majority of Southern states mandatorily require, instead, the teaching of "moral" precepts regarding sex, including the doctrine that sex should only occur within marriage, which stands in stark contrast to the realities of sexual behaviors in

the U.S. It also stigmatizes a wide range of sexual behaviors and, when used as the centerpiece for incomplete and stigmatizing sex education curricula — has a demonstrably detrimental impact on students' ability to protect their sexual health — including access to effective HIV prevention and early access to HIV diagnoses and care for a person living with HIV. Impeding the delivery of accurate, comprehensive sexual education for young people in the South is a drastic form of structural violence that clearly escalates the region's rates of unintended pregnancies, HIV and STI transmission and ability to engage and retain those living with HIV in the testing, treatment and care they need. It also arguably has a knock-on effect on the rates of IPV inflicted on Southern women and girls.

While these forms of structural violence are contributing to disproportionate rates of HIV among Black women and insufficient access to care for Black women living with HIV, they also have visible detrimental impacts on Latinos as well. Eight out of the ten states[29] experiencing the greatest rates of increase in their Latino population are Southern states (according the CDC's definition of the region). This population growth is resulting in an emerging ethnic minority population that has its own needs for culturally and linguistically appropriate health and sex education — as well as services. It is already evident that these states are not adequately prepared to meet these needs and that this burgeoning Latino population is experiencing structural violence as a result of these deficits that may be further magnified by language barriers, recent immigration and immigration status.[30]

Policy Recommendations:

- Expand Medicaid for all U.S. states
- Eliminate all federal funding sources that have been used to support "abstinence only" sex education in light of evidence that it is completely ineffective.[31]
- Increase public awareness of the CDC's recommended guidelines for sex education as a medically accurate "minimum standard" for effective school-based sex education. At present, this curriculum is taught in fewer that half of all high schools and only one fifth of middle schools,[32] despite the fact that 47% of high school students report having had sex and the U.S. teen birth rate is the highest of any industrialized country.[33]
- Increase funding for affordable and adequate services for HIV testing, diagnoses and medical care from accessible and trusted providers who can engage and maintain them in uninterrupted HIV care and treatment. Ensure that such services are easily accessible and have broad hours. Insurance coverage for all adults and children is essential to accomplishing this. Coverage gaps generate late HIV diagnoses.
- Ensure the provision of adequate and affordable HIV information, education, services as well as incentivized HIV testing for women, delivered by trusted community-based providers to low-income women and girls, especially in Southern states. Increase investment in community-based organizations to deliver these prevention, testing, education and linkage to care services, as such providers are recognized by the National HIV/AIDS Strategy[34] as essential to improving rates of retention in the HIV care and treatment continuum.

Transgender women: The experience of transgender women of color vividly illustrates the structural violence imposed on people rendered socially invisible and, therefore, excluded from essential structural and institutional supports. Intensive stigma blocks their access to employment and results in "poverty, unstable housing, disproportionate policing, and criminalization, and a lack of access to health care"[35]. Until very recently, almost no publicly funded services existed to engage and retain transgender women in HIV prevention care and treatment.

One outcome of this is extraordinarily high rates of HIV infection: 56% of Black, 17% of White and 16% of Latina transgender women receiving HIV testing have tested HIV positive in the U.S.[36]

This is likely to be an under-estimation given that, in nearly all HIV and social service delivery systems, transgender women are still routinely miscounted. They are categorized either as men who have sex with men or as cisgender women, consequently obscuring and dismissing their presence and unique needs.

Policy Recommendations:

- Develop and fund service provider trainings that result in service environments welcoming and respectful to transgender and gender-nonconforming individuals.
- Require all publicly funded providers of health care services to adopt the two-step process for collecting and recording gender identity

information recommended by the Center of Excellence for Transgender Health.[37] Require that all public entities collecting epidemiological data (including publicly funded research) replace their use binary gender identification systems with the above two-step system that is inclusive of transgender and other gender categories as well as cisgender men and women.

Sex workers: Sex workers are affected by similar invisibility, stigmatization, criminalization and dearth of supportive services. Sex workers are adults (mostly women) who engage in consensual transactional sex acts with other consenting adults for money or other necessities. The term sex work recognizes and respects that individual autonomy and agency are possible even in the context of exceedingly limited circumstances. People coerced or forced to sell sex (as minors or as trafficked adults) are not sex workers. The goal of creating a greater range of employment options for sex workers need not conflict with the obligation to respect their right to choose their work. Research shows that "decriminalization of sex work could avert the largest percentage of HIV infections among sex workers and clients…over the next decade."[38]

Trafficking, by contrast, is an egregious human rights violation involving violence, abduction, deception, or other forms of coercion. People (mostly women) are trafficked for forced labor as domestics, factory hands and agricultural workers and for sexual exploitation. UNAIDS makes a clear distinction between sex workers and people trafficked for sexual exploitation. It further notes that sex workers are often well positioned to identify people who have been trafficked for sexual exploitation and to connect them to appropriate legal and social services. Their ability to do so, however, is compromised by their own criminalized status.

For many transgender women and other marginalized people of all genders, sex work is a form of labor that remains accessible when stigma, poverty, criminalization and other forms of structural violence blocks their access to other jobs. The very few data available suggest that HIV prevalence among cisgender female sex workers may be about 17%[39] (with findings ranging from 0.3 to 32%). Like transgender women, the real number of U.S. sex workers living with and at risk of HIV is unknown. Like undocumented immigrants, sex workers' existence is criminalized and they are excluded by their status from access to essential structural supports. Furthermore, undocumented sex workers face multiple forms of criminalization, likely compounding barriers to such structural supports.

Policy Recommendations:

- Decriminalize sex work.
- Support the development of adequate, peer-designed health and social services for sex workers and other highly vulnerable populations and increase funding for such services (such as women who use drugs, street-based youth, undocumented immigrants, currently and recently incarcerated people) *To be effective, these must peer-led, address a range of issues (not just HIV), and offer linkage to accessible trauma-informed care and legal services as needed*

Policy Recommendations to generally address the impact of structural violence on HIV among women:

- Fully maintain all Ryan White Program Part D services. For women living with HIV and caring for children, these wrap-around services are critical to staying in care. They also provide culturally relevant entry points into care for underinsured women and girls living with HIV.
- Identify and promote effective cultural sensitivity, IPV and HIV training for all staff working in institutions that provide social and medical services to women at high risk of HIV and IPV which are tailored to the communities they serve, so they can:
  - Screen competently for IPV, HIV risk, drug dependency, etc.
  - Respond appropriately to the range of needs being presented including offering Post-Exposure Prophylaxis (PEP) after rape, assisted referral to woman-friendly drug dependency services and shelter, mental health and legal support services to women experiencing IPV.
  - Provide education about and access to PrEP (Pre-Exposure Prophylaxis) and other woman-initiated, discreet HIV prevention tools (including microbicides, once approved). Support policies where PrEP education occurs during routine reproductive health visits and HIV testing. Fear of IPV can make it impossible for women to insist on male or female condom use during sex.

More IPV specific prevention efforts are needed in conjunction with structural violence prevention:

Women living with HIV and IPV have the same needs

as those at high risk — access to adequate health care, a decent education, protection from abuse, stable employment with a living wage and safe, affordable housing. Accessing these institutional supports is crucial to meeting the needs of women living with and vulnerable to HIV and experiencing IPV. The impact of lifetime experience of IPV on a woman or girl's risk of HIV acquisition and the higher rates of IPV among women living with HIV has been widely identified and documented. This brief seeks to shed light on the ways in which structural violence in women's lives shapes their vulnerability to both IPV and HIV, and how these factors interact synergistically to curtail the effectiveness of public health interventions that fail to take the impact of structural risk into account. Structural violence in the form of inadequate education, early child bearing due to inadequate health care (including contraception access) and limited job prospects, for example, put women at increased risk of IPV by hindering her ability to leave a violent relationship and support her children on her own. These and other factors (such as mass incarceration of male partners, low-wage work, immigration difficulties, etc.) can simultaneously exacerbate women's HIV risk and leave her less able to access the care and treatment she needs if she is living with HIV. It is insufficient for public health interventions to address IPV or HIV specifically, outside of the context of strategies to address structural violence that conditions women's risk of HIV and IPV. The high attrition rates that plague efforts to retain women living with HIV in a continuum of care is material evidence of the ineffectiveness of taking a segmented and disconnected view of women's HIV-related needs. Coming in for a medical appointment or attend a support group for battered women often is not a high priority for a woman who has to hold down a second job, protect her kids from guns and drugs, or avoid deportation. Interventions occurring in parallel to address the woman's situation holistically have the greatest likelihood for success.

Policy Recommendations for greater IPV prevention and to mitigate detrimental impact of structural violence on personal violence:

- Support funding for curriculum development, training and implementation of peer navigators and other peer-based supports to assist survivors of IPV in getting their survival needs met and deciding how best to disclose their HIV status to their families. The inability to do this safely can inhibit women's access to care and, thus, can exacerbate their disease progression.
    - In one study, almost half (45%) of women living with HIV reported being subjected to physical abuse after disclosing their status.[40]
- The value of increased screening for IPV is undermined if sufficient interventions such as "trauma informed care, and support services (both long and short term) are not immediately available to those who need them. Addressing housing instability among women living with HIV[41] is vital to their well-being, as it is also for women experiencing IPV, regardless of their HIV status.
    - Annually, nearly five million U.S. women experience IPV and 10 million U.S. children are exposed to domestic violence.[42] A 2013 "snapshot" survey showed that, in one day alone, domestic violence service providers were unable to meet nearly 10,000 requests for help — 45% of them for emergency shelter. Due to government funding cuts, 43% of IPV service providers had to reduce their staff in recent years while experiencing both more requests for help and increases in the severity of the abuse reported.[43]

Conclusion

The role of violence in the health of women in the United States is complex and multi-faceted. This brief aimed to unravel some key ways in which structural violence impacts the HIV epidemic among women in the U.S., specifically identifying the way in which structural violence can serve to further personal violence. The policy recommendations included in this brief are intended as a starting off point to better address the interconnectedness of structural and personal violence, helping propel the concept that while a continued need for discrete and comprehensive approaches to personal violence are needed, such changes will be more effective when made alongside structural changes. This brief by no means encompasses each way structural and personal violence further the HIV epidemic and impair the quality of health of women living with HIV. However, the issues and policy solutions presented in this brief are meant to prompt further review of such under-examined issues, as well as generate policy changes to address them.

References

1 Kaiser Family Foundation Fact Sheet: Women and HIV/AIDS in the United States (2011 August).

2 Article forthcoming: Stone VE.(2011). HIV/AIDS in Women and Racial/Ethnic Minorities in the U.S. Current Infectious Disease Reports, [Epub ahead of print] PubMed PMID: 22139589.

3 White House Interagency Federal Working Group Report: "Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender–Related Health Disparities." September 2013. Available at https://www.whitehouse.gov/sites/default/files/docs/vaw-hiv_working_group_report_final_-_9-6--2013.pdf

4 Ibid.

5 United Nations Development Programme. "HIV and the Law: Risks, Rights & Health. Geneva: United Nations Development Programme," July 9 2012. Available at http://www.undp. org/content/dam/undp/library/HIV-AIDS/Governance of HIV/Responses/Commissions report final-EN.pdf

6 Structural Violence Definition. http://www.structuralviolence.org/structural-violence/

6 Johan Gultang. "Violence, Peace and Peace Research." Journal of Peace Research Vol. 6, No. 3 (1969), pp. 167-191. Available at https://www.jstor.org/stable/422690?seq=1#page_scan_tab_contents

8 Kaiser Family Foundation. "Women's Health Insurance Coverage Fact Sheet." February 2016. Available at http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/

9 Rachel Garfield and Anthony Damico. Kaiser Family Foundation. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update." January 2016. Available at http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

10 Southern Poverty Law Center. "Injustice on our Plates: Immigrant Women in the Food Industry." 2010. Available at https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/Injustice_on_Our_Plates.pdf

11 Kaiser Family Foundation. Medicaid resources. http://kff.org/medicaid/

12 Susan Reif and Carolyn Mcallaster. New Republic. "Stigma and Poverty Make HIV/AIDS Deadlier in the Deep South." April 22, 2015. Available at https://newrepublic.com/article/121619/why-does-hivaids-kill-more-people-deep-south

13 Teresa Wiltz. Washington Post. "Southern states are now epicenter of HIV/AIDS in the U.S." September 22, 2014. https://www.washingtonpost.com/national/health-science/southern-states-are-now-epicenter-of-hivaids-in-the-us/2014/09/22/9ac1525a-39e6-11e4-9c9f-ebb47272e40e_story.html

14 U.S. Centers for Disease Control and Prevention. "HIV in the Southern United States Issue Brief." May 2016. Available at https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf

15 Southern AIDS Strategy Initiative. https://southernaidsstrategy.org/research/

16 H. Irene Hall, Tian Tang, Lorena Espinoza. Conference on Retroviruses and Opportunistic Infections (CROI). "Late HIV Diagnosis in Metropolitan Areas of the United States and Puerto Rico Abstract." February 2015. Available at http://www.croiconference.org/sessions/late-hiv-diagnosis-metropolitan-areas-united-states-and-puerto-rico

17 Louisiana Department of Health and Hospitals. "National Women and Girls HIV/AIDS Awareness Day Fact sheet." March 2012. http://new.dhh.louisiana.gov/assets/oph/HIVSTD/hiv-aids/2012/Women_Publisher_FactSheet_2012.pdf

18 U.S. Centers for Disease Control and Prevention. "HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2014" Vol 26. Available at http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf

19 Mark A. Schuster et. al. "HIV-Infected Parents and their Children in the United States." 2000. 90,1074–1081.

20 Reif S, Safley D and Caroly McCallaster. A Closer Look: Deep South Has the Highest HIV-related Death Rates in the United States. Southern HIV/AIDS Strategy Initiative, November 2015. www.southernaidsstrategy.org. "The Census Bureau defines the Southern US as consisting of Alabama, Arkansas, Delaware, Florida, Georgia, Louisiana, Kentucky, Maryland, Mississippi, Oklahoma, North Carolina, south Carolina, Tennessee, Texas , Virginia, West Virginia and the District of Columbia."

21 CDC. "HIV in the Southern United States Issue Brief." May 2016.

22 Reif S., Wells 30 Shocking Domestic Violence Statistics That Remind Us It's An EpidemicPence B., Hall I, et al. HIV Diagnosis, Prevalence and Outcomes in Nine Southern States. J Community Health 2014. (https://southernaids.files.wordpress.com/2015/01/hiv-diagnoses-prevalence-and-outcomes-in-nine-southern-states-final.pdf)

23 Ibid.

24 Centers for Disease Control. Disparities in Diagnoses of HIV Infection Between Blacks/African Americans and Other Racial/Ethnic Populations – 37 States, 2005—2008. Mortality and Morbidity Weekly Report, 2011, 60(4):93-98.

25 Sanders L., McCallaster C., and Allison Rice. Medicaid Expansion in the South. May 10, 2016. http://southernaidsstrategy.org.

26 Kaiser Family Foundation. "Fact Sheet: Women and HIV/AIDS in the United States." 2014. Available at http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/

27 Wade Goodwyn. National Public Radio. "Texans Try To Repair Damage Wreaked Upon Family Planning Clinics." January 28, 2016. Available at http://www.npr.org/2016/01/28/464728393/texas-tries-to-repair-damage-wrought-upon-family-planning-clinics.

28 Guttmacher Institute. "State Policies in Brief: Sex and HIV Education." March 2016. Available at https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_SE.pdf

29 Pew Research Center: Hispanic Trends. "Mapping the Latino population by state, county and city." August 29, 2013. Available at http://www.pewhispanic.org/2013/08/29/ii-ranking-latino-populations-in-the-states/

30 Susan Reif, Kathryn Whetten and Elena Wilson. Southern AIDS Strategy Initiative & Duke Center for Health Policy and Inequalities Research "HIV/AIDS Epidemic in the South Reaches Crisis Proportions in Last Decade." Available at http://www.housingworks.org/i/news-media/research-report-final.pdf

31 New York Times. "President Obama cuts funding for all abstinence-only sex education." February 16, 2016. Available at http://nytlive.nytimes.com/womenintheworld/2016/02/18/president-obama-cuts-funding-for-all-abstinence-only-sex-education/

32 Associated Press. "CDC offers guidelines for schools' sex education topics." January 18, 2016. http://medicalxpress.com/news/2016-01-cdc-guidelines-schools-sex-topics.html

33 National Conference of State Legislatures. State Policies on Sex Education in Schools. February 2016. http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx

34 U.S. Centers for Disease Control and Prevention. "Understanding the HIV care continuum." July 2016. https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

35 Prevention Justice. "HIV Criminalization, Poverty, and Health care Access – United States' Violations of the International Convention on the Elimination of All Forms of Racial Discrimination." Available at http://www.preventionjustice.org/wp-content/uploads/2014/08/CERD-Report.pdf

36 U.S. Center for Disease Control and Prevention. "HIV Among Transgender People Fact Sheet." April 2016. http://www.cdc.gov/hiv/group/gender/transgender/

37 University of California, San Francisco. Center of Excellence for Transgender Health. "Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services." 2009. Available at http://transhealth.ucsf.edu/trans?page=lib-data-collection

38 Chris Beyrer, et al. Lancet. "An Action Agenda for HIV and Sex Work." 2015 Jan 17; 385(9964): 287–301. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302059/

39 G. Paz-Bailey G, et al. AIDS Behav. "Prevalence of HIV Among U.S. Female Sex Workers: Systematic Review and Meta-analysis." February 2016. Available at http://www.ncbi.nlm.nih.gov/pubmed/26914165

40 see Gielen AC, McDonnell KA, Burke JG, et al. Matern Child Health J. "Women's lives after an HIV-positive diagnosis: disclosure and violence." 2000;4(2):111–120.

41 Will Rudy. AIDS.gov "Housing grants for HIV + women experiencing domestic violence." October 10, 2014. "https://blog.aids.gov/2014/10/housing-grants-for-hiv-women-experiencing-domestic-violence.html

42 Alanna Vagianos. Huffington Post. "30 Shocking Domestic Violence Statistics That Remind Us It's An Epidemic." February 13, 2015. Available at http://www.huffingtonpost.com/2014/10/23/domestic-violence-statistics_n_5959776.html

43 Ibid.