

I. Title: HIV Criminalization, Poverty, and Health care Access – United States’ Violations of the International Convention on the Elimination of All Forms of Racial Discrimination

II. Reporting Organization(s)

Organizations involved focus on HIV, with an emphasis on access to prevention, care, treatment, and support that is grounded in human rights and equity.

AIDS Foundation of Chicago (AFC), Chicago, IL – State/Local
Center for HIV Law and Policy (CHLP), New York City, NY – National
Counter Narrative Project, Atlanta, GA – National/Regional
HIV Prevention Justice Alliance (HIV PJA), Chicago, IL – National
National Working Positive Coalition (NWPC), New York City, NY – National
Positive Women’s Network of the United States of America (PWN-USA), Oakland, CA – National
Sero Project, Milford, PA – National
Treatment Action Group (TAG), New York City, NY and Washington D.C. – National
Women with a Vision, New Orleans, LA – State/Local

III. Issue Summary

Since the early 1980s, it has been abundantly clear to the United States (US) government that HIV/AIDS was impacting people of color disproportionately. Yet in 2014, the 30th anniversary of the discovery of the human immunodeficiency virus (HIV), the number of new HIV infections has remained flat for more than 15 years, while the racial disparities have persisted. In fact, those disparities may be getting worse.

According to the Centers for Disease Control and Prevention (CDC), Blacks represent approximately 12% of the US population, but accounted for an estimated 44% of new HIV infections in 2010. They also accounted for 44% of people living with HIV infection in 2009. Unless the course of the epidemic changes, at some point in their lifetime, an estimated 1 in 16 Black men and 1 in 32 Black women will be diagnosed with HIV infection.¹ Disparities persist in the estimated rate of new HIV infections in Hispanics/Latinos. In 2010, the rate of new HIV infections for Latino males was 2.9 times that for white males, and the rate of new infections for Latinas was 4.2 times that for white females.²

At the urging of AIDS activists in the US, for the first time in the history of the epidemic, the US implemented a National HIV/AIDS Strategy (NHAS) in 2010, a document with a set of five-year targets designed to reduce new infections, increase access to care for people living with HIV, and to reduce disparities in health outcomes for racial and ethnic groups disproportionately impacted. With the implementation of the NHAS, the US expressed a compelling vision to be fulfilled by 2015:

...become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or

¹ CDC. *HIV among African Americans*. (February 2014). Available at: <http://www.cdc.gov/nchhstp/newsroom/docs/CDC-HIV-AA-508.pdf>

² CDC. *HIV among Hispanics/Latinos* (December 3, 2013). Available at: <http://www.cdc.gov/hiv/risk/raciaethnic/hispaniclatinos/index.html>

socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.³

In the 2013 CERD report submitted by the US government, the NHAS was cited as tool to address racial disparities in the HIV epidemic:

201. In July 2010, the United States issued a National HIV/AIDS Strategy to: (1) reduce HIV incidence; (2) increase access to care and optimize health outcomes; and (3) reduce HIV-related health disparities. Also, in March 2012 a working group was established by Presidential Memorandum to look at health-related disparities and the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities. A broad commitment to address disparities in HIV prevention and care involving racial and ethnic minorities and other marginalized populations; reducing HIV-related mortality in communities at high risk for HIV infection; adopting community-level approaches to reduce HIV infection in high-risk communities; and reducing stigma and discrimination against people living with HIV.⁴

As we approach the end of the NHAS target period, it is almost certain that the goal to reduce racial disparities in health outcomes, treatment and care will fall short. The US government's response continues fail to recognize that high infection rates are due in part to a combination of unjust and uneven policies and laws that enforce racism, stigma, criminalization, and discrimination, thus hindering access to health. These prevailing social factors have long perpetuated the epidemic among communities of color and challenged public health authorities for the past 30 years. The above-listed organizations submit that this disparity – in part due to laws, policies and practices – continues to systemically discriminate against communities of color; increases vulnerability to HIV transmission and to stigma and discrimination following HIV diagnosis; and places people of color living with HIV at undue risk for criminalization and human rights violations.

These failures also represent a violation of the US' international obligations as a State Party to the International Convention on the Elimination of All Forms of Racial Discrimination (CERD),⁵ as communities of color, and particularly gay, bisexual and transgender people of color (collectively known as “LGBT” people of color, who have been a historically socially marginalized group), are increasingly vulnerable to HIV and stigma. This report analyzes these human rights violations by (I) providing an overview of their sociopolitical context, and then examining three key social drivers that continue to impact the disparity of HIV amongst communities of color in the US and limit progress on meeting its obligations as a party to CERD. The key drivers are (II) Criminalization, (III) Employment & Poverty, and (IV) Health Care Access. These social factors are not independent of each other, but are strongly intersectional and crosscut each other as influential drivers of the epidemic along gender and racial lines.

Analysis shows racial discrimination in direct contravention of CERD,⁶ particularly in light of the assertion in General recommendation No. 32 that the, “principle of equality underpinned by the

³ White House Office of National AIDS Policy. *National HIV/AIDS Strategy for the United States* (July 2010). Available at: <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

⁴ US Government. *Periodic Report of the United States of America to the United Nations Committee on the Elimination of Racial Discrimination – Concerning the International Convention on the Elimination of All Forms of Racial Discrimination* (June 12, 2013). Available at: http://www.ushrnetwork.org/sites/ushrnetwork.org/files/periodic_icerd_report_of_the_usg_2013.pdf

⁵ International Convention on the Elimination of All Forms of Racial Discrimination (hereinafter “CERD”), 660 U.N.T.S. 195, entered into force Jan. 4, 1969, *ratified by the United States of America* Oct. 21, 1994.

⁶ *Id.* art. 1(1).

Convention . . . [includes] substantive or de facto equality in the enjoyment and exercise of human rights as the aim to be achieved by the faithful implementation of its principles.”⁷

I. Sociopolitical Context

As previously mentioned, the CDC report that despite representing only 14% of the US population, Blacks accounted for nearly half of all new HIV infections among adults and adolescents in 2010.⁸ Based on population size, this represents a new infection rate 8 times higher than that of white Americans. The Latino population also experiences a disparity compared to white counterparts, with an infection rate that is 3 times higher.⁹

Evidence of persistent racial disparities in HIV/AIDS diagnoses can be noted by observing epidemiology in different regions of the United States that have large majority people of color populations, particularly the US South, where a majority of Blacks in the United States have lived since slavery to the present.¹⁰ Large Latino populations also live in the Southern region, particularly in Texas and Florida, where HIV rates are alarmingly high in the metropolitan areas of both states.¹¹

Sexual orientation and gender identities also exacerbate the discriminatory effects. There are almost no other groups that demonstrate the persistence of racial discrimination as a driver of the HIV rates in the US than the epidemic among Black men who have sex with men, and Black transgender women. Multiple reports reveal that black men who have sex with men – including young, gay and bisexual men - account for the highest number of new HIV infections.^{12 13} Although Blacks are only 12% of the US population, Black men who have sex with men had almost the same number of new infections in 2010 as white men who have sex with men (10,600 vs. 11,200 respectively).¹⁴

The epidemic is particularly pronounced in Atlanta, Georgia, a city known to have large numbers of Black gay residents. Research conducted as recently as of March 2014 found the rate of HIV incidence in young Black gay men in Atlanta, Georgia at 12.1% a year.¹⁵ This rate is one of the highest figures ever recorded in a population of a resource-rich nation, and means that a young, Black gay man sexually active at 16-years-old is 60% likely to be diagnosed with HIV by the age of 30. In attempting to understand factors contributing to the high incidence rate, the study’s researchers found a lack of health insurance

⁷ Committee on the Elimination of Racial Discrimination, *General Recommendation No. 32, The meaning and scope of special measures in the International Convention on the Elimination of All Forms of Racial Discrimination* ¶ 6 (75th Sess., 2009).

⁸ *Supra* note 1

⁹ *Supra* note 2

¹⁰ AIDS Vu. *Illustrating HIV/AIDS in the United States: Black Persons*. Available at: <http://aidsvu.org/wp-content/uploads/data-sets/AIDSVu-Black.pdf>

¹¹ AIDS Vu. *Illustrating HIV/AIDS in the United States: Hispanic/Latino Persons*. Available at: <http://aidsvu.org/wp-content/uploads/data-sets/AIDSVu-Hispanic.pdf>

¹² CDC. *HIV Among African American Gay and Bisexual Men* (May 21, 2014). Available at: <http://www.cdc.gov/hiv/risk/raciaethnic/bmsm/facts/index.html>

¹³ CDC. *HIV and Young Men Who Have Sex with Men* (June 2012). Available at: http://www.cdc.gov/healthyouth/sexualbehaviors/pdf/hiv_factsheet_ymsm.pdf

¹⁴ CDC. *HIV among Gay and Bisexual Men* (March 2014). Available at: <http://www.cdc.gov/nchhstp/newsroom/docs/CDC-MSM-508.pdf>

¹⁵ Sullivan PS, Peterson J, Rosenberg ES, Kelley CF, Cooper H, et al. (2014) *Understanding Racial HIV/STI Disparities in Black and White Men Who Have Sex with Men: A Multilevel Approach*. PLoS ONE 9(3): e90514. doi:10.1371/journal.pone.0090514. Available at:

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0090514>

coverage, unemployment, and incarceration as considerable social determinants of disparity among Black gay men.¹⁶

Black transgender people are affected by HIV in devastating numbers. In the largest survey ever conducted of transgender people in the US, the 2011 *National Transgender Discrimination Survey* reports that 20.23% of survey respondents reported to be HIV positive and 10% were unaware of their status.¹⁷ This compares to 2.64% of transgender respondents of all races and 2.4% for the general Black population in the US. CDC data reports that by race/ethnicity, Black transgender women have the highest percentage of new HIV positive test results.¹⁸

In 2010, Black women accounted for nearly two-thirds (64%) of all estimated new HIV infections, although they represent only 13% of the female population – an incidence rate 20 times higher than that for white women. Latina women face an incidence rate 8 times higher than that for white women. Over half of all women living with HIV in the US are Black, 19% are Latina, and 18% are white. If current trends continue, 1 in 32 Black women in the US will be diagnosed with HIV in their lifetime.¹⁹

Most notably, as numerous research studies demonstrate that Blacks are less likely to engage in risky behavior compared to their white counterparts, racial discrimination in many areas of American life are often cited as contributing factors to the HIV epidemic on communities of color.²⁰ In attempting to understand factors contributing to the high incidence rate among young Black gay men, researchers found that a lack of insurance, unemployment, and incarceration were drivers of the HIV epidemic.²¹ Transgender people of color face a lack of access to employment opportunities which may lead to poverty, unstable housing, disproportionate policing, and criminalization, and a lack of access to health care.²²

Moreover, the US government failed to address the Committee’s finding of “growing disparities in HIV infection rates for minority women (art. 5 (e) (iv))”²³ in its latest State Party’s report.²⁴

¹⁶ *Supra* note 15

¹⁷ National Gay & Lesbian Taskforce. *National Transgender Discrimination Survey – Report on Health Care* (October 13, 2010). Available at: http://transequality.org/PDFs/NTDSReportonHealth_final.pdf

¹⁸ Centers for Disease Control. *HIV among Transgender People*. (December 9, 2013). Available at: <http://www.cdc.gov/hiv/risk/transgender/>

¹⁹ Henry J. Kaiser Family Foundation. *Women and HIV/AIDS in the United States* (March 6, 2014). Available at: <http://kff.org/hiv/aids/fact-sheet/women-and-hiv/aids-in-the-united-states/>

²⁰ Gregorio A Millett, John L Peterson, Stephen A Flores, Trevor A Hart, William L Jeffries, Patrick A Wilson, Sean B Rourke, Charles M Heilig, Jonathan Elford, Kevin A Fenton, Robert S Remis *Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: a meta-analysis*. *The Lancet* 28 July 2012 (Volume 380 Issue 9839 Pages 341-348 DOI: 10.1016/S0140-6736(12)60899-X)

²¹ Sullivan PS, Peterson J, Rosenberg ES, Kelley CF, Cooper H, et al. (2014) *Understanding Racial HIV/STI Disparities in Black and White Men Who Have Sex with Men: A Multilevel Approach*. *PLoS ONE* 9(3): e90514. doi:10.1371/journal.pone.0090514. Available at: <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0090514>

²² National Center for Transgender Equality and the National Gay and Lesbian Task Force. *National Transgender Discrimination Survey – Employment and Economic Security* (November 2009). Available at: http://www.thetaskforce.org/downloads/reports/fact_sheets/transsurvey_prelim_findings.pdf

²³ Committee on the Elimination of Racial Discrimination, *Concluding Observation: United States of America* ¶ 33 (72d Sess., 2008), U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008). Available at: http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=USA&Lang=EN.

²⁴ See United States of America, *Seventh to ninth periodic report of States parties to the Committee on the Elimination of Racial Discrimination* (85th Sess., 2014), U.N. Doc. CERD/C/USA/7-9 (October 3, 2013).

General recommendation No. 32 proscribes such harmful effects for these communities and individuals, as well as the failure to act to mitigate them, as a violation of international obligations under CERD, stating, “the ‘grounds’ of discrimination are extended in practice by the notion of ‘intersectionality’ whereby the Committee addresses situations of double or multiple discriminations – such as discrimination on grounds of gender or religion – when discrimination on such ground appears to exist in combination with . . . grounds listed in article 1 of the Convention.”²⁵

II. Criminalization

Issues of unjust laws that enforce rampant criminalization, policing, and incarceration of communities of color and LGBT people of color not only infringe on human rights, but deepen and widen the disparity of HIV in complex ways. In this regard, the State contravenes its international obligations not to, “permit public authorities or public institutions, national or local, to promote or incite racial discrimination,”²⁶ and to, “adopt immediate and effective measures . . . with a view to combating prejudices which lead to racial discrimination and to promoting understanding, tolerance and . . . propagating the purposes and principles of the Charter of the United Nations, the Universal Declaration of Human Rights, the United Nations Declaration on the Elimination of all Forms of Racial Discrimination, and this Convention.”²⁷

According to a 2014 publication released by the Center for HIV Law and Policy entitled *A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV*:

LGBT youth and adults, and particularly LGBT youth and people of color, experience pervasive profiling and discriminatory treatment by local, state, and federal law enforcement agents based on actual or perceived sexual orientation, gender, gender identity or expression, or HIV status. Such gender and sexuality-based profiling often takes place in conjunction with and compounds profiling and discriminatory treatment based on race, color, ethnicity, national origin, tribal affiliation, religion, age, immigration status, and housing status, among other determinants²⁸

Furthermore, the report details both through narrative and statistics that LGBT communities of color, particularly transgender women of color and youth, are “endemically profiled” as engaging in sex work and other sexual offenses.²⁹ In such situations, the possession of condoms is used as evidence of prostitution (leading to condom confiscation and criminalization), further compounding the discriminatory treatment of LGBT communities color, but also denying the ability of individuals to protect themselves from sexually transmitted infections, including HIV.³⁰ Often many of these individuals are Black and Latina transgender women, including immigrant women, who face significant issues of employment discrimination or lack of economic opportunities to begin with, and are forced with no choice but to engage in sex work to survive.

²⁵ *General Recommendation No. 32*, *supra* note 7, at ¶ 6.

²⁶ CERD, art. 4(c); *See also*, Committee on the Elimination of Racial Discrimination, *General Recommendation No. 15, Article 4 of the Convention* ¶ 7 (42d Sess, 1993) (“Public authorities at all administrative levels, including municipalities, are bound by this paragraph. The Committee holds that States parties must ensure that they observe these obligations and report on this.”).

²⁷ CERD, art. 7.

²⁸ Center for HIV Law and Policy. *A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV* (May 2014). Available at: http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/Roadmap_For_Change_full_report.pdf

²⁹ *Supra* note 28

³⁰ *Supra* note 28

Thirty-two states in the US currently criminalize the exposure and transmission of HIV through sex, shared needles, and any other theoretical or actual exposure to bodily fluid.³¹ Many of these laws criminalize exposure of HIV through biting and spitting as well, “routes” scientifically proven to have negligible risk of transmission of HIV.³² Advocates argue that in such cases proof of intent or actual transmission is not required. Legal intent is satisfied by evidence of sexual contact, regardless of the actual risk of transmission entailed by the act, including oral or non-penetrative sexual acts. Moreover, neither condom use nor viral load suppression through treatment are acceptable defenses to the presumption of intent, despite the fact that both have been medically shown to greatly diminish the risk of transmission, especially when used in combination.

For people of color living with HIV, these laws violate their, “right to equal treatment before tribunals and all other organs administering justice.”³³ Although there is limited access to the full number of actual convictions under HIV-related laws, ProPublica utilized and compiled sample data provided by the Sero Project to find that race data was available for 322 records involving HIV-related convictions nationwide.³⁴ According to ProPublica, “Offenders were reported as Black or African American in nearly two-thirds of the records (n=186), while whites made up the rest of the records (n=136).”³⁵ These numbers parallel general trends in the disparate criminalization of people of color and are indicative of underlying structural racism.³⁶ The US claims that the rights to public health and medical care are, “guaranteed to persons in the United States without regard to race . . . , and interference with them may be criminally prosecutable under a number of statutes.”³⁷ The state should address the interference with these rights caused by its criminalization of HIV. Not surprisingly, each year, an estimated one in seven persons living with HIV pass through a correctional or detention facility.³⁸

The Joint United Nations Programme on HIV/AIDS (UNAIDS) recognizes the human rights and public health concerns implicated by HIV criminalization. In a report on HIV criminalization, UNAIDS concluded that all laws and policies related to HIV, as well as all treatment and prevention efforts, should be based on sound scientific and medical evidence, and that stronger government commitment to HIV

³¹ Center for HIV Law and Policy. *Ending and Defending Against HIV Criminalization: State and Federal Laws and Prosecutions* (May 12, 2014). Available at: <http://www.hivlawandpolicy.org/resources/ending-and-defending-against-hiv-criminalization-state-and-federal-laws-and-prosecutions>

³² NAM Publications. *Non-sexual HIV exposure or transmission*. Aidsmap (2010). Available at: <http://www.aidsmap.com/Non-sexual-HIV-exposure-or-transmission/page/1444047/>

³³ CERD, art. 5. See also Committee on the Elimination of Racial Discrimination, *General Recommendation No. 20, Non-discriminatory implementation of rights and freedoms* ¶¶ 2, 5 (51st Sess., 1996) (“Whenever a State imposes a restriction upon one of the rights listed in article 5 of the Convention which applies ostensibly to all within its jurisdiction, it must ensure that neither in purpose nor effect is the restriction incompatible with article 1 of the Convention as an integral part of international human rights standards. . . it is the obligation of the State Party concerned to ensure the effective implementation of the Convention . . . To the extent that private institutions influence the exercise of rights or the availability of opportunities, the State Party must ensure that the result has neither the purpose nor effect of creating or perpetuating racial discrimination.”)

³⁴ Hernandez, Sergio. *How we built Our HIV Crime Data Set*. ProPublica (December 1, 2013). Available at: <http://www.propublica.org/article/how-we-built-our-hiv-crime-data-set>

³⁵ *Id.*

³⁶ Federal Bureau of Prisons. *Inmate Ethnicity and Inmate Race* (May 2014). Available at: http://www.bop.gov/about/statistics/statistics_inmate_ethnicity.jsp and http://www.bop.gov/about/statistics/statistics_inmate_race.jsp

³⁷ *Seventh to ninth periodic report of States parties to the Committee on the Elimination of Racial Discrimination*, *supra* note 24, at ¶ 109.

³⁸ CDC. *HIV in Correctional Settings* (February 20, 2014). Available at: <http://www.cdc.gov/hiv/risk/other/correctional.html>

prevention, treatment, care, and support are the most effective way to address HIV.³⁹ Thus, to the extent HIV-related laws and policies, criminal and otherwise, deviate from accepted scientific and medical evidence, the United States fails in its obligation to, “guarantee the right of everyone, without distinction as to race . . . in the enjoyment of . . . the right to public health [and] medical care . . .”⁴⁰

III. Poverty and Employment

Increasingly, HIV is considered a disease associated with poverty. According to the CDC, poverty, “can limit access to health care, HIV testing, and medications that can lower levels of HIV in the blood and help prevent transmission. In addition, those who cannot afford the basics in life may end up in circumstances that increase their HIV risk.”⁴¹ This dimension of the epidemic implicates the rights of people living with HIV, “to work, to free choice of employment, to just and favourable conditions of work, [and] to protection against unemployment,”⁴² and, “to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution.”⁴³

Black transgender women particularly end up in circumstances that increase their HIV risk. More data from the *National Transgender Discrimination Survey* finds that Black transgender people had an unemployment rate of 26%, nearly four times the rate of the general population.⁴⁴ In addition to increased experiences with harassment, physical and sexual assault in the workplace, half of Black transgender women in the survey report having to sell drugs or perform sex work for survival. With less economic opportunity and social protections, Black transgender women face increased risk of HIV infection, criminalization and incarceration by police, as well as violence by engaging in sex work.⁴⁵

Discrimination based on sex work is frighteningly similar to what is described in General recommendation No. 29 as “discrimination against members of communities based on forms of social stratification such as caste and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights . . .”⁴⁶ Recommended measures for such discrimination include:

- (c) Review and enact or amend legislation in order to outlaw all forms of discrimination . . . in accordance with the Convention;
- (k) Take into account, in all programmes and projects planned and implemented and in measures adopted, the situation of women members of the communities, as victims of multiple discrimination, sexual exploitation and forced prostitution;

³⁹ Joint United Nations Programme on HIV/AIDS (UNAIDS) Report: Ending overly broad criminalization of HIV non-disclosure, exposure and transmission - Critical scientific, medical and legal considerations, May 2013.

⁴⁰ CERD art. 5(e)(iv). See also *General Recommendation No. 20*, *supra* note 33, at ¶ 2.

⁴¹ Centers for Disease Control. *Socioeconomic Factors Affecting HIV Risk* (June 25, 2013). Available at: <http://www.cdc.gov/nchhstp/newsroom/HIVFactSheets/Epidemic/Factors.htm>

⁴² CERD art. 5(e)(i). See also *General Recommendation No. 20*, *supra* note 33, at ¶ 2.

⁴³ CERD art. 5(b). See also *General Recommendation No. 20*, *supra* note 33, at ¶ 2.

⁴⁴ National Gay and Lesbian Taskforce. *Injustice at Every Turn: A look at Black respondents in the National Transgender Discrimination Survey* (September 2011). Available at: http://www.thetaskforce.org/reports_and_research/ntds_black_respondents

⁴⁵ National Gay and Lesbian Taskforce. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (February 3, 2011). Available at: http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf

⁴⁶ Committee on the Elimination of Racial Discrimination, *General Recommendation No. 29, Article 1, paragraph 1 of the Convention* (57th Sess., 2002).

- (l) Take all measures necessary in order to eliminate multiple discrimination . . . against women, particularly in the areas of personal security, employment and education;
- (hh) Take substantial and effective measures to eradicate poverty among descent-based communities and combat their social exclusion or marginalization.⁴⁷

HIV positive Black men who have sex with men are also subject to economic pressure and concerns. A study examining factors of the HIV epidemic that are concentrated among black men who have sex with men found that HIV positive Black men who have sex with men were significantly more likely to be unemployed compared to HIV negative peers.⁴⁸ The same study also found HIV positive Black men were comparatively more likely to engage in unprotected sex and be diagnosed with a sexually transmitted infection. The study revealed that 50% of men in the study were poor, exhibited symptoms of depression, and expressed internalized homophobia. Economic concerns were a significant factor in homelessness as well as non-engagement with the medical system.

Failure to address these issues is not only counterproductive to public health measures aimed at ameliorating the HIV epidemic; it also legitimates and perpetuates stigma and discrimination on the basis of race, gender identity, and sexual orientation. Yet the United States claims to “engage broadly and at all levels in measures to combat prejudice and promote understanding and tolerance.”⁴⁹ The state must meet its obligations under CERD by making real and substantial efforts to address these serious human rights violations.

IV. Health care access

Health care access presents a significant opportunity for addressing the human rights of individuals and communities of color affected by HIV. The Gardner (Treatment) Cascade or HIV Continuum of Care is considered to be a benchmark model in assessing the delivery of health care for people living with HIV across the continuum of care, from diagnosis, linkage to care, retention in care, receiving antiretroviral therapy and achieving viral suppression. When broken down by race, Blacks are shown to have worse outcomes across the continuum, with fewer diagnosed, linked, retained and virally suppressed than other racial groups.⁵⁰ Such evidence of disparity through the continuum amounts to a violation of the obligation to ensure, “the right to public health, medical care, social security and social services.”⁵¹ Moreover, it presents an opportunity for public health to implement policy that can substantially scale-up the delivery of the health care for communities of color living with HIV.

However, even with the promise and progress made to expand health care access through the Affordable Care Act (ACA) and potentially resolve accessibility issues faced by communities of color, incomplete and uneven implementation continues to complicate health care access particularly in states that have chosen not to expand Medicaid, due to a 2012 Supreme Court ruling, making this provision the ACA optional for states.⁵² Only two Southern states, Arkansas and Kentucky, have opted to expand the program, even though the increase in federal funding would bring a net savings to states budgets who opt

⁴⁷ *Id.* at ¶¶ 1(c), 2(k), 2(l), 7(hh).

⁴⁸ Mayer KH, Wang L, Koblin B, Mannheimer S, Magnus M, et al. (2014) *Concomitant Socioeconomic, Behavioral, and Biological Factors Associated with the Disproportionate HIV Infection Burden among Black Men Who Have Sex with Men in 6 U.S. Cities*. PLoS ONE 9(1): e87298. doi:10.1371/journal.pone.0087298

⁴⁹ *Seventh to ninth periodic report of States parties to the Committee on the Elimination of Racial Discrimination*, *supra* note 24, at ¶ 210.

⁵⁰ AIDs.gov *HIV/AIDS Care Continuum* (December 12, 2013). Available at: <http://aids.gov/federal-resources/policies/care-continuum/>

⁵¹ CERD art. 5(e)(iv). See also *General Recommendation No. 20*, *supra* note 33, at ¶ 2.

⁵² Henry J. Kaiser Family Foundation. *A Guide the Supreme Court’s Decision on Medicaid Expansion* (August 1, 2012). Available at: <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>

into the program. Additionally, issues of discrimination and racism within the health care system complicate access to health care to LGBT people of color, but also perpetuate poor health outcomes such as treatment adherence and limit achieving optimal viral suppression.

Medicaid Non-Expansion:

As previously mentioned, the Southeastern US contains the highest rates of HIV across the nation, primarily impacting communities of color. Consequently, the region also represents the highest rates of uninsured people. For this reason the lack of Medicaid expansion, particularly in the South, presents dire consequences in the accessibility of health care. According to the Kaiser Family Foundation:

In states that do not expand Medicaid, millions of poor adults will be left without a new coverage option, particularly poor uninsured Black adults residing in the South, where most states are not moving forward with the expansion. Four in ten uninsured Blacks with incomes low enough to qualify for the Medicaid expansion fall into the gap, compared to 24% of uninsured Hispanics and 29% of uninsured Whites. These continued coverage gaps will likely lead to widening racial and ethnic as well as geographic disparities in coverage and access.⁵³

Nearly 60,000 uninsured and low-income people living with HIV reside in states that are not expanding Medicaid, but are otherwise eligible.⁵⁴ Without the expansion of Medicaid, many health care institutions are also closing facilities in many rural communities due to a loss of projected revenue from new patients, which further complicates access to medical care and antiretroviral therapy, in regions of the country with large poor, rural populations with relatively high concentrations of people living with HIV.⁵⁵ Undocumented immigrants are also systematically excluded from health care reform and the health care system.

This reality is in stark contrast with the assertion regarding self-determination, under General recommendation No. 21, that, “Governments are to represent the whole population without distinction as to race, [or] colour . . .” By contributing to an overwhelming racial disparity in health care outcomes and then refusing to address it, the state violates the rights of people of color living with HIV in contravention of CERD.

Discrimination and Racism in Health Care

Communities of color and LGBT people of color face elevated discrimination and racism in the US health care system, which detrimentally affects engagement in health care and results in poorer health outcomes. Discrimination and racism particularly affects those vulnerable to HIV and living with HIV.

Health care implementation derailed by discrimination and racism amounts to the State’s failure to ensure, “the right to public health, medical care, social security and social services.”⁵⁶ Experiences with

⁵³ Henry J. Kaiser Family Foundation. *The Impact of the Coverage Gap in States not Expanding Medicaid by Race and Ethnicity* (December 17, 2013). Available at: <http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/>

⁵⁴ Snider JT, Juday T, Romley JA, Seekins D, Rosenblatt L, Sanchez Y, Goldman DP. *Nearly 60,000 uninsured and low-income people living with HIV/AIDS live in states that are not expanding Medicaid*. Health Affairs (March 2014). Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24590935>

⁵⁵ Olorunnipa, Toluse. *Obamacare Cutbacks Shut Hospitals Where Medicaid Went Unexpanded*. Bloomberg (November 24, 2013). Available at: <http://www.bloomberg.com/news/2013-11-25/obamacare-cutbacks-shut-hospitals-where-medicaid-went-unexpanded.html>

⁵⁶ CERD art. 5(e)(iv). See also *General Recommendation No. 20*, supra note 33, at ¶ 2.

discrimination include outright refusal of care both due to race and gender expression, violence and harassment, sexual abuse, lack of provider knowledge, and inaccessibility to insurance.⁵⁷ Across all experiences transgender respondents of color report higher elevated risk of abuse, refusal of care and poorer health outcomes. As a result of discrimination overall, transgender people, particularly transgender women of color, are more likely to delay or postpone both preventative and post-diagnosis care, including getting tested for HIV.

Many other LGBT people of color also frequently delay or avoid seeking medical attention for fear of discrimination. The Center for American Progress found that among Black lesbians, only 35% had a mammogram in the past two years, compared to 60% of white lesbians and bisexual women.⁵⁸ Moreover, according to the National Association of State and Territorial AIDS Directors (NASTAD), “stigma and other social determinants influence the HIV care continuum before a diagnosis is even made.”⁵⁹ In fact, gay Black and Latino men were more likely to delay seeking medical care after being diagnosed with HIV than their straight counterparts due to stigma.⁶⁰

The state is complicit in disparate negative outcomes to the extent it legitimates stigma and discrimination and fails to address the issues they implicate. Discrimination aggravates HIV health disparities and worsening health outcomes among Blacks living with HIV.⁶¹ The longitudinal study analyzed treatment adherence amongst HIV positive Black men who have sex with men. Strong adherence to treatment equated to better health outcomes and achieving viral suppression. However, the study found that participants only took 60% of prescribed treatment on average, with racial discrimination being the main significant factor affecting treatment adherence in the cohort.⁶²

IV. Concluding Observations

CERD made prior recommendations in 2008 related to issues summarized above:

Paragraph 33: The Committee regrets that despite the efforts of the State party, wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, the high incidence of unintended pregnancies and greater abortion rates affecting African American women, and the growing disparities in HIV infection rates for minority women (art. 5 (e) (iv)).

⁵⁷ *National Transgender Discrimination Survey Report on Health and Health Care*, (examining experiences of discrimination by transgender people in the US health system.)

⁵⁸ Moodie-Mills, Aisha C. *Jumping the Broom: Why Black gay and Transgender Americans Need More Than Marriage Equality*. Center for American Progress (January 19, 2012). Available at: <http://americanprogress.org/issues/race/report/2012/01/19/10962/jumping-beyond-the-broom/>

⁵⁹ National Alliance of State & Territorial AIDS Directors and National Coalition of STD Directors. *Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black & Latino Men*. (May 2014). Available at: <http://www.nastad.org/docs/NASTAD-NCSD-Report-Addressing-Stigma-May-2014.pdf>

⁶⁰ Dunn, Melissa; Moodie-Mills, Aisha C. *The State Gay and Transgender Communities of Color in 2012: The Economic, Education and Health Insecurities These Communities are Struggling With and How We Can Help Them*. Center for American Progress (April 13, 2012). Available at: <http://americanprogress.org/issues/lgbt/news/2012/04/13/11493/the-state-of-gay-and-transgender-communities-of-color-in-2012/>

⁶¹ Bogart LM, Wagner GJ, Galvan FH, Klein DJ. *Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV*. *Ann Behav Med*. 2010 Oct;40(2):184-90. doi: 10.1007/s12160-010-9200-x. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20552416>

⁶² *Id.*

V. U.S. Government Report

Paragraph 134: Description of the enactment of the ACA to counteract disparities in health care and increase access to medical services for communities of color.

Paragraph 140: The 2011 release of the Action Plan to Reduce Racial and Ethnic Health Disparities, by HHS. Outlines the goals and actions it will take to reduce racial and ethnic health disparities, building on the ACA

Paragraph 201: Description of the release of the National HIV/AIDS Strategy to: (1) reduce HIV incidence; (2) increase access to care and optimize health outcomes; and (3) reduce HIV-related health disparities. Also, in March 2012 a working group was established by Presidential Memorandum to look at health-related disparities and the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities. A broad commitment to address disparities in HIV prevention and care involving racial and ethnic minorities and other marginalized populations; reducing HIV-related mortality in communities at high risk for HIV infection; adopting community-level approaches to reduce HIV infection in high-risk communities; and reducing stigma and discrimination against people living with HIV.

VI. Legal Framework

Article 1

1. In this Convention, the term "racial discrimination" shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

Article 2

1. States Parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races, and, to this end: (a) Each State Party undertakes to engage in no act or practice of racial discrimination against persons, groups of persons or institutions and to ensure that all public authorities and public institutions, national and local, shall act in conformity with this obligation;

(b) Each State Party undertakes not to sponsor, defend or support racial discrimination by any persons or organizations;

(c) Each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists;

(d) Each State Party shall prohibit and bring to an end, by all appropriate means, including legislation as required by circumstances, racial discrimination by any persons, group or organization;

Article 4

States Parties condemn all propaganda and all organizations which are based on ideas or theories of superiority of one race or group of persons of one colour or ethnic origin, or which attempt to justify or promote racial hatred and discrimination in any form, and undertake to adopt immediate and positive measures designed to eradicate all incitement to, or acts of, such discrimination and, to this end, with due regard to the principles embodied in the Universal Declaration of Human Rights and the rights expressly set forth in article 5 of this Convention, inter alia:

- (a) Shall declare an offence punishable by law all dissemination of ideas based on racial superiority or hatred, incitement to racial discrimination, as well as all acts of violence or incitement to such acts against any race or group of persons of another colour or ethnic origin, and also the provision of any assistance to racist activities, including the financing thereof;
- (b) Shall declare illegal and prohibit organizations, and also organized and all other propaganda activities, which promote and incite racial discrimination, and shall recognize participation in such organizations or activities as an offence punishable by law;
- (c) Shall not permit public authorities or public institutions, national or local, to promote or incite racial discrimination.

Article 5: In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:

(d) Other civil rights, in particular:

- (i) The right to freedom of movement and residence within the border of the State;
- (iii) The right to nationality;

(e) Economic, social and cultural rights, in particular:

- (i) The rights to work, to free choice of employment, to just and favourable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favourable remuneration;
- (iii) The right to housing;
- (iv) The right to public health, medical care, social security and social services;
- (v) The right to education and training;
- (f) The right of access to any place or service intended for use by the general public, such as transport hotels, restaurants, cafes, theatres and parks.

Article 6

States Parties shall assure to everyone within their jurisdiction effective protection and remedies, through the competent national tribunals and other State institutions, against any acts of racial discrimination

which violate his human rights and fundamental freedoms contrary to this Convention, as well as the right to seek from such tribunals just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination.

Article 7

States Parties undertake to adopt immediate and effective measures, particularly in the fields of teaching, education, culture and information, with a view to combating prejudices which lead to racial discrimination and to promoting understanding, tolerance and friendship among nations and racial or ethnic groups, as well as to propagating the purposes and principles of the Charter of the United Nations, the Universal Declaration of Human Rights, the United Nations Declaration on the Elimination of All Forms of Racial Discrimination, and this Convention

VII. The CERD Committee General Comments

1. *General recommendation No. 15*

- i. 1. “When the International Convention on the Elimination of All Forms of Racial Discrimination was being adopted, article 4 was regarded as central to the struggle against racial discrimination. At that time, there was a widespread fear of the revival of authoritarian ideologies. The proscription of the dissemination of ideas of racial superiority, and of organized activity likely to incite persons to racial violence, was properly regarded as crucial. Since that time, the Committee has received evidence of organized violence based on ethnic origin and the political exploitation of ethnic difference. As a result, implementation of article 4 is now of increased importance.”
- ii. 7. “Article 4 (c) of the Convention outlines the obligations of public authorities. Public authorities at all administrative levels, including municipalities, are bound by this paragraph. The Committee holds that States parties must ensure that they observe these obligations and report on this.”

2. General Recommendation No. 20:

- i. 2. “Whenever a State imposes a restriction upon one of the rights listed in article 5 of the Convention which applies ostensibly to all within its jurisdiction, it must ensure that neither in purpose nor effect is the restriction incompatible with article 1 of the Convention as an integral part of international human rights standards. . .”
- ii. 5. “. . . it is the obligation of the State Party concerned to ensure the effective implementation of the Convention and to report thereon under article 9 of the Convention. To the extent that private institutions influence the exercise of rights or the availability of opportunities, the State Party must ensure that the result has neither the purpose nor the effect of creating or perpetuating racial discrimination.”

3. General Recommendation No. 21:

- i. 9. “The right to self-determination of peoples has an internal aspect, that is to say, the rights of all peoples to pursue freely their economic, social and cultural development without outside interference. . . In consequence, Governments are to represent the whole population without distinction as to race, colour, descent or national or ethnic origin.”
- ii. 10. “. . . In accordance with article 2 of the International Convention on the Elimination of All Forms of Racial Discrimination and other relevant international documents, Governments should be sensitive towards the rights of persons belonging to ethnic groups, particularly their right to lead lives of dignity, to preserve their

culture, to share equitably in the fruits of national growth and to play their part in the Government of the country of which they are citizens. . .”

4. General Recommendation No. 29:

- i. “The Committee on the Elimination of Racial Discrimination, . . . Strongly reaffirming that discrimination based on “descent” includes discrimination against members of communities based on forms of social stratification such as caste and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights, . . . Strongly reaffirming that discrimination based on “descent” includes discrimination against members of communities based on forms of social stratification such as caste and analogous systems of inherited status which nullify or impair their equal enjoyment of human rights, Recommends that the States parties, as appropriate for their particular circumstances, adopt some or all of the following measures:”
- ii. “(a)Steps to identify those descent-based communities under their jurisdiction who suffer from discrimination, especially on the basis of caste and analogous systems of inherited status, and whose existence may be recognized on the basis of various factors including some or all of the following: . . . private and public segregation, including in housing and education, access to public spaces, . . . ; limitation of freedom to renounce inherited occupations or degrading or hazardous work; subjection to dehumanizing discourses referring to pollution or untouchability; and generalized lack of respect for their human dignity and equality;”
- iii. “(c)Review and enact or amend legislation in order to outlaw all forms of discrimination based on descent in accordance with the Convention;”
- iv. (e)Formulate and put into action a comprehensive national strategy with the participation of members of affected communities, including special measures in accordance with articles 1 and 2 of the Convention, in order to eliminate discrimination against members of descent-based groups;
- v. (f)Adopt special measures in favour of descent-based groups and communities in order to ensure their enjoyment of human rights and fundamental freedoms, in particular concerning access to public functions, employment and education;
- vi. (k)Take into account, in all programmes and projects planned and implemented and in measures adopted, the situation of women members of the communities, as victims of multiple discrimination, sexual exploitation and forced prostitution;
- vii. (l)Take all measures necessary in order to eliminate multiple discrimination including descent-based discrimination against women, particularly in the areas of personal security, employment and education;
- viii. (v)Ensure, where relevant, that judicial decisions and official actions take the prohibition of descent-based discrimination fully into account;
- ix. (y)Organize training programmes for public officials and law enforcement agencies with a view to preventing injustices based on prejudice against descent-based communities;
- x. (hh)Take substantial and effective measures to eradicate poverty among descent-based communities and combat their social exclusion or marginalization;”

5. General Recommendation No. 32:

- i. “6.The Convention is based on the principles of the dignity and equality of all human beings. The principle of equality underpinned by the Convention combines formal equality before the law with equal protection of the law, with substantive or de facto equality in the enjoyment and exercise of human rights as the aim to be achieved by the faithful implementation of its principles.
- ii. “7. . . . The “grounds” of discrimination are extended in practice by the notion of “intersectionality” whereby the Committee addresses situations of double or multiple

discrimination - such as discrimination on grounds of gender or religion – when discrimination on such a ground appears to exist in combination with a ground or grounds listed in article 1 of the Convention. Discrimination under the Convention includes purposive or intentional discrimination and discrimination in effect. . . .”

VIII. Other UN Body Recommendations

- *Joint United Nations Programme on HIV/AIDS (UNAIDS) Report: Ending overly broad criminalization of HIV non-disclosure, exposure and transmission - Critical scientific, medical and legal considerations, May 2013*: report recognizes the overly broad problem of HIV criminalization which both raises human rights concerns and complicates public health efforts
 - Conclusions:
 - Ensure that all laws and policies applicable to HIV, including criminal law, are informed by the best scientific and medical evidence relating to HIV transmission, prevention and treatment.
 - Expand evidence-informed HIV prevention, treatment, care and support programmes that enable all individuals to know their HIV status and help them reduce risk of transmission.
 - Advocate stronger government commitment and action to expand HIV prevention, treatment, care and support services as the most effective way to address the HIV epidemic.
- *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, April 27, 2010*: examines the impact of standard of health and the criminalization of same-sex conduct, sexual orientation, sex work and transmission
 - Conclusions:
 - Only intentional, malicious HIV transmission can be legitimately criminalized; however specific criminal laws concerning HIV transmission are generally unnecessary
 - Decriminalization is necessary in response to each of the aforementioned issues, along with a comprehensive right to health approach.
- *Committee on Economic, Social, and Cultural rights, August 11, 2000*: recognizes that diseases like HIV have created new obstacles for the realization of the right to health and must be taken into account
 - Conclusions:
 - Paragraph 18 proscribes any discrimination in access to health and underlying determinants on the grounds of race, color...health status (including HIV/AIDS)...social or other status, which has the intention or nullifying or impairing the equal enjoyment or exercise of the right to health.

IX. Recommended Questions

1. In developing the next version of the NHAS, how can the US recognize and address social drivers of HIV with an actual plan that effectively mitigates the disparity of the HIV epidemic along gender and racial lines?

X. Suggested Recommendations

1. The mandated systematic repeal of all HIV criminalization laws and/or the modernization of such statutes to reflect accurate, up-to-date medical information and science on the routes, risks, and consequences of HIV. This includes the passage of the Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination (REPEAL) Act, currently being considered by Congress (H.R. 1843/S.1790) as a critical first step to addressing unjust HIV criminalization laws.
2. The immediate expansion of Medicaid across all US states to alleviate issues of the uninsured and lack of access to health care faced by communities of color, people living with HIV and to improve racial disparities along the HIV continuum of care. Additionally, the reauthorization of the Ryan White Care Act as a fundamental safety-net to ensure access to health care for all people living with HIV.
3. Development of mechanisms to monitor the progress on addressing racial health disparities and issues of health care access within the context of the Affordable Care Act roll-out and implementation.
4. Support for the integration of trauma-informed care frameworks and practices into the US health care system to address issues of internalized trauma among communities of color that stem from intersectional experiences with racism, sexism, poverty, homophobia, transphobia, stigma, discrimination, criminalization, incarceration and/or violence.
5. Ensure that all health care providers and the health care system are providing culturally competent services by developing effective cultural competency and other relevant training.
6. The development of a strong and effective operational plan through the new iteration of the NHAS that focuses on impacting social drivers in the HIV epidemic in the US, and is far more ambitious in its targets, and should follow the post 2015 development agenda being drafted by UNAIDS, which is calling for 90% reductions in new infections, discrimination and deaths by 2030.
7. Federal support and resources for improved transgender-competent health care and social outreach to the transgender population; developing robust, non-stigmatizing and accurate data surveillance of transgender people through the National Behavioral Health Survey (NHBS); and implementing transgender-specific policies to expand access to health care and employment opportunities/protections, particularly for transgender women, as a high-impact prevention strategy.