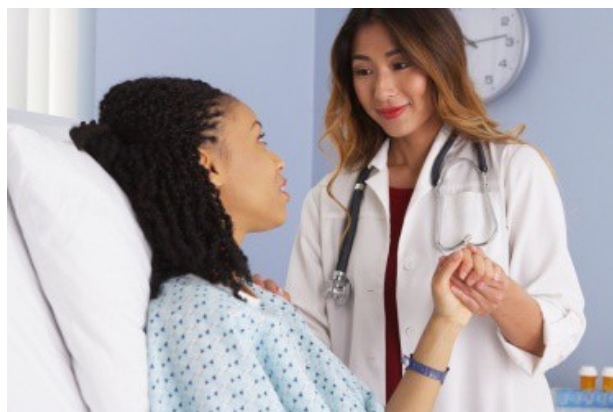


## Activists Must Address HIV in Reproductive Justice Advocacy

by Melanie Medalle and Nerissa Irizarry

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In the United States, approximately 1.2 million people are living with HIV. Unfortunately, because of the intersection of multiple systems of oppression, many of these individuals lack access to adequate HIV and AIDS treatment, including testing availability, retention in care, viral suppression, and access to mental health services and social support systems. In this way, they are often denied the autonomy to freely make decisions about their bodies, relationships, and children—fundamental rights sought by those in the reproductive justice movement. In order to comprehensively address the consequences of ingrained prejudice faced by many people living with HIV, activists must approach HIV advocacy using a reproductive justice framework.



Many people living with HIV are often denied the autonomy to freely make decisions about their bodies, relationships, and children—fundamental rights sought by the reproductive justice movement.

A disproportionate number of those living with HIV in the United States are people of color. For example, in 2010, Black gay, bisexual, and other men who have sex with men had the highest number of new HIV diagnoses among all men who have sex with men. Less frequently discussed, however, is the fact that Black women, while only 13 percent of the country's female population, represented [64 percent of all new HIV diagnoses among women in 2010](#). Black women also accounted for [60 percent](#) of the total number of women living with HIV in the United States in 2010. While the likelihood of a white woman being diagnosed with HIV in her lifetime is [1 in 526](#), the likelihood for a Latina woman is 1 in 106; for Black women, that chance increases to 1 in 32.

And those skewed numbers continue in terms of treatment options too. Through antiretroviral therapy, for example, people living with HIV can achieve an undetectable viral load, which means having low levels of HIV in the blood. Viral suppression is critical for overall health and well-being, and it is associated with reduced instances of transmission. While rates of viral suppression vary across all populations, there are still significant [racial disparities](#). Approximately 21 percent of Black people are virally suppressed, compared with 30 percent of white people.

These statistics arise out of a cycle of inequality. Advancements in HIV antiretroviral treatment and health-care delivery in the past two decades means that it is now less likely that an HIV diagnosis will result in death. For people with economic resources and access to quality health care and treatment, these progressions in medication and care make HIV manageable as a chronic illness. For people without these resources, however, living with HIV means navigating a complicated web of interlocking medical, social, and legal oppressions—oppressions that are even further exacerbated for people of color, queer people, people with substance addictions, or other vulnerable populations.

Poor women and women of color, for example, suffer from a lack of access to quality and affordable HIV health care. This is a particularly salient issue for women in the southern states, where the concentration of HIV cases and new diagnoses is the highest in the nation. And yet, only two southern states have chosen to expand Medicaid—which can be literally life-saving in terms of less expensive HIV treatment and management—under the Affordable Care Act. Meanwhile, on the prevention side of the equation, biomedical research, access to pre- and post-exposure prophylaxis medications, and access to comprehensive sex education for young people have all focused on cisgender gay men as the primary population in need, gravely neglecting women or transgender individuals.

Furthermore, there exists a lack of trauma-informed prevention and care for vulnerable populations living with or at risk of acquiring the virus. Recent studies have shown that both lifelong and immediate trauma may influence likelihood of behaviors that increase HIV risk, and that past or ongoing trauma and PTSD significantly disturb the ability of individuals to remain in HIV treatment. Overall, without access to treatment, people living with HIV will have significantly shorter life expectancies.

Beyond immediate care and prevention, people living with HIV are often subject to criminalization statutes, which rely on representations of the disease based on unfounded fears, rather than current scientific knowledge. For example, Georgia’s criminal HIV statute makes it a crime for an HIV-positive person to spit on a police officer, despite the fact that this act cannot transmit the virus. HIV criminalization laws, which largely prohibit nondisclosure, exposure, and transmission, are on the books in [32 U.S. states](#), Guam, and the U.S. Virgin Islands. They maintain a culture of silence and shame around sex, often stopping people from getting tested for fear that a positive diagnosis will relegate them to a position where their identity is based on the virus they live with.

These disparities in care and prevention, combined with punitive legal policies, perpetuate a stigma around HIV that paints many people living with the disease as medically pathological, sexually deviant, and a drain on social resources. In turn, these stereotypes are quietly carried over into other spheres of sexual health and reproductive justice. For example, for women living with HIV, disclosure of HIV status could mean social ostracism, isolation, and in too many instances, violent retaliation and murder at the hands of aggrieved partners. In just one such instance, Cicely Bolden, a Dallas woman living with HIV, was murdered in 2012 by her partner. When interrogated by Dallas police about the killing, her partner stated, “She killed me, so I killed her.”

These words remind us of the persistent, insidious beliefs that HIV is a death sentence, that people living with the virus wield it as a biological weapon, and that they ultimately deserve violent retribution for perceived transmission. In this sense, HIV criminalization laws and stigma-based interpersonal violence further frustrate the ability of people living with HIV to exercise sexual and reproductive agency.

Reproductive justice provides an intersectional analytical framework that allows us to interrogate interlocking systems of power, and to address the root causes and the distributive impact of oppressive sexual and reproductive health policy, law, and culture on the lives of people living with HIV. As such, activists are well positioned to apply this framework to HIV advocacy. Collective action and advocacy at this intersection are critical to realizing reproductive justice, for those living with HIV and those without it.

<http://rhrealitycheck.org/article/2014/12/02/activists-must-address-hiv-advocacy-using-reproductive-justice-framework/>