

**September 2008 – Where’s Our National Campaign Against Homophobia? • Spit and Other “Deadly Weapons” • The United States’ HIV Immigration Travel Ban Eliminated? Not So Fast!**

## Where’s Our National Campaign Against Homophobia?

By Walt Senterfitt

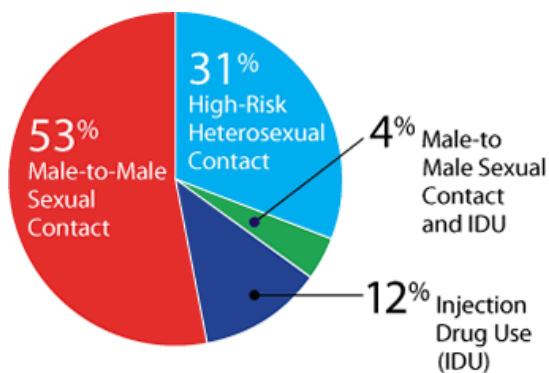
The long-delayed release of the CDC's new HIV incidence estimates for the United States coincided with the opening of the International AIDS Conference (IAC) in Mexico City. These two events had one striking common theme: gay and bisexual men and other men who have sex with men (MSM) are the core of the epidemic in the US and in many other parts of the world and must be at the core of the response in order to end AIDS.

The majority of new HIV infections (more than 57%) are among gay, bisexual and other MSM. [See page 5 about terminology] Gay men are 10 to 30 times more likely to get HIV than are heterosexual men and the population at large, in the US and worldwide.

The resources dedicated to HIV prevention and research among gay men, however, are not proportionate to their centrality in the epidemic. Prevention money is not following the epidemic. Furthermore, the total “pot” for HIV prevention is way too small, and shrinking. Thus, the CDC reports that fewer than 8% of gay and bisexual men surveyed in 15 cities received group-level HIV prevention services and only 15% received individual-level interventions, i.e. 85-92 % of all MSM at risk for HIV are not receiving the currently most effective prevention support.

If the CDC study had reached all gay and bisexual men, including those in small towns and rural areas as well as those who would be afraid to participate in such a survey, the true number of gay men not being reached with effective prevention would no doubt exceed 95%! This critical failure affects MSM of all races and ethnicities, but is most dire among Black, Latino, American Indian and Asian and Pacific Islander gay men whose risk of acquiring HIV is several times higher than the already sky-high risk for white gay men.

**Estimated Number of New HIV Infections, by Transmission Category, 2006**



Source: CDC HIV/AIDS Facts, August 2008 (<http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/incidence.htm>)

## The Government’s Non-Response

Why is there such a gap between the epidemic and the government's response? For starters, there is a scarcity of

accepted interventions for gay men that, in turn, is caused by a historic underinvestment in research on HIV prevention among MSM. Only four of the 30 “best-evidence” prevention interventions in the CDC’s current updated “Compendium of Evidence-based Interventions” and only four of the 17 packaged “DEBIs” (shorthand for a CDC project called Diffusion of Effective Behavioral Interventions) are directed at MSM. State and local health department and community-based organization prevention programs are strongly encouraged, if not outright required, to use these interventions in their federally-funded programs.

A strong legacy of fear and resistance abounds in the federal government and, therefore, in academic research to honest and open discussion of sex and sexuality in federally funded research, messaging and programming – and that is most especially true for homosexuality, transgenderism and all other forms of “non-normative” or diverse sexuality. While this taboo is broadly cultural, it owes its specific foundation in HIV prevention to the “Helms Amendment” which forbids the use of any federal prevention program and evaluation dollars for anything that might be considered “promoting” sex or sexual behavior outside of heterosexual sex within marriage. Though somewhat ameliorated by legislative compromise and judicial decisions, this provision – originally known as “no promo homo” – remains on the books as Section 2500 of the federal Public Health Service Act (42 U.S.C. Section 300ee(b), (c), and (d)) and is enforced by the Centers for Disease Control and Prevention (CDC).

While there is not such a clear legal restriction on using federal money for research into homosexual behavior and identity and prevention interventions for

MSM, there have been periodic Congressional efforts to impose such limitations. As a result, National Institutes of Health (NIH) program announcements and peer review panels have effectively self-censored in such a way as to effectively hamper this critical research.

### **“De-gay-ifying” HIV/AIDS**

There has also been a consistent tendency over at least the last 15 years within much of the AIDS community itself – and certainly by the media and other institutions of civil society enlisted in the struggle against HIV/AIDS – to “de-gay-ify” HIV/AIDS. For example, messages stress that HIV is an “equal opportunity virus” and that anyone can be at risk, emphasize children and women at risk, and stress that HIV/AIDS is, in its majority, now an epidemic in communities of color (while simultaneously neglecting to stress that those most disproportionately impacted in communities of color are gay and bisexual men).

This direction in messaging was in part well intended, to combat the widespread assumption that if you are not a white gay man, AIDS is not your problem and you are not at risk. It was also meant to get beyond the intensified stigmatization of gay men and focus on the behaviors that put one at risk. This approach has been embraced by many HIV positive and other gay men who fear the added stigmatization of having “gay” remain widely associated with “HIV/AIDS” in public consciousness. Even from the start though, this approach was a capitulation to rather than a confrontation of societal stigma and prejudice against gay people, against transgender people, against all people who are sexually “non-normative.” And it didn’t work. Homophobia still is rampant, dollars have gone elsewhere, and, alone among the exposure

categories, HIV infection rates among gay men are rising.

HIV transmission and the AIDS epidemic are not just about the behavior. They are also about the social and structural context of the behavior, about the vulnerability and resilience of communities and populations, about individuals living in communities having the awareness, tools and support to protect themselves and their partners. Homophobia is itself a major risk factor, as well as part of the risk context or vulnerability, for HIV transmission among MSM and, indirectly, for sexual transmission from men to women.

The International AIDS Conference stressed repeatedly the need to move the social and structural context, environment and interventions front and center. The CDC and the NIH have long given lip service to this dimension, but have devoted neither the money and other resources nor confronted the barriers to do so. There are no structural and social interventions whatsoever in the CDC's Compendium of Effective Interventions or DEBIs. There is nothing in the public portfolios of the CDC, NIH, SAMHSA (Substance Abuse & Mental Health Services Administration) or HRSA (Health Resources and Services Administration) that confront and target homophobia as a key barrier to ending the US HIV epidemic.

### **Mexico's Example**

The IAC also highlighted the experience of the Mexican national health ministry and national AIDS program in targeting homophobia as a central priority in its HIV prevention response. The national AIDS program, CENSIDA, led by an openly gay and HIV positive physician, Jorge Saavedra, has for the last several years engaged in social marketing and

community mobilizations against homophobia and has funded local campaigns.

The IAC was preceded by the First International March Against Stigma, Discrimination and Homophobia to the central national square in Mexico City. The march included tens of thousands of Mexicans from all sectors of civil society with Dr. Saavedra and the Mexican Minister of Health in the front rank. In his welcome to the opening ceremony of the Conference, the conservative Catholic President of the Mexican Republic, Felipe Calderon, called for a continuing national campaign to end homophobia. While Mexican activists in the trenches may be rightly skeptical of the hypocritical gap between rhetoric and reality, can you imagine George Bush saying this or HHS Secretary Leavitt in such a march?

Mexico is heavily Roman Catholic, socially conservative, and ruled by its most conservative national political party. If it can nevertheless recognize the fight against homophobia as central – and say so – why can't the United States?

### **Therefore, We Demand:**

1. That the agencies responsible for leading the federal government's response to the AIDS crisis take the lead in announcing and orchestrating as a public health priority an explicit, multi-faceted, multi-year campaign against homophobia, stigma and discrimination against sexual diversity.
2. That this campaign be embraced and supported by state and local governments as well, and by media, non-governmental and private sector organizations with any relation to the fight against AIDS.

3. That the campaign include social marketing and other appropriately targeted messaging as well as funding for innovative local and national community mobilizations, individual and group level interventions.
4. That the lead agencies and community partners assess all current laws, policies and programs that explicitly or implicitly reinforce homophobia and stigma and/or act as barriers to effective anti-homophobia messaging and interventions, and change or propose changes to such laws and policies as soon as possible. This includes a careful review and, where necessary, revision of all current and future guidelines relating to HIV/STD/drug abuse prevention programs and a specific effort to repeal all vestiges in law of the original "Helms Amendments."
5. That, affirmatively, promoting healthy expressions of diverse sexuality be recognized as a key requirement of advancing public health and should therefore be reflected as appropriate in all health-related publications and guidelines. This specifically includes guidelines, funding and curricula for adolescent and school health programs related to sex, sexual behavior and sexual identity.
6. That the NIH, through the Office of AIDS Research and other mechanisms, and in coordination with the CDC, prioritize the development of social and structural interventions and strategies that will most effectively undermine public and private homophobia, stigma and discrimination. These must include the development of better measurement and evaluation tools for assessing progress against homophobia and stigma, for social and structural interventions in general, and for combination prevention packages or strategies.
7. That this campaign against homophobia and for healthy sexual diversity must primarily be funded through new funding as part of a renewed and expanded national commitment to end AIDS, rather than by reducing funding of other effective programs and research.
8. That this campaign recognize and reflect the multiple, interlocking social and structural strategies needed to combat the other root causes of the continued HIV epidemic, including, in particular, racism and xenophobia, women's oppression, transphobia, mass imprisonment, the "war on drugs," disenfranchisement of youth, and homelessness and other manifestations of poverty. Homophobia manifests quite differently in different communities and in combination with other forms of social oppression. Our response must be commensurately sophisticated and well matched.

We ask for input, collaboration and support in this effort from our partners and allies throughout the AIDS movement and communities as well as other fighters for social justice. Recognizing the centrality of gay, bisexual and other men who have sex with men in the response to this epidemic, and demanding an appropriate national response, in no way should distract us from other critical campaigns and emphases in the fight to end AIDS. Rather, a grounding in **all** the truths that ending AIDS is a fight for social justice and that "an injury to one is an injury to all" will make us stronger, each and all.

## Terminology – Culture, Identity and Behavior

How to refer to men who have sex with other men, exclusively or some of the time is a challenge for which there is no easy solution. “Gay” came to be used most commonly, but only within the last few decades and many men, even many who readily identify as exclusively homosexual, have never or no longer embrace the term. For some it is too heavily associated with white men to be acceptable; yet other proposed terms such as “same gender loving” have not achieved widespread consensus either.

For others, “gay” is too limiting or old-fashioned, when sexuality is much more diverse and fluid. For some, it implies a connection to a particular community or subculture they do not wish to embrace, or refers too much to an identity rather than a behavior. “Bisexual” is also problematic for many, even those who acknowledge having sex with both men and women. Many men who have sex with other men identify themselves as heterosexual, straight or other terms for culturally normative sexual behavior and identity.

Because of this complexity and lack of consensus, and the desire to be behaviorally descriptive in discussing HIV risk and in targeting HIV prevention efforts, the CDC and community allies came up with the term “men who have sex with men” or MSM. This works for some purposes, but how many individuals identify themselves as an MSM? This term, while epidemiologically accurate and inclusive, is often criticized for leaving out the critical aspects of identity, culture and community in understanding sexuality and diverse sexual expression. Yet to simply say “gay” or “gay and bisexual” may mistakenly imply that the speaker assumes that all men who have sex with other men are essentially the same, and understand their sexuality the same way.

For want of a better solution, we have used “gay,” “gay and bisexual,” “MSM” or “gay, bisexual and other MSM” more or less interchangeably in this article. We are quite aware, though, of the very important cultural and individual differences and contradictions in any such shorthand references and, more importantly, in figuring out how to reach and support everyone to whom this rubric applies.

### Spit and Other “Deadly Weapons”

By Coco Jervis

In May of this year, a 42-year-old HIV positive man in Texas who spat at a police officer during an arrest received a cumulative sentence of 35 years by a Dallas court after a jury was convinced that the man had used his saliva as a “deadly weapon.” More than 180 media outlets around the world picked up news

of the case – but only a handful clarified the impossibility of contracting HIV by being spit on. Since then, the media has reported on at least three other cases of the criminal prosecution of people accused of exposing others to HIV by spitting.

Criminalizing transmission of HIV exacerbates vulnerability to infection; it has no preventative effects, further

stigmatizes people already living with HIV, and discourages others from disclosing their status or being tested, since it is only those who actually get tested who are subject to prosecution. Further, these cases undermine the efforts of public health and community advocates who have worked tirelessly over the years to educate the public about HIV transmission.

The Centers for Disease Control and Prevention (CDC) has long maintained that contact with saliva, tears, or sweat does not expose others to an appreciable risk of HIV transmission. In light of increasing HIV prevalence in the United States, it is incumbent upon the CDC to combat dangerously misleading information concerning the transmission and communicability of HIV being advanced through the criminal prosecutions of people living with HIV. Effective HIV communication and education strategies that are accessible to the public are needed immediately.

HIV advocates are coming together to call on the CDC for leadership on this issue. CHAMP is circulating a sign-on letter urging the CDC to position itself as the primary resource for accurate information about HIV transmission, using clear messaging and key spokespersons to communicate to the widest possible

audience. The letter encourages the CDC to work in close collaboration with state health departments, legal and policy advocates, and community educators nationwide to increase the range and type of HIV/AIDS education materials created specifically for those working within the criminal justice and court systems.

The letter also calls on the CDC to develop a rapid communication response, including fact sheets that address transmission myths to combat scientifically unfounded prosecutorial and judicial responses to HIV exposure incidents as well as the related media and public misinformation about HIV transmission.

CDC leadership on this issue could end the government's role in reinforcing HIV-related stigma. The CDC must address the baseless prosecution of HIV positive people. To read and sign on to the [community letter](http://www.champnetwork.org/criminalization-hiv-transmission-sign-letter) to the CDC, please go to <http://www.champnetwork.org/criminalization-hiv-transmission-sign-letter>.

HIV positive people should not have to suffer the fear of prosecution, persecution and disclosure by the judicial system. It is time for us to work collaboratively to stop the needless and inhumane criminalization of people living with HIV.

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## **The United States' HIV Immigration Ban Eliminated? Not So Fast!**

*By Coco Jervis*

In July, Congress passed an amendment that lifted the statutory ban on the admission of people with HIV into the United States as part of the reauthorization of PEPFAR, the global AIDS bill now known as the Tom Lantos and Henry J. Hyde U.S.

Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. Advocates around the world who have worked tirelessly for years on this issue have rightly celebrated this as a significant achievement for people living with HIV/AIDS, immigrant justice and human rights advocates.

Contrary to common perception, however, the ban remains in effect. This

win reversed the ban as codified in 1993, but it still lives in regulations promulgated by the Department of Health and Human Services (HHS). In other words, Congress restored authority to HHS, the administrative agency responsible for public health, to determine whether someone's HIV status is grounds for denial of entry. As things currently stand, advocates still have a long way to go before all vestiges of this discriminatory policy are truly eliminated.

### **A History of the Travel Ban**

In 1987, HHS – working through the Center for Disease Control's Department of Public Health Service – added HIV to the list of exclusionary “communicable diseases of public health significance” in the Immigration and Nationality Act (INA). Since then, HIV positive immigrants, refugees and travelers have been barred from immigrating, traveling to, or transiting through the United States, unless a discretionary waiver is granted. Furthermore, HIV positive immigrants without a green card who are already in the country have faced tremendous obstacles adjusting their status, and many have been denied access to life-saving health care as a result.

In 1991 and again in 1993, HHS attempted to remove HIV from the list of exclusionary communicable diseases, which would have eliminated the ban. At that time, organized response from conservative politicians and their base in the radical right blocked bringing immigration policy in line with scientific understanding of HIV transmission. In 1992, President Clinton made a campaign promise to lift the ban, but he was forced to renege under pressure from both sides of the aisle. Then in 1993, conservative Senators Don Nickles and Jesse Helms introduced legislation to enshrine the ban in statutory law, stripping

HHS and the executive branch of the power to overturn the ban.

Practically speaking, with the ban once again under the purview of HHS, nothing has changed for people living with HIV traveling through or immigrating to the United States. Just as in the past, only in exceptional circumstances – and usually with good legal help – can people living with HIV obtain residency in the U.S. via a discretionary waiver. In order to qualify for a green card waiver, an applicant must first prove that they have a close familial relationship – defined as a parent, child or (heterosexual) spouse – of a lawful U.S. citizen. Then they must show that their admission into the country will not endanger the public health or create burdensome public health care costs. From 1987 to 1992, while HHS controlled the process, only three such waivers were granted for people living with HIV or AIDS.

Over the past 21 years, the results of this discriminatorily policy have been profound. As Dr. Nancy Ordober, founder of the Coalition to Lift the Bar, summarized during a 2006 congressional hearing:

“The ban has resulted in countless AIDS-related fatalities abroad as individuals are unable to access life-saving medications or are targeted for violence based on HIV status, or real or presumed sexual orientation; and significant health risks inside the U.S., as immigrants, prospective immigrants, and visitors either are actively deterred from seeking HIV testing and treatment, or avoid contact with providers out of fear of putting their immigration status in permanent limbo or worse. If they are low-income or poor, they either don't have recourse to the full slate of public programs and services they need to stay healthy or may be unaware of what services they

are entitled to. Simply put, this policy has been a wholesale violation of human rights and a threat to public health inside and outside the U.S.”

While the restoration of authority to HHS is a significant step forward in ultimately doing away with the ban, advocates must pressure the agency to remove HIV from the list of “communicable diseases of public health significance.” As Dr. Ordovery explained in a recent conversation, “HHS is where the ban lived, administratively, for the first six years of its life [1987-1993], and it did plenty of damage there. If the entry ban ends up solely an HHS matter, it will be critical for us to maintain our vigilance and unity, so that the administration doesn’t split the ban – lifting it for travelers and some visa holders, but keeping it in place for long-term visa seekers and immigrants.”

### **Support to Eliminate the Ban**

Advocates across the country and worldwide are supporting a full repeal of the U.S. HIV-related travel and immigration ban. To pressure HHS Secretary Michael Leavitt and the new administration to eliminate HIV from the list of communicable diseases, advocates have issued a number of organizational statements of support, action alerts, and sign-on letters calling for just that. Earlier this month, Congressional champions, led by Representatives Henry Waxman (D-CA), Barbara Lee (D-CA), and Howard Berman (D-CA), sent a [letter](#) to President Bush urging him to remove HIV from the list of exclusionary communicable diseases.

In the coming months, Secretary Leavitt, in consultation with the Department of Homeland Security, will convene a panel of experts (hopefully including representatives from non-governmental organizations) to review the immigration ban. Additionally, proposed revised

regulations will be open to a public comment period. The results of the comment period will be reported to Congress and published in the Federal Register.

### **Lessons from the Past**

A cautionary tale for what may lie ahead: In 1991, then Secretary of HHS Louis Sullivan proposed revised regulations that would have eliminated the HIV ban. However, right wing leaders were able to galvanize their constituency to submit an unprecedented 35,000 letters and postcards opposing the proposal. Only after the public comment period was extended did immigrant rights and the LGBT communities respond in force with over 110,000 letters supporting removal of the ban. Despite this show of support, the highly public and politicized nature of the debate and the strong anti-immigrant fervor of the time (similar to that of today) prevented any action after the comment period ended.

More recently, in November of 2007, the Department of Homeland Security, at the request of the Bush Administration, touted new proposed streamlined rules that they alleged would speed up the process by which HIV positive foreign nationals could get a short-term travel visa into the country. However, the proposed rules, in effect, would have made it even more difficult and problematic for people living with HIV to travel to the U.S.

### **A Need for Continuing Advocacy**

Lifting the ban will be just another beginning. According to Vishel Trivedi, immigration project manager at Gay Men’s Health Crisis, “Once we’re confident that HHS will remove HIV from the list, we need to focus on more practical aspects of eliminating the vestiges of this

discriminatory policy." Immigrations and Customs Enforcement (ICE) will have to identify and release everyone currently in detention because their HIV positive status made it impossible to adjust their immigration status, and all ICE officials, immigration judges, and counselor and embassy personnel abroad must be instructed that HIV is no longer grounds for inadmissibility.

There is also a database controlled by the U.S. Department of Homeland Security and U.S. State Department of all individuals who have applied for an HIV-related discretionary entry waiver that includes their names, countries of origins

and other identifying indicators. As Trivedi explained, "The names in this database clearly must be expunged, and the database itself must be destroyed."

In order to truly lift the ban and ensure that the needs of HIV positive travelers and immigrants are met, the advocacy community must come together and focus its attention on HHS to remove HIV from the list of communicable diseases. Once that victory is achieved, there will be ongoing work to remove all other vestiges of this discriminatory, fear-based policy, including meaningful access to health care and HIV prevention for foreign born people living in the United States.

## **GET INVOLVED! TAKE ACTION!**

### **Fight the Criminalization of People Living With HIV**

This summer, people living with HIV have faced a wave of criminal charges for activities with extremely limited or no risk of HIV transmission. CHAMP is calling on the CDC to adopt a communications strategy to combat dangerously misleading information about the transmission of HIV and to work with officials and advocates to counter baseless criminal prosecutions of people living with HIV. Click the link below to read and sign onto the letter. The deadline for both organizations and individuals to join the letter is September 30.

<http://www.champnetwork.org/criminalization-hiv-transmission-sign-letter>

### **Work to Remove the Travel Ban Permanently**

Join the **Lift the Bar** list serve by contacting Nathan Schaefer, Gay Men's Health Crisis, at [nathans@gmhc.org](mailto:nathans@gmhc.org).

**HHSWatch**, a watchdog newsletter from CHAMP, monitors and reports on activities related to HIV prevention at Health and Human Services agencies, including CDC, NIH, HRSA and SAMHSA.

*HHSWatch is a resource for community members, policy advocates, researchers and anyone interested in more fully understanding and tracking the committees, panels and administrators whose recommendations and decisions affect our work.*

**HHSWatch** is committed to providing an outlet for those concerned about infringements upon science-based HIV prevention and treatment, and will respect your wishes for confidentiality. If you are interested in contributing information or suggesting a story, please contact [champ@champnetwork.org](mailto:champ@champnetwork.org).



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