POSITIVE WOMEN'S NETWORK
USA

Women Speaking Up
and
Standing for Change:

The United States Positive Women's Network and HIV/AIDS Policy in the Next Administration and Congress

Abstract:

The United States has failed to implement a coordinated strategy to address HIV and AIDS systematically throughout relevant sectors in the U.S. This has resulted in increased infections in particularly vulnerable communities, as well as inefficient delivery of care, treatment, and support services.

The United States Positive Women's Network, the only national membership body of women living with HIV, believes the next Administration must develop and implement a National AIDS Strategy that sets and evaluates ambitious targets to comprehensively address the HIV epidemic in the United States.

Furthermore, United States HIV and AIDS policies and programs continue to operate under the paradigm that HIV/AIDS is primarily a disease of gay men and other men who have sex with men (MSMs). While MSMs do bear a disproportionate burden of HIV infections in the U.S., in part due to homophobia, rates of HIV infection in women have risen over the past 27 years such that women currently account for almost one-third of new HIV diagnoses in the United States. HIV/AIDS is the leading cause of death among Black women aged 25 to 34 in the United States. And women living with HIV experience disproportionate lack of access to care, treatment, and support services.

Women of color and women in poverty are especially vulnerable to poor health outcomes – with or without HIV infection.

To reduce the rate of new HIV infections among women, particularly women of color, and to increase access to care and utilization of treatment and support services, women living with HIV must be meaningfully involved in the design, implementation, monitoring and evaluation of HIV policy and programs.

This paper outlines some of the legislative and resource allocation priorities of women living with HIV in the United States. We look forward to ongoing dialogue with the new Administration and Congress on these critical matters.

I. Who We Are: The U.S. Positive Women's Network

The U.S. Positive Women's Network (PWN) was founded in June, 2008, by 28 HIV-positive women reflecting the diversity of the U.S. epidemic, with initial funding from the Ford Foundation. We are **the only national group led by and for HIV-positive women** addressing issues that affect women living with HIV in the U.S.

Currently a project of WORLD (Women Organized to Respond to Life-threatening Disease) in Oakland, California, the PWN has quickly grown to a membership of over 400 women living with HIV with representation from over 15 States.

The U.S. Positive Women's Network strengthens the strategic power of women living with HIV in the United States by:

1) Identifying, cultivating, and supporting leadership among women living with HIV in the U.S.
2) Building capacity for collective action between individuals and organizations working in the field of women and HIV
3) Engaging in strategic campaigns to change policy.

II. Purpose of this Document

The U.S. economy and health care infrastructure are failing millions of Americans, with a devastating impact on women living with HIV. The Ryan White Treatment Modernization Act will sunset in 2009, unemployment rates and poverty levels are rising, the burden on social service providers and the nonprofit sector is ever-increasing, and investment in service delivery by the private sector is expected to drastically reduce over the next few years. Budget cuts and dwindling resources for service delivery often disproportionately impact women living with HIV, who already are socio-economically vulnerable.

At this critical moment, the U.S. Positive Women's Network urges that the next President and Congress of the United States make a commitment to develop, fully fund and implement an outcomes-based National AIDS Strategy that takes into account the unique needs of women and girls living with HIV or who are at risk for contracting the virus.

To ensure this, women living with HIV and those who work with them must be meaningfully involved in the development, implementation, monitoring and evaluation of such a National AIDS Strategy.

This Executive Summary is intended to help inform the next Administration and Congress as well as the HIV community and other allies about the legislative and resource allocation priorities of HIV positive women throughout the U.S. as a comprehensive plan to address the domestic HIV epidemic is developed.

This document was created by the Founding Members of the Positive Women's Network, utilizing our life experiences as HIV-positive women and community advocates, together with data gathered from surveys and focus groups of HIV-positive women throughout the U.S., individual interviews with HIV positive women, and expertise from allies, including members of AIDS Coalition to Unleash Power (ACT-UP) Philadelphia, the BABES Network, the Center for Health Justice, the Community HIV/AIDS Mobilization Project (CHAMP), the HIV Law Project's Center for Women and HIV Advocacy, Kaiser Family Foundation, the National Association of People With AIDS (NAPWA), the National Working Positive Coalition, the National Women and AIDS Collective (NWAC), and The Well Project. .

We are deeply inspired by and indebted to every woman whose life has been transformed by an HIV-positive diagnosis, and the work of our allies in this struggle. The U.S. Positive Women's Network is committed to transparently and accountably representing the voice of over 300,000 women living with HIV in the United States.

III. Background: The HIV Crisis Among U.S. Women

According to 2006 estimates by the Centers for Disease Control and Prevention (CDC), there are nearly 300,000 women living with HIV in the United States[i], not including transgender women, for whom no accurate national data are available. Studies show that HIV prevalence is higher among the transgender male-to-female (MTF) population than any other population (27.7% based on a 2008 review of U.S. studies[ii], with some studies demonstrating rates double that for the African-American MTF population).

Over the last 27 years, the epidemic's toll on women has steadily worsened and now appears to have stalled at a stubbornly high level. In 1985, the earliest year for which data is available, women represented 8% of HIV infections. By 2006, the proportion of the epidemic among women had more than tripled to 27% of HIV infections in the U.S[iii].

The HIV epidemic among women in the U.S. is disproportionately made up of women of color and low-income women. **Over 80% of women living with HIV in the U.S. are women of color.** While African American women comprise about 12% of the U.S. female population, 66% of new AIDS diagnoses among women in 2006 were among African American women. Latinas represented 16% and Caucasian women 17% of new AIDS diagnoses in that same year, though they comprise 13% and 68% of the U.S. female population respectively[iv].

Over 80% of women diagnosed with HIV were infected through heterosexual contact, and about 17% through intravenous drug use. The epidemic is taking a particular toll among younger women and low-income women. Over 60% of women newly diagnosed with HIV are between the ages of 13 and 39. According to the HIV Cost and Services Utilization Study (HCSUS), 64% of women with HIV receiving regular medical care had annual incomes under $10,000 compared to 41% of men. Additionally, the majority of women with HIV in the study (76%) had children under 18 in their homes[v].

Women living with and at risk for contracting HIV report disproportionate rates of violence, including both physical and sexual abuse. The underlying factors fueling this violence are many of the same that fuel the HIV epidemic among women – including sexism and poverty.

The U.S. Positive Women's Network notes that there are some groups for whom there is no accurate national data on HIV incidence and prevalence rates - including transgender populations, the Asian and Pacific Islander community, and the Native American community. While this report does discuss some of the needs of the transgender community, it is difficult to accurately represent the unique needs of transgender women living with HIV in the U.S., as they are often classified as MSM (Men who have Sex with Men). We strongly recommend the CDC push States to adopt gender identity in HIV surveillance data to address this critical issue.

IV. The Unique Needs of Women at Risk for and Living with HIV in the U.S.

Women in the U.S. need an effective response to HIV that takes into account the realities of women's bodies and lives. This response should begin with addressing stigma and discrimination against people living with HIV and AIDS and should continue with analysis in the following areas:

Prevention

Drastic under-funding of prevention programs, gender inequity that leads to power imbalances and violence in relationships, discrimination against persons with variant gender identity, and the lack of support for community programs to innovate and expand effective prevention interventions, leave transpeople, women of color and low-income women especially vulnerable to HIV infection – independently of their own risk behavior.

Our federal government has chosen to fund abstinence-only-until-marriage programs which have proven highly unsuccessful -- rather than expanding comprehensive sexuality education programs that unquestionably reduce unintended pregnancy and sexually transmitted infections, including HIV. Young women have a right to medically accurate, evidence-based information to protect their sexual health, and to education that does not spread gender stereotypes and misinformation.

Additionally, because there currently **exists no female-controlled HIV prevention device,** women effectively do not have the option of protecting themselves from contracting HIV or other sexually transmitted infections without their male partner's consent.

Testing

A series of barriers to testing and early diagnosis cause women with HIV to be tested later in their diagnosis than men and progress faster to an AIDS diagnosis. Additionally, women with HIV tend to experience worse health outcomes overall than men with HIV.

Perceptions in the community of who is at risk for (and therefore needs to be tested for) HIV have deadly consequences for women. Women are less likely than gay men to perceive themselves as being at risk for contracting HIV through unprotected sexual intercourse. This fact points to the failure of HIV prevention efforts and testing campaigns related to women in the U.S. In addition, health care providers, HIV testers, and counselors are less likely to offer testing to women than they are to gay men and other men who have sex with men.

Furthermore, the National Women and AIDS Collective, a collective of women-led organizations working with HIV-infected and affected women, has identified States where there exists a financial disincentive to test women for HIV[vi], and where women are actually discouraged from HIV testing. This fatal disincentive is a consequence of the CDC's current and flawed HIV/AIDS Surveillance system, which defines a woman's risk as the risk behavior of her male partner.

Research

Women and men are physiologically different, and may respond differently to medications. Additionally, HIV may have a different impact on women's bodies than on the bodies of men. In the majority of clinical trials, women are significantly less likely to be represented. This makes it challenging to apply research outcomes to the lives of women. Currently there is a lack of data on how medications work in women's bodies and the implications of hormonal and life cycle changes related to HIV progression.

As the proportion of older women living with HIV and being diagnosed with HIV grows, research on menopause and HIV is becoming increasingly imperative. Further, the scarcity of systematic research, including research on treatment-as-prevention, to address the diverse prevention needs of girls and women has left us ill-equipped to break the persistent rates of HIV incidence of women in this country.

V. Women's Role in the Community: Childbearing, Caretaking, and the Economy of Care

The impact on women living with HIV is often larger than a woman's own individual health issues.

Women around the globe carry the heaviest burden within the HIV and AIDS economy of care. As primary caretakers within their families they have the responsibility of attending to the needs of their husbands or partners, children, and at times grandparents. When a family member is infected with HIV, it is most often the woman who attends to health needs, and stretches family resources to feed and care for them. If the woman herself is HIV positive, she will attend to her own needs only after taking care of her family – many times at a cost to her personal health.

Over three -quarters of women living with HIV in the U.S. have at least one child under the age of 18 in their homes, and medical care systems must incorporate the realities of parenting to address women's health needs. Without available childcare or coverage of transportation costs for dependent children, women with HIV are likely to postpone or altogether neglect medical appointments.

Special Focus: Women Affected by Incarceration

Research shows that incarcerated women are 36 times more likely than non-incarcerated women to be living with HIV[vii]. In addition, women who live in geographic areas with high incarceration and post-incarceration rates are at greater risk for acquiring HIV—independent of their own behavioral risk[viii]. This is true even if a woman herself has not been incarcerated and if she has a low number of male sexual partners.

Rates of HIV are even higher among female prisoners than male prisoners – women State prisoners are more than 60% more likely than incarcerated men to be HIV-positive [ix], leading some researchers to believe that risk factors for HIV infection are inextricably linked with the impact of imprisonment.

The lack of available prevention tools inside prisons puts both men and women at risk for contracting HIV – and the unacceptably high rate of incarceration among Black men has devastating consequences for their lives, their communities and the women they return to.

As well as facing stigma and discrimination in prison, HIV-positive women report inconsistent and non-confidential access to anti-retroviral medications, and their medications are sometimes changed to an alternative regimen – which can result in resistance, increased side effects, and poorer health outcomes. Linkage to care upon leaving prison is spotty at best, and must be improved to include comprehensive and compassionate medical care, mental health, and substance use treatment.

VI. Access to Health Care and Consequent Health Outcomes of HIV-Positive Women in the U.S.

Among women, the number of deaths from HIV-associated illnesses and from AIDS are highest among African-American women. HIV is currently the leading cause of death among Black **women** aged 25-34 – compared to the 5th leading cause of death among **women** overall in that age category[x].

Key drivers of poor health outcomes include poverty, unemployment and a lack of health insurance. In the U.S., women living with and at risk for contracting HIV tend to disproportionately experience all three of these factors.

Approximately half of all people living with HIV in the U.S. do not receive care[xi]. Of these, over half are women[xii]. According to the Women's Interagency HIV Study (WIHS), one in four women for whom Highly Active Anti-Retroviral Therapy (HAART) is medically indicated are not on the regimen[xiii]. History of physical or sexual abuse, current drug use, and non-White race were all associated with lack of HAART use.

The HIV Cost and Services Utilization Study (HCSUS) found that women with HIV were more likely to postpone care because they lacked transportation (26% compared with 12% of men), and more likely to postpone care because they were too sick to go to the doctor (23% compared with 14% of men)[xiv].

In the same study, women with HIV receiving care were additionally much less likely than men with HIV receiving care to be covered by private insurance (14% compared to 36%), and more likely than men to be covered by Medicaid (61% compared with 39%), qualifying for Medicaid as pregnant women or as parents of a dependent child. Latinas were the most likely of any group to be uninsured at the time of their HIV diagnosis.

For transgender women, many issues complicate care. Applications for health insurance may be denied when transgender status is disclosed or transition medical history is given to a potential insurer. Additionally, transgender women report high rates of discrimination with health care providers as well as in the workplace, which reduces their ability to access quality medical care[xv].

According to a recent American Foundation for AIDS Research (AmFAR) survey, women living with HIV also experience high levels of stigma and discrimination[xvi], including stigma experienced from health care providers with respect to decisions about sexual and reproductive health options and childbearing. Many HIV-positive women report being discouraged from having children by health care providers – even though with appropriate treatment and care, the chances of vertical HIV transmission have been reduced to less than 2 percent.

VII. Action Agenda: An Interconnected Web

The HIV pandemic in the United States shines a spotlight on systems of education, access to housing and food, economic opportunity, job security, and health infrastructure that are fragmented and broken. It is evident that additional resources will be needed across the board for domestic HIV prevention, care, treatment and support services. The U.S. Positive Women's Network believes that a variety of legislative and resource allocation solutions will be needed, *along with political will,* to raise the overall condition of women and communities in the United States to effectively address the effect HIV has on millions of its residents.

The following are our recommendations:

1) **Develop and implement a coordinated, results-oriented National AIDS Strategy to reduce HIV incidence and increase access to and utilization of care, with input from all relevant sectors.**

This National AIDS Strategy must be evidence-based and outcomes-oriented; and must address social and structural injustices, with an emphasis on addressing inequities based on gender, race, ethnicity, poverty, and sexual orientation. This should begin with decreasing gender, racial, and socioeconomic inequity in access to HIV education, prevention, testing, treatment, care, and support. This Strategy should rely on evidence-based policy and programming, set ambitious and credible targets for improved outcomes, require annual reporting on progress toward goals, and engage multiple sectors, including HIV-positive individuals representing highly affected communities, in the development of the National AIDS Strategy. To effectively address the needs of women, HIV-positive women and other populations vulnerable to HIV infection must be included in the creation, development, monitoring, and evaluation of this Strategy.

2) **Address Economic Injustice in the U.S. that Adversely Affects Women, Especially those Living with HIV.**

A comprehensive solution to the HIV epidemic among U.S. women must begin with addressing inequity with a special focus on economic injustice. Women in the U.S. earn $0.77 for every dollar earned by a man for comparable work. For women of color, the wage gap is even wider. This fosters a climate of economic dependency where women lack negotiating power in relationships – including power and efficacy to negotiate safe sex. Until we raise the overall quality of life for women in the United States, women will continue to be vulnerable to HIV infection. **We need a real living wage for all workers in the U.S. In the meantime, we must close the wage gap to give women equal pay for equal work.**

Additionally, develop and invest in a diversity of employment opportunities for people living with HIV.

Of individuals surveyed by the National Working Positive Coalition National Employment Needs Survey, 84% had been employed at the time of their HIV diagnosis. 81% reported having lost employment; and of those, 69% reported that HIV played a role in their loss of employment. An HIV diagnosis should not equal a sentence to a lifetime of poverty. While health may play a role in the ability to work for some people living with HIV/AIDS (PLHAs), 92% of those able to work but not currently working said their health and outlook would improve if they were working. However, many PLHAs currently receiving disability are anxious about re-entering the workforce, as they risk losing their SSI benefits without knowing whether they will be able to work without getting sick.

We recommend the Social Security Administration expand the Ticket to Work program with an emphasis on expanding Employment Networks in States with high levels of unemployment and which are hard-hit by the U.S. epidemic, such as the Gulf South. In addition, entitlement programs are currently set up to discourage individuals who return to school as full-time students – forcing them to choose between increasing their earning potential or keeping their benefits. These regulations are clear examples of how women are continually unempowered to provide a means of resources and support for themselves and their families without the threat of further loss of inadequate government resources.

We also call on the next Congress to pass an Employment Non-Discrimination Act that protects the rights of all individuals by including gender identity.

3) Advance HIV prevention justice to break through the stubborn persistence of high incidence of HIV in women.

We must end the drastic under-funding of domestic HIV prevention by providing an additional $877 million in the omnibus appropriations bill for FY 2009 and an additional $4.8 billion over 5 years -- the amounts specified by CDC in the Congressional hearing on why HIV infection in the U.S. is at such high levels. These resources should also provide support for community groups to create effective HIV prevention programs for women, rather than restricting them to cookie-cutter programs mandated by CDC.

In addition, we must invest in research to close our knowledge gaps, including but not limited to the development and roll-out of HIV prevention tools that – unlike the traditional male condoms – are under the control of women themselves, such as microbicides and an HIV vaccine. The National Institutes of Health (NIH) and CDC must collaborate with community partners on a comprehensive research program on HIV prevention in women that includes research on structural factors such as poverty, access to health care and housing. And we must continue to invest in the groundbreaking research of Anti-Retroviral Treatment as prevention.

We must lift the ban that prohibits the use of federal funds for syringe exchange programs, which unquestionably reduce HIV transmission in injection drug users and their partners without increasing drug use.

Young women have a right to medically accurate, evidence-based information to protect their sexual health, and funds going to ineffective and sexist abstinence-only programs should be re-directed to comprehensive sexuality education.

AIDS awareness and prevention programs must not set women and gay men against each other by exaggerating the role of covertly bisexual men ("on the down low") in HIV transmission. The programs should instead encourage healthy communication, combat homophobia and gender bias, and provide prevention tools as well as targeted testing campaigns to people of all genders and sexual orientations. To combat the incidence of HIV, public health programs and government policies must confront anti-transgender bias and violence, in order to decrease vulnerability to HIV among transgender-women of all races, and address violence against women, homophobia, and gender bias.

4) Invest in Local, State and National HIV Leadership that is Accountable to Women.

We need a gender-specific, comprehensive and compassionate response to the HIV epidemic in this country. Policies and programs remain predicated on an outdated male paradigm for male bodies and the life circumstances of men at risk, although women now comprise almost one-third of HIV infections in the U.S. Due to the history of the HIV epidemic in the U.S., leadership on HIV has been dominated by accountability to the needs of men who have sex with men. We need national leadership grounded in the unique issues affecting HIV-positive women and women vulnerable to contracting HIV.

To make this happen, HIV-positive women, including transgender women, must be meaningfully involved in decision-making about the development of policies and programs to prevent and provide care for HIV. A recent example where this inclusion has not adequately occurred is within the global dialogue around circumcision of men as an HIV prevention tool. We believe that circumcision may present an elevated risk to some women and must be studied and discussed thoroughly before there is a rush to scale-up.

On the local and State level, systems must be changed to facilitate the participation of HIV-positive women. This includes practical provisions for childcare at community meetings, and increased investment in training women to participate as consumers. Additionally, the nonaligned consumer requirement on Planning Councils is a barrier to the meaningful involvement of women with HIV. Because of the high levels of stigma and non-disclosure in some communities around the U.S., the few women who are active advocates and “out” or “public” with their diagnosis tend to be hired by community organizations and AIDS Service Organizations, and consequently cannot operate as non-aligned consumers on Planning Councils. The Ryan White Treatment Modernization Act should additionally develop and implement measures of community accountability for those who serve as consumer advocates.

5) Health care for women means health care for families.

Medical bills cause over half of the bankruptcies in the U.S. today and destroy millions of lives, as well as devastating families and communities. We must implement Universal Health Care that ensures comprehensive access to quality health care for all people without placing an undue burden on the middle class, and those who are unemployed or under-employed.

In addition, we need a family-centered approach to care for all women, including those living with HIV. Since over three-quarters of HIV-positive women in the U.S. have at least one child under the age of 18 living in their homes, medical care and support services should take this into account when planning for the realities of women’s lives.

While there currently exist funding streams and resources, albeit limited, to support children who are HIV positive, programs to support *affected* children and families are extremely limited. As the number of children and families affected by HIV continues to grow, it is critical to create programs designed to serve these children and families and designate adequate financial resources to sustain these programs. Currently, access to health care -- including preventative education and HIV care and treatment, is largely dependent on where a woman lives and how much money she has. This -- in a country as wealthy as the U.S.—represents an abject failure in universal access in terms of equal opportunity for HIV prevention, treatment, and care.

6) Eliminate the 75/25 split in the next version of the Ryan White Treatment Modernization Act.

The stipulation that 75 percent of monies should go to core medical services, and that support services are capped at 25 percent of overall spending, ties the hands of local planning bodies allocating resources. Ultimately, the 75/25 split prevents communities from funding what they know is needed to keep people in care – including transportation and culturally specific services. Local jurisdictions should have the authority to determine how their Ryan White dollars – dollars of last resort—should be spent to keep people with HIV in care.

7) Increase funding across the board for domestic HIV/AIDS support services such as housing, mental health, substance use.

While the number of people living with HIV in the U.S. increases every year, funding levels for domestic HIV programs have remained steady – effectively creating a decline in resources per person. Therefore, to meet the growing need for more HIV-related support, increased access to safe and stable housing, mental health services, and substance-use services for people living with HIV will directly result in fewer HIV infections and more HIV-positive people in care. This can be achieved through increased funding for Ryan White Programs, Housing Opportunities for People With AIDS (HOPWA), and the Substance Abuse and Mental Health Services Agency (SAMHSA).

8) Ensure universal access to treatment and care for all persons diagnosed with HIV.

In many States, individuals with HIV must develop an AIDS diagnosis before they qualify for access to affordable or free anti-retroviral therapy. By the time a patient develops an AIDS diagnosis, she may have developed other complicating illnesses and conditions, and her diagnosis will be more difficult and more expensive to manage.

The U.S. Positive Women's Network calls on our next Congress to pass the Early Treatment for HIV Act (ETHA): S. 860; H.R. 3326) to expand Medicaid coverage for people living with HIV **before** they develop AIDS. Passing ETHA would give individual States the option to provide comprehensive health care including anti-retroviral medication as soon as a low-income person learns s/he is HIV positive. By creating an eligibility category for Medicaid based solely on HIV status, ETHA would improve health and quality of life, reduce HIV mortality by 50% to 60%, and because prevent treatment results in a significant reduction in HIV infectiousness, the spread of HIV would be prevented[xvii]. Further, we must ensure that research on existing and new anti-HIV drugs must evaluate for differences in effectiveness or side effects in women.

We must additionally close the gaps in treatment access by:

a) Fully funding the AIDS Drugs Assistance Program (ADAP)

There are currently two States (Indiana and Montana) which have ADAP waiting lists with several other States utilizing cost-containment strategies, including reduced ADAP formularies and cost-sharing. Reduced ADAP formularies result in people with HIV not having access to needed medication – including medications to maintain mental and physical health, and medications needed to keep people in care. The PWN recommends that ADAP formularies in all States be expanded to cover mental health drugs, drugs for co-infection, and medications which address the side effects of Anti-Retroviral Therapy.

b) Allowing ADAP to count towards True out-of Pocket

costs (TrooP) for Medicare Part D

Medicare is the second-largest source of HIV and AIDS care in the United States, serving 100,000 people with AIDS. However, because ADAP expenditures do not currently count towards a Medicare beneficiary's "true out-of-pocket" costs, beneficiaries never reach the spending threshold where Medicare will pick up most of their drug costs. This keeps people with HIV and AIDS from accessing lifesaving treatment. ADAP spending must count towards Medicare True Out-Of-Pocket (TrOOP) spending.

VIII. Conclusion

A comprehensive solution to the HIV epidemic among women in the United States means holistic solutions for communities. We will never effectively reduce HIV infections among women in the U.S. without addressing the underlying causes of women's vulnerability. Nor will we ever effectively keep women in medical care with positive health outcomes without taking into account the true context of women's lives.

To systematically address the HIV epidemic among U.S. women, the next Administration's response must:

1) Be based on Human Rights, and include an analysis of factors that make some populations disproportionately vulnerable to acquiring HIV as well as vulnerable to worse health outcomes once diagnosed.
2) Set ambitious and credible goals for reducing new HIV infections and increasing access to and utilization of care.
3) Invest in prevention technologies that put prevention directly in the hands of women.
4) Lift women out of poverty by ensuring a real living wage for all U.S. workers.
5) Develop a health care system that provides quality affordable care to all residents of the U.S.
6) Address HIV stigma and discrimination against people with HIV as well as those who are especially vulnerable to HIV infection, such as racial, ethnic, and sexual minorities.
7) Implement Prevention Policies and Programs based on sound scientific evidence.
8) Involve HIV-positive individuals and those vulnerable to HIV infection in decision making at the local, state and national level.
9) Design systems of medical care to include the necessary supportive services to keep women and people in poverty in care.
10) Ensure access to medication and treatment for HIV to everyone who needs it, regardless of income level or stage of diagnosis.

11) Increase funding for mental health services, housing, and substance abuse services.

The U.S. Positive Women's Network looks forward to working with our next Administration and Congress to achieve these ambitious goals.

As the only nationally representative body for an estimated 300,000 women living with HIV in the United States, we look forward to continued dialogue with the Transition Team and next Administration and Congress on issues relating to U.S. women living with and at risk for contracting HIV.

Contact:

Naina Khanna
Coordinator, U.S. Positive Women's Network
National Advocacy Coordinator, WORLD
(Women Organized to Respond to Life-threatening Disease)
414 13th Street, Oakland, CA 94608
510.986.0340
www.womenhiv.org

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