



POLICY PRIORITIES

OUR VISION

Our vision is a world where all self-identified women living with HIV (WLHIV) can live long, healthy, and dignified lives, free from stigma and discrimination. Because the HIV pandemic globally and domestically has been propelled by racism, poverty, misogyny and intersectional stigma, we understand that achieving our vision requires an approach to policy advocacy that takes these factors into account while centering the thought leadership, representation and voices of communities that are directly and disproportionately impacted. We recognize and appreciate that significant advocacy is already underway on behalf of people living with HIV. Our policy priorities are strategically chosen to fill gaps that we perceive in the landscape, including places we perceive opportunities to uplift the voices of people living with HIV (PLHIV) and/or racial, gender, and economic justice for PLHIV. In particular, we seek to elevate the analysis of potential impacts of particular policies holistically, especially as they will be experienced by women of color, women of trans experience, low-income women and women from the U.S. South and territories – in our own policy agenda and in the broader field.

In this political moment, we are facing grave challenges to the health, human rights, security, and bodily autonomy of our community. We commit to respond to those challenges with all our political and personal capital. But despite this need for reactive advocacy, our vision also demands that we push the edges of what is broadly considered politically possible. Thus, we seek to uplift, support and, where necessary, create transformative campaigns that redistribute power away from the systems that have not served us and which actively harm our communities.

In the process, we are committed to building long term and sustainable political power for our people. As a result, our policy agenda reflects:

- 1. Defensive campaigns to maintain the programs, services and policies on which women living with HIV rely for survival.**
- 2. Long-term investment in interrogating, disrupting and eventually dismantling oppressive systems --- holding them to account for decades of neglect and even exploitation.**
- 3. Visioning and creating alternative systems, institutions and processes that serve our communities better.**

Our agenda contemplates a world where all WLHIV can control our own bodies, sexuality and reproductive possibilities; where access to non-stigmatizing, trauma-informed, comprehensive health care is available regardless of gender expression, country of origin or immigration status; and where all WLHIV have economic security, safety and self-determination. Our vision demands that our communities are free from interpersonal, structural and state-sanctioned violence and that we are free from surveillance, confinement and the carceral state – regardless of race, HIV status, immigration status, how we earn money and which substances we use. Outlined here are our policy priorities to achieve this vision.

UNIVERSAL HEALTH CARE

OUR VISION

All women living with HIV will have access to high-quality, culturally relevant, non-stigmatizing and affordable health care and services to achieve emotional, mental and physical wellness, regardless of sex at birth, race, immigration status or ability to pay.

Current State of Play:

Health care for WLHIV in the U.S. is currently delivered through a patchwork of systems. More than half a million PLHIV rely on the Ryan White program for medical and associated services. Over 40% of PLHIV nationally are on Medicaid and about a quarter of PLHIV are covered through Medicare. A PWN survey in 2015 found that 44% of our members were on Medicaid. 20 million people have gained coverage since the Affordable Care Act (ACA) was passed in 2010.

The ACA significantly expanded access to care for WLHIV by reducing discrimination, improving the quality and consistency of care, and by reducing financial barriers to health care for low-income people. Specifically, the ACA prevented insurers from discriminating against people with people with chronic and pre-existing medical conditions, women and those who are aging. Caps on out-of-pocket costs and subsidies provided through the creation of state insurance marketplaces or “exchanges” made the private insurance market affordable to millions for the first time. Importantly for PLHIV, the ACA permitted and incentivized states to expand Medicaid coverage to all individuals up to 138% of the Federal Poverty Line (FPL).

Yet, with all of its advances, the ACA has faced severe opposition and has come under repeated attack from corporate interests and conservative ideology. A 2012 Supreme Court case eliminated the federal mandate to expand Medicaid coverage. As a result, virtually all Southern states, where racial, economic and health inequities persist, and where nearly half of U.S. WLHIV reside, have refused to expand coverage under the program. The law provides no coverage for undocumented immigrants, with limited coverage for other immigrants. Further, the ACA maintained the federal ban on abortion coverage. The law also failed to offer a publicly funded coverage option as an alternative to the private insurance market -- maintaining a health care system largely driven by profit and private interests instead of public health.

Our vision reflects the critical need to defend, protect and build upon the progress of the ACA while advancing

real universal health care. For these reasons:

At the Federal Level, We Support:

1. Creation of a Federal Single Payer Health Care System

To truly achieve health care for all, we cannot depend on companies driven by profit. Achieving universal health care will require divestment from and disruption of reliance on the private insurance market, which should be replaced by a system-wide transformative shift to a single government insurance program that covers all comprehensive medical services that uphold full sexual and reproductive autonomy for all people. We recommend the passage of federal legislation that builds on the successes of the Medicaid and Medicare programs in ensuring quality care for people who are low-income, people with disabilities and the elderly. Current proposals aligned with this vision include:

Expanded & Improved Medicare for All Act & Medicare for All (H.R. 676 and S. 1804)

Legislation proposing a single-payer, government-run system has been introduced in the Senate and the House. H.R.676 Ellison (D-MN) and S. 1804 Sanders (D-VT) both lay the groundwork to establish a national health insurance program that would extend Medicare benefits to all U.S. residents. Under both single-payer proposals, health care would be free. Senator Sanders has been advancing this solution since the 1990s, and the Medicare for All proposal has gained significant support in Congress, with 16 co-sponsors in the Senate and 121 co-sponsors in the House at the time of writing.

Medicare Extra for All

The Center for American Progress (CAP) has also introduced Medicare Extra for All legislation model, outlining a more gradual approach to achieving universal coverage that combines federal insurance programs including Medicare, Medicaid and the Children's Health Insurance Program into a single system that all U.S. residents would be eligible to join. Unlike the Medicare for All proposals, most families would have to pay at least some premiums. Families below

150% of the federal poverty level would be exempt from paying these premiums; others would pay on a sliding scale based on income. Newborns and people turning 65 would be automatically enrolled in Medicare Extra for All, expanding the program over time.

2. Maintaining and Fully Funding the Ryan White Care Program

The Ryan White program remains a critical source of high-quality, lifesaving health care for half a million PLHIV in the U.S. The program largely works well for WLHIV by providing quality medical care along with services that support wellness and help WLHIV gain access to care. Ryan White should be maintained and expanded, while the quality and availability of reproductive health and mental health care are improved. To achieve this, funding for Ryan White must be increased.

3. Expanding Access to Health Care for All Immigrants, Regardless of Immigration Status

Immigrants face tremendous barriers in accessing health care, including language barriers, cost, fear of being reported to authorities and policies that fully exclude or aim to deter access to government services. Brazen anti-immigrant rhetoric and the intensification of violent immigration enforcement tactics have forced many immigrants underground in recent years, delaying and in some instances causing them to completely avoid seeking critical health services for fear of being deported and separated from their families and communities. These policies are couched in language that frames immigrants as burdensome or problematic, failing to recognize that this nation was founded on mass genocide of indigenous people by immigrants, and that borders are drawn by those in power to support their political and economic interests.

- We support removing legal and policy barriers that hinder immigrant access to health care including:
- Remove the 5-year ban on enrollment for Medicaid and the Children's Health Insurance Plan (CHIP).
- Allow all immigrants to fully participate in and receive subsidies for ACA marketplace insurance exchanges.

We oppose any use of "public charge" determinations, assessing how likely an immigrant is to use public services and government subsidized health care, to exclude and deter immigrants from lower-income countries or to adjust the immigration status of current

immigrants. To that end, we strongly oppose the collection of immigration status data by any service delivery or health care entity.

At the Federal Level, We Oppose:

1. Efforts to Diminish Coverage Gains Made under the ACA

Following the ACA's passage, insurance plans had to provide necessary prevention services at no cost, including well-woman visits, counseling and screening for intimate partner violence, HIV screening and contraception counseling and dispensing. Section 1557 of the Affordable Care Act prohibited discrimination on the basis of sex and gender identity in health care settings. Attempts to undermine the ACA have included attacks on these protections as well as proposals to radically upend the funding structure of the Medicaid program by capping federal funding contributions to state programs at fixed rates that do not account for unpredictable medical costs and fluctuating state budgets. We will continue to actively oppose efforts to diminish or undermine the current health care law, coverage, access and ACA protections through legislation, regulation, appropriations or through the use of executive orders.

2. Cuts to Medicaid and Medicaid Work Requirements

Medicaid is the single largest source of coverage for people with HIV in the U.S. and should be fully maintained. Medicaid is a jointly funded state and federal health insurance program for low-income people and people with disabilities. Prior to the ACA, state Medicaid programs were only required to cover low-income children and some of their parents, low-income pregnant women, certain low-income seniors and some individuals with disabilities under the age of 65. Before the ACA, many adults living with HIV were forced to wait until their disease progressed to an AIDS diagnosis before being categorically eligible to receive Medicaid coverage. As a result of the program's expanded eligibility through the ACA, Medicaid covered 42% of PLHIV nationally by 2014, compared with 36% in 2012.

Accordingly:

We will continue to oppose any legislation that caps federal funding contributions to state Medicaid programs at fixed rates that do not account for unpredictable medical costs and fluctuating state budgets. Proposals such as per capita caps (limits on the amount of funding a state can receive per Medicaid

enrollee) and block grants (fixed grants given directly to states) are likely to result in states being forced to cut services for low-income residents, including seniors and people with disabilities.

We oppose any program shifts that erect barriers to maintaining coverage through Medicaid such as work requirements, onerous eligibility reporting and lockout periods for beneficiaries who fail complete an annual eligibility redetermination process or report a change in income by a deadline. These practices will disproportionately impact low-income women and people of color.

At the State Level, We Support:

1. Statewide Single-Payer Health Plans

State-level single-payer legislation has been introduced in 26 states at one time or another and several states are currently building support for advancing campaigns for publicly funded universal health care programs. PWN supports the passage of state-level single payer legislation, along with requisite and sustainable funding structures.

2. Expanding Medicaid in Every State and U.S. Territory

One of the most successful components of the ACA was the expansion of Medicaid, allowing states to extend coverage solely based on income. To date, 33 states have expanded Medicaid, which covers over 40% of people living with HIV and has expanded access to care for millions of other low-income and vulnerable communities. Yet many states, notably in the South, where some of the deepest health and HIV disparities persist for low-income and people of color, have failed to expand the program. All states should expand access to comprehensive care, including sexual and reproductive care and gender transition-related care, inclusive of hormone therapy and gender affirming surgery, by expanding Medicaid.

At the State Level, We Oppose:

The Addition of Work Requirements for Participants in Medicaid

The purpose of the Medicaid program is to expand access to care for low-income people. Yet for the first time in the program's history, states have been given permission by the Centers for Medicaid and Medicare Services (CMS) to impose work requirements as a condition for Medicaid eligibility as part of a radical restructuring of the 50-year old program. At the

time of writing, three states (AR, IN, KY) have already been approved to implement work requirements for Medicaid, and eight more have applications pending. Most people on Medicaid who can work are already working, often in low-wage jobs that do not provide health care coverage. The majority of those who are not working report facing barriers to employment, such as illness or caregiving responsibilities. In some states with low-income thresholds for Medicaid eligibility, working at minimum wage could actually disqualify people from Medicaid.

There is no data showing that imposing work requirements for people with HIV would be beneficial to our health. In fact, this change is likely to exacerbate barriers to health care and economic insecurity for low-income PLHIV. We ardently oppose the implementation of work requirements for Medicaid beneficiaries as well as policy proposals that condition Medicaid expansion on work requirements.

ECONOMIC JUSTICE

OUR VISION

We envision a world where women living with HIV face no negative employment or economic consequences related to their health status, sex, gender or gender expression, family responsibilities, race or ethnicity. Further, we envision a world where women living with HIV are fully supported and prepared to participate in the workforce in ways that we choose.

Current State of Play:

Women with HIV occupy spaces where the impacts of racism, patriarchy, transphobia, trauma, poverty and HIV intersect. While economic insecurity can create vulnerability to acquiring HIV in the first place, for people diagnosed with HIV, our diagnosis can lead to a lifetime of poverty as a result of harmful policies. Poverty erects significant barriers to health care, while undermining the dignity, safety and self-determination of people living with HIV and increasing vulnerability to criminalization and interpersonal and structural violence.

Women and people of trans experience living with HIV are more likely than men to live below the federal poverty line (FPL), yet they are also more likely to hold significant caretaking responsibilities for chosen and extended family members. People of trans experience face persistent gender-based discrimination, surveillance and hyper-criminalization that contribute to higher rates of unemployment and poverty, the effects of which are amplified for people of color. Having a criminal record may erect an insurmountable barrier to finding and maintaining employment as well as to accessing safety net services, such as SNAP (food stamps), Temporary Aid for Needy Families (TANF) and subsidized housing. Without intervention, these inequities will persist and grow, restricting agency and basic quality of life for the majority of PLHIV who are people of color, low-income, and/or LGBTQ.

For many living with HIV, their diagnosis has been a sentence to a lifetime of poverty, because eligibility for life-sustaining programs such as the AIDS Drugs Assistance Program (ADAP), some medical care services and housing programs require enrollees to earn less than a specified amount of money annually to qualify for benefits. Under these “income eligibility caps,” PLHIV are forced to keep their incomes below a certain level to maintain access to life-extending medications, stable housing and other services. As a result, individuals who attempt to earn more to support themselves and their loved ones may be penalized and excluded from care, as many employers still do not offer affordable,

comprehensive health insurance coverage to their employees. This is an outrageous violation of human rights, requiring people to be poor in order to obtain necessary health care and services.

We strive to uphold the human rights and agency of PLHIV by removing barriers to economic security.

At the Federal Level, We Support:

1. Advancing Opportunities for Employment for People Living with HIV

If considering entering the workforce after years of being on disability, PLHIV may face significant obstacles. These include a lack of accessible and accurate information about work incentives and eligibility for programs, concerns about losing access to essential benefits, the fear of getting sick and ending up out of work and disqualified for benefits, and lack of assistance in navigating the transition to work. Any employment opportunities made available to PLHIV should fully support the principles of self-determination, informed consent, and voluntary participation, while seeking to minimize risk to the individual and any dependents.

- PWN supports policies and programs that increase the ability of PLHIV to navigate job transitions and career advancement without concerns about loss of access to health coverage, housing, nutrition assistance, or income.
- The Department of Education (Rehabilitation Services Administration), Department of Labor (Employment and Training Administration, and the Office of Disability Employment Policy) should coordinate the creation of a federal jobs and vocational rehabilitation program specifically for people living with HIV that supports rather than hinders the ability to remain in care and in receipt of vital services. The program should specifically address barriers to employment experienced by PLHIV who are people of color, immigrants, women and of trans experience.

- Ryan White-funded service delivery settings should integrate employment services, professional skills development, vocational rehabilitation, and computer literacy programs.

2. Implementing Federal “Ban the Box” Legislation for Public and Private Employers

The U.S. leads the world in incarceration rates, with Black and Latinx people bearing the brunt of decades of racially motivated overpolicing, surveillance and discriminatory treatment in court proceedings. An estimated 70 million U.S. adults have histories of arrest or conviction. For communities vulnerable to HIV, housing instability, mental illness, substance use, racism and transphobia may place them at risk for being targeted by law enforcement. Thus, a significant percentage of U.S. PLHIV have a history of contact with the criminal justice system. Many employers disqualify job seekers with a history of contact with the criminal justice system, creating a vicious cycle of poverty that may span generations. Legislation like S.842 (/ H.R.1905 Cumming (D-NY), the Fair Chance to Compete for Jobs Act of 2017, which would prohibit federal employers and contractors from asking job applicants about their criminal history, attempts to address this inequity. Broadly referred to as “Ban the Box” legislation, these efforts would remove barriers to employment for people with a history of criminal justice contact in both the public and private sector.

3. Strengthening Employment Discrimination Protections for People of Trans Experience

People of trans experience face tremendous levels of discrimination and violence, contributing to high levels of unemployment and poverty. More than one in four people of trans experience have lost a job due to bias, and more than three-quarters have reported some form of workplace discrimination. The Equality Act would expand federal civil rights protections to include sexual orientation and gender identity. Introduced in 2015 by Sen. Jeff Merkley (D-OR) and Rep. David Cicilline (D-RI), the Equality Act would expand the Civil Rights Act of 1964 to include explicit protections against sexual orientation and gender identity-based discrimination in employment, housing, education, and public

accommodations.

4. Eliminating the Ban on Federal Benefits for People Convicted of Drug Felonies

The legacy of the War on Drugs has devastated and economically depressed many communities of color. Yet the same individuals navigating the aftermath and trauma of incarceration remain excluded from federal programs that may support their economic security and successful reentry. The lifetime ban on essential federal benefits, including SNAP (food stamps) and Temporary Aid to Needy Families (TANF), imposed by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), and restrictions on access to housing for people convicted in state or federal courts of felony drug offenses should be repealed. Additionally, the Higher Education Act’s ban on student financial aid for individuals with drug-related convictions should be removed, and questions regarding criminal history for drug-related offenses should be omitted from the Free Application for Federal Student Aid (FAFSA).

At the Federal Level, We Oppose:

1. Cuts to the Social Safety Net

The current administration has waged an unprecedented war on poor people and people of color. Massive tax cuts were passed for the ultra-wealthy, creating tremendous strain on the federal government’s ability to fund programs that support a basic quality of life for low-income and middle-class people. Recent funding proposals from the administration continue to target these programs for drastic cuts while prioritizing the escalation of excessive military and defense spending. We fight legislative and budget proposals that exacerbate inequities for low-income people and actively oppose federal attempts to cut or restrict funding for programs that provide low-income people living with HIV with assistance in accessing food (SNAP), health care (Medicaid, Medicare and Ryan White), housing/utilities (HOPWA and LIHEAP), and income (TANF).

2. Adding a Citizenship Question on the 2020 Census

The Constitution requires that every resident of the U.S. be counted every 10 years, regardless of citizenship or immigration status. Data from the census determines how political districts are drawn, how many legislators each state gets to represent their interests in Congress, and importantly, how billions of dollars of federal funding for vital public services are allocated. Adding the question that has not been featured on a

formal census since the Jim Crow era is likely to have a chilling effect on the participation by immigrants, who, with other communities of color, have been historically undercounted. We oppose this effort to suppress the political power of people of color and the attempt to deprive states with large immigrant populations of key federal funding sources critically important to the health of PLHIV.

At the State/Local Level, We Support:

1. Living Wage Legislation

Implement state and local policies that support the rights of all people to work and be paid a living wage. The federal minimum wage is far too low for people to survive and take care of their families, and additionally fails to account for local cost of housing and cost living, which may vary greatly. In recent years, advocates for low-wage workers have moved to take matters into their own hands at the state and city level, by proposing and passing living wage legislation.

2. “Ban the Box” Policies and “Fair Chance” Hiring Laws

Ten states to date have mandated the removal of conviction history questions from job applications for private employers. Some states and cities have also passed legislation requiring that inquiries into criminal background be delayed until a conditional job offer has been made or delaying criminal history questions until a later stage in the interview process. These are collectively known as “Fair Chance” Hiring Laws. In addition, some city and county governments have established preference for contracting with vendors that “Ban the Box” on job applications. To advance economic opportunities for people living with and communities affected by HIV, PWN-USA supports the expansion of such laws.

3. Inclusive Paid Sick, Safe, and Family and Leave Policies

Restrictive definitions of family constructed by the government fail to capture the depth and complexities of informal support networks and caregiving systems that allow many WLHIV to attend school, engage in health care, and care for loved ones. Inclusive paid leave policies that recognize chosen and extended family, informal support networks and caregiving responsibilities should be implemented at the local and state level. These policies should also reflect a standard for flexible use of personal time or sick time for navigating experiences surviving intimate partner, sexual

violence and navigating the criminal justice system. Arizona, Rhode Island and the three biggest U.S. cities — New York, Los Angeles and Chicago—have passed laws giving workers the legal right to take paid time to care for chosen family, and eight states and more than 30 counties and cities have enacted paid sick and safe leave policies that support survivors of domestic violence or sexual assault.

4. Expanding Employment Opportunities for PLHIV through Increased Collaboration Between State Agencies

State Departments of Labor, state vocational rehabilitation agencies, and state HIV agencies should collaborate to expand opportunities for participation in job training, placement, education and return-to-work programs for PLHIV.

SEXUAL & REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

OUR VISION

PWN-USA works towards a world where full reproductive justice and bodily autonomy, including the right to pleasurable sex, are upheld for any person of any gender and any HIV status. Bodily autonomy is the idea that individuals have the right to control what does and does not happen to their bodies.

Current State of Play:

Reproductive rights for women and sexual and reproductive health care for LGBTQ people have come under repeated and worsening attack in the ideological war on our bodies. But these rights and services are neither optional nor incidental to our survival. They are essential aspects of health care that can dramatically affect our lives. Ideologically driven policies and funding shifts designed to control or restrict sexual and reproductive agency especially impact low-income women, women of color, immigrants and those who are undocumented by minimizing decision-making power, creating opportunities for discrimination and limiting access to necessary health care services and skilled providers. Further, women living with HIV and women of trans experience of any HIV status continue to face persistent HIV-related and gender-based stigma and discrimination from providers. Thus, compounding oppressions exacerbated by the administration's economic, environmental, immigration and criminal justice policies have intensified the fight for reproductive justice and the need for truly intersectional advocacy.

The ability to exercise our reproductive rights, including creating families of our choice, should never be limited by ability to pay, gender expression, gender identity, HIV status, immigration status or race. Low-income women's reproductive autonomy should not be restricted by the State because they rely on Medicaid or another public payer. Everyone, including undocumented minors, should have access to safe, legal and affordable abortion and contraception, and all people of all ages and genders should receive medically accurate information to make informed choices about their health.

Thus, in this moment and beyond, PWN-USA's agenda seeks to advance policies that would uphold the full spectrum of sexual and reproductive health and rights (SRHR) for people living with HIV of all ages and gender experiences. This includes access to non-stigmatizing care that affirms the right to enjoy sexual intimacy, and to choose if, when and how to have a family, free from coercion, violence, poverty and other forms of reproductive oppression.

At the Federal Level, We Support:

1. Repealing the Federal Ban on Abortion Funding by Passing the Each Woman Act

Low-income women should have the right to the full spectrum of reproductive health services regardless of where they receive care. Congress should pass the Each Woman Act to reverse the Hyde amendment and other related federal abortion restrictions.

2. Maintaining the Title X Family Planning Program

The Title X Family Planning Program is the only federal funding program dedicated to family planning. Title X providers serve a large number of low-income Black and Latinx women and provide high-quality, comprehensive family planning services, including contraception, counseling services and STI and HIV screenings, at reduced or no cost. Maintaining a comprehensive Title X program is imperative to the sexual and reproductive health of low-income women of color. We support maintaining robust funding for Title X and oppose changes in the Title X funding priorities that prioritize abstinence-based education or "natural" family planning methods, which in any way limit access to contraceptive methods or abortion, or which inhibit access to skilled providers offering evidence-based care and comprehensive, non-judgmental and non-stigmatizing health education.

3. Fully Integrating Comprehensive Sexual and Reproductive Health Care Throughout the Ryan White Program

Ryan White Part D has historically provided high-quality, non-stigmatizing sexual and reproductive health (SRH) care to women with HIV of reproductive age and youth and adolescents living with HIV. Given the disparities in access to quality SRH care, we should build on Part D's successes by leveraging best practices and implementing standards for culturally relevant, non-stigmatizing, sex-positive sexual and reproductive health care services for all people with HIV, independent of gender, gender identity, age, clinic type or payer source.

4. Eliminating the Prescription Requirement for Oral Contraceptives

Despite significant scientific and medical advances, including consensus on the efficacy of treatment as prevention (TasP) or U=U, data which shows that PLHIV who are virally suppressed cannot transmit HIV, WLHIV continue to face barriers to accessing non-stigmatizing sexual and reproductive health care. A 2015 study of WLHIV in the U.S. (n=180) reported that fewer than half of respondents of reproductive age had been asked if they needed birth control by their providers in the past year. The same study also reported that transportation and childcare presented barriers to keeping medical appointments and filling prescriptions. Requiring a prescription for pill for birth control pills is just another barrier that should be eliminated to make it easier to exercise our reproductive rights. The sale of oral contraceptives over the counter without a prescription is safe and should be approved by the FDA. Oral contraceptives should also be covered by insurance companies at no cost.

At the Federal Level, We Oppose:

1. Any Laws Restricting or Limiting Access to Safe, Legal Abortion

Comprehensive sexual and reproductive health care includes access to safe and legal abortion.

- Anti-abortion policy riders that are introduced as a part of the federal appropriations process, including efforts to specifically defund comprehensive reproductive health providers like Planned Parenthood, should be actively opposed.
- Legislation that creates barriers to abortion care, including proposals to truncate the window of time during which individuals can legally access abortion care, as well federal agency practices that hinder access to abortion for people in custody by U.S. Immigration, should be actively opposed.

4. Religious Refusal and “Religious Freedom” Policies Designed to Legalize Discrimination

Women, people of color and LGBT people disproportionately face discrimination in health care settings. We oppose any policies that grant providers with a license to discriminate by placing personal beliefs and “religious freedom” over their patients’ need for comprehensive sexual and reproductive health care, including abortion and contraception.

At the State Level, We Support:

1. Public and Private Insurance Coverage for all Sexual and Reproductive Health Care Services, Regardless of Gender Identity

State public and private insurance plans should cover the full range of sexual and reproductive and family planning services for people living with HIV, regardless of gender identity, including access to PrEP, gamete washing and storage, gender transition-related care, contraception and pre- and postnatal care, inclusive of doula and midwife birthing support.

2. Repealing Laws Criminalizing Negative Pregnancy Outcomes

Some states have adopted laws or misused existing law to apply criminal punishment or other penalties to women for actions that are interpreted as harmful to their own pregnancies. They have been used to criminalize women who had stillbirths or miscarriages and are often broad enough to encompass any behavior that can be perceived as harmful, such as not wearing a seatbelt while pregnant. Examples include Utah, which has allowed prosecution of some miscarriages as murder; Georgia, which attempted to and failed to pass a law that would have investigated all miscarriages as potential homicides; Indiana, South Carolina and Mississippi, which have all brought murder charges against women who had stillbirths; and Indiana, which has prosecuted a woman for attempting suicide while she was pregnant. They are most commonly used to criminalize pregnant women who use drugs, like in Tennessee, where it is a crime to birth a child with symptoms of drug exposure.

This makes women afraid to seek medical care both during and after a pregnancy. Women of color are disproportionately prosecuted under these laws. These laws overlap with abortion restrictions to deny women control of their bodies, privacy and medical decisions; they also exacerbate trauma related to these pregnancy outcomes and should be repealed.

3. Coverage for an Extended Supply of Contraception by Public and Private Insurers

Though the CDC recommends providing a year supply of contraceptives as a best practice in avoiding unintended pregnancy, many insurers only provide a one-month supply at time. Many barriers may prevent WLHIV from getting to a pharmacy to refill prescriptions,

including transportation, childcare or other caretaking responsibilities. To facilitate consistent access to contraception, we support legislation that requires both public and private insurers provide a year's supply of contraception at a time.

At the State Level, We Oppose:

State Legislation Increasing Barriers to Accessing Abortion Care

"20-week abortion bans" are laws that ban abortion after or around 20 weeks gestation and seek to undermine access to safe and legal abortion established by *Roe v. Wade*, which allows abortions up until fetal viability, generally medically recognized around 24 weeks gestation. Though 99 percent of abortions occur before 21 weeks gestation, the need for later abortions is often accompanied by complex medical circumstances.

The anti-abortion movement towards implementing 20-week bans is being used as a long-view strategy to persuade the Supreme Court to overturn *Wade*. To date, 20-week bans have been enacted in 21 states and blocked in two states. As at the federal level, laws truncating the time period making abortions legally accessible, especially in places where abortion care has become increasingly inaccessible, should be actively opposed.

ENDING CRIMINALIZATION

OUR VISION

We envision and work toward a future in which our communities are no longer subject to over-policing, surveillance, and brutality at the hands of law enforcement, and where those with a history of interaction with the criminal justice system have full rights and dignity.

Current State of Play:

In the U.S., policing and criminal justice practices tend to reinforce societal inequity by targeting communities that are already marginalized and oppressed. In particular, Black people, non-Black people of color, queer and trans people, people who use drugs, sex workers and immigrants are disproportionately targeted by law enforcement and too often face violent interactions with police. These same communities are those most affected by the U.S. HIV epidemic. Interactions with the criminal justice system can be especially dangerous for marginalized communities - causing risk of loss of employment, income, parental rights, isolation, dehumanization and interruptions in health care - and too frequently, even death at the hands of the State. Mass incarceration disrupts communities and families.

PLHIV are specifically targeted by HIV criminalization laws, which punish us for behavior that would otherwise be legal were it not for our HIV positive status, including sexual intimacy, spitting and donating organs. Other laws that target communities already vulnerable to violence and HIV include those that prosecute people for sex work or for using drugs. Under these laws, people become criminals for carrying condoms or clean needles, for using drugs or for supporting themselves with survival sex. Rather than protecting anyone, these laws create a deadly climate for sex workers and people who use drugs by directly punishing prevention measures that people may use to reduce risk, and creating barriers to people seeking help when they are in danger.

On top of existing prejudices that may already exist due to racism, homophobia, transphobia, misogyny and HIV-related stigma, the collateral consequences of surviving criminalization may have a lifelong impact. Survivors can be barred from accessing housing, employment, health care, and essential safety net programs, and may be separated from their families, loved ones and communities. Immigrant survivors may be vulnerable to revocation of their residency permission, detention and deportation. Criminalization survivors, particularly women, are also vulnerable to abuse, violence, and exploitation. Some states permanently prohibit survivors who have been convicted of felonies from voting, severing them from a fundamental civil right. As criminal

justice system survivors are often part of marginalized communities, these policies only serve to silence and disenfranchise them in policy development.

At the Federal Level, We Support:

1. Passing the REPEAL (Repeal Existing Policies that Encourage and Allow Legal) HIV Discrimination Act

Originally introduced by Congresswoman Barbara Lee (D-CA) in 2011, this legislation would incentivize and provide guidance to help over 30 states and U.S. territories follow in the footsteps of Iowa, Colorado and California in modernizing their discriminatory HIV-specific laws, bringing them in line with contemporary understanding of HIV transmission. In addition, we urge the Senate to introduce companion legislation.

2. Passing the Pretrial Integrity and Safety Act

Originally introduced in 2017 by Senators Kamala Harris (D-CA) and Rand Paul (R-KY) and by Representatives Ted Lieu (D-CA) and Carlos Curbelo (R-FL), the Pretrial Integrity and Safety Act would provide grants to states to help them eliminate the use of money bail as a requirement of pre-trial release in criminal cases. Currently, people can be held up to a year without ever being charged of a crime simply because they cannot afford to pay for bail. This practice unjustly punishes low-income individuals, as it prolongs separation from family, community, work, school and other life responsibilities. For PLHIV, pretrial detainment may cause a disruption in critical care and treatment.

3. Removing the U.S. Entry Ban on Sex Workers

Currently, the United States considers “inadmissible” any person who has engaged in sex work for the ten years preceding an application for an visa, admission, or adjustment of status. This policy is grounded in stigma and penalizes people who have bravely come forward as sex worker advocates or publicly disclosed their history of sex work. The entry ban should be lifted.

At the Federal Level, We Oppose:

1. Attempts to Revive the “War on Drugs”

The “War on Drugs” was instigated and sustained to disrupt, destabilize and suppress the political power of communities of color. Nearly half a century of discriminatory and draconian drug policies in the U.S. have resulted in continued mass incarceration and devastation of Black and Latinx communities, who are overpoliced and receive disproportionately harsh sentences for drug-related charges. This reliance on punitive approaches instead of treating addiction as a health issue has stalled adoption of harm reduction measures such as the implementation of syringe exchanges and safe injection sites. Today, in the midst of a nationwide public health opioid overdose crisis that killed 66,000 people in 2017, the administration has encouraged punitive solutions that threaten the lives of people who use drugs. Any attempt to reignite a draconian federal crackdown on drugs to impede the shift toward harm reduction-grounded drug policies reform or to reduce funding for solutions grounded in harm reduction approaches should be opposed.

2. Cooperation, Data Sharing and Resource-Sharing between Local Law Enforcement Agencies and Immigration and Customs Enforcement (ICE)

Immigrants who come into contact with the criminal justice system are often denied essential health care access and legal services. Additionally, they can be detained indefinitely, which means PLHIV may be completely unable to access care and medications.

- We oppose any expansion of ICE for the purposes of policing immigrant communities.
- We oppose the sharing of local law enforcement data with any immigration authorities, including ICE and Border Patrol, through programs such as Secure Communities (S-Comm) and the 287g program, which currently supports cooperation between ICE and dozens of local police departments. Any cooperation between ICE and local police departments should be ended immediately, and no further applications under the 287g program should be accepted.

At the State/Local Levels, We Support:

1. Modernization of State HIV Criminalization Laws

State laws criminalizing the alleged non-disclosure, exposure and transmission of HIV perpetuate HIV-related stigma and impede the public health goals of testing, treatment and prevention. They undermine the safety and bodily autonomy of PLHIV, who are often legally required to disclose their HIV status to sexual partners regardless of actual risk of transmission and even when doing so may put them in danger of violence. HIV criminalization laws may increase vulnerability to violence, and when prosecutions occur, PLHIV may endure the loss of privacy, housing and/or child custody as well as facing incarceration and, in some states, even having to register as a sex offender. States should modernize their HIV criminalization laws to bring them in alignment with current scientific understanding of HIV transmission. Reforms should seek to dispel HIV exceptionalism, promote shared responsibility for sexual decision-making, protect all people living with HIV regardless of viral load and support the right to disclose when one feels safe. Laws that impose sentence enhancements for sex workers diagnosed with HIV or people who use drugs living with HIV should also be eliminated.

2. Decriminalization of Sex Work

Sex work is labor and deserves the same legal protections as other forms of employment. Decriminalizing sex work would end the overpolicing and incarceration of people who do sex work, both of which increase vulnerability of sex workers to violence, abuse and exploitation. Last year, a law that would remove criminal penalties for sex work, the Reducing Criminalization to Promote Public Safety and Health Amendment Act of 2017, was introduced in Washington, D.C. Other municipalities should introduce similar legislation.

3. Elimination of “Condoms as Evidence” Policies

Several cities have or had a “condoms as evidence” policy, which allows the possession of condoms to be used as the basis for a solicitation charge or for police harassment. For example, while it’s not illegal in New York city to possess condoms, possession of “too many” can be used as evidence of sex work. Police can also confiscate and destroy condoms that they find. These policies make it impossible for sex workers to protect themselves and deprive people who do sex work agency

in their decisions about contraceptive use. A 2012 NYC sex worker survey summary showed 46% of respondents reported not carrying condoms out of fear they would be harassed by police. About half of respondents reported that police had confiscated, damaged or destroyed their condoms. In 2013, San Francisco banned the use of condoms as evidence of sex work completely. In 2014, California became the first state in the country to pass a law (AB 336) that requires a court to state explicitly that the presence of condoms is relevant to the individual case before prosecutors can use them as evidence of sex work.

In a number of states, people who are charged with doing sex work can also be mandatorily tested for HIV, and sex workers with HIV may receive more severe sentences, even in cases where no transmission was possible due to the type of sexual activity, condom use or undetectable viral load. These practices are coercive and rooted neither in protecting people who do sex work nor in advancing public health and should be ended.

4. Adoption of Harm Reduction Policies and Funding for Harm Reduction Services

- States should fund and create more syringe access programs (SAPs) that allow people who inject drugs/ substances with a place to deposit used needles and get new ones. To facilitate this, states should also repeal laws that cap the number of syringes that can be purchased or that criminalize syringe possession. In 2017, New York introduced legislation (A6258/S1082) that would decriminalize both sale and possession of hypodermic needles. This policy shift will promote public health and the safety of people who use drugs by allowing people to protect themselves from communicable diseases.
- Create safe injection facilities (SIFs) where people who inject drugs have the opportunity to inject drugs under the supervision of trained medical staff, preventing overdoses and reducing sharing of injection equipment. Harm reduction practices produce better health outcomes, protect human rights and help reduce criminalization rates. In 2018, San Francisco will become the first city in the U.S. to open safe injection sites.

5. Eliminate Felony Disenfranchisement Policies

Twenty-one states prohibit people convicted of felonies on parole from voting; 3 states (FL, IA, KY) deny the right to vote to all people convicted of any felonies for the rest of their lives, even after they have served their sentences; and 7 states permanently disenfranchise

people for certain felony offenses only. Each state that allows restoration of voting rights implements their own process, but the processes are usually so difficult to navigate that few people attempt them. Felony disenfranchisement laws also have a clear disparate racial impact, affecting 1 in 13 Black voters compared to 1 in 56 non-Black voters. Disenfranchisement policies are a tool of racial injustice, meant to prevent Black people from leveraging their power at the polls.

At the State Level, We Oppose:

Any Attempt to Expand Criminal Penalties for People Based on HIV Status

In 2015, Rhode Island Rep. Robert Nardolillo (R) introduced H5245 that would criminalize PLHIV for not disclosing their status prior to sex. Rhode Island was then one of the few states that did not already have a non-disclosure law. Other state legislatures, including Texas, have contemplated such efforts in recent years. We oppose all such attempts to introduce or reinvigorate policies that target PLHIV for criminal prosecution based on their status. This would be a step back in bringing these laws into alignment with modern science.

TRANS RIGHTS, SAFETY & JUSTICE

OUR VISION

We envision and work toward a future in which all people of trans experience are supported to live fulfilling, secure and happy lives, free from all forms of violence, harassment, hostility or discrimination.

Current State of Play:

People of trans experience are forced to navigate social and political hostility, prejudice, discrimination and violence that compromise their safety and most basic rights on a daily basis. Since the 2016 election, there have been increased efforts to dismantle protections against discrimination based on gender identity in schools, at work, and in health care facilities. New “religious objection” policies have been proposed and implemented at the federal and state levels, explicitly permitting discrimination against transgender people in all areas of their lives.

Failure to protect transgender people from discrimination based on gender identity means that autonomy to exist in one’s own body is subject to the whims of employers, medical professionals and the government. People of trans experience may be at more risk than ever of being denied employment, housing, health services and medication, along with access to public restrooms that match their gender. In health care settings, stigma and bias against people of trans experience may compromise access to quality services, as well as policies restricting what can be covered by payer sources. For transgender people living with HIV, it can be nearly impossible to find culturally relevant and non-stigmatizing health services and providers.

Widespread societal stigma against people of trans experience means that they are routinely subject to misinformed and oppressive policies that deny them dignity and agency over their own bodies. Because transgender people also face significant barriers to employment, poverty rates are also high, which may increase vulnerability to acquiring HIV.

The administration has made comments alleging that providing health care for transgender people in the military poses an undue burden. People of trans experience have always been more likely than cisgender people to be targeted by violence, but an increase in discriminatory policies and corresponding rhetoric by the highest levels of government appear to correlate with an increase in hate crimes against transgender people.

Data shows that law enforcement may disproportionately target trans and gender non-conforming people. If incarcerated or detained, people of trans experience generally do not have access to gender-appropriate facilities, increasing the risk of assault and violence. Gender-affirming care is rarely available in jails, prisons, or detention facilities.

At the Federal Level, We Support:

1. Maintaining Section 1557 of the ACA: Non-discrimination Protections for Sexual Orientation and Gender Identity

Section 1557 of the Affordable Care Act prohibits discrimination in health care coverage. In 2016, the Health and Human Services Department (HHS) adopted a rule clarifying that sex discrimination in the section also includes gender discrimination against people of trans experience. However, in May 2017, the Trump administration announced that it was considering rescinding that clarification. Without this critical protection, people of trans experience would likely face more discrimination in health care settings including the denial of services or gender-affirming care. To prevent providers from attempting to deny care to people of trans experience, PWN-USA demands that the clarifying rule explicitly protecting gender identity be maintained.

2. Passing the Do No Harm Act

Introduced by Representatives Joe Kennedy III (D-MA) and Bobby Scott (D-VA) in 2017, the Do No Harm Act would amend the federal Religious Freedom Restoration Act (RFRA) to ensure that federal religious freedom protections are not used to discriminate against women and LGBTQ people. RFRA was originally created to protect the right of minority groups to exercise their religious freedom. However, it has since been used to allow imposition of religious freedom at the expense of other people’s rights. In the 2014 Hobby Lobby decision, the Supreme Court ruled that corporations could use RFRA to make religious objections. Hobby Lobby used RFRA to justify denying their employees insurance coverage for birth control. Since then, RFRA has also been used by a business owner to justify firing their employee for being transgender. The Do

No Harm Act would change the language of RFRA to specifically prevent it from being used as a defense for discrimination against marginalized people.

At the Federal Level, We Oppose:

1. Religious Exemption Guidance and Laws Granting License to Discriminate

Efforts that seek to protect the ability to object to providing services on “religious” grounds essentially argue that it is a violation of people’s religious beliefs to compel them to provide services that go against those beliefs. This effort to legalize discrimination based on “religious objections” was cemented in the creation of the Department of Health and Human Services’ new Conscience and Religious Freedom Division, announced in January 2018. This division provides an avenue for medical professionals to sue on the basis of religious discrimination if they are compelled to provide certain services or are punished for not providing them. Providers could easily use this to deny abortions, contraceptives or any health care to LGBTQ individuals. HHS should promote health equity and protections for marginalized communities who are more likely to experience discrimination while seeking health care.

At the State Level, We Support:

1. Laws Facilitating Gender Marker Corrections on Legal Documents

Having correct legal documents is a necessary step to finding employment, getting medical care, and traveling without harassment. Many states require proof of clinical treatment, often surgery, before people of trans experience are allowed to make gender marker changes on legal documents like birth certificates and driver licenses. These requirements are coercive and compel transgender people to get costly, permanent, medically unnecessary and sometimes unwanted procedures just to have their gender identity recognized. States should eliminate clinical treatment and court-ordered requirements and follow in the steps of states like Oregon, Washington and California, which permit gender marker change through an affidavit alone, where an individual attests that no fraud is intended.

2. Expanding Gender Identity Options on Legal Documents

In 2017, California passed SB 179 (The Gender Recognition Act) which allows for a non-binary gender marker option on driver’s licenses. This is important because it recognizes that individuals who identify outside of the gender binary of male/female should be able to get legal documents that affirm their identity.

3. State and Local Gender Identity Non-discrimination Laws

While the fate of federal anti-discrimination protections is still uncertain, states and cities can adopt anti-discrimination protections that explicitly protect people of trans experience by including gender identity. This can include protecting against discrimination in workplaces, schools, public businesses, and health care facilities. States should take the initiative to protect their residents of transgender experience. Currently, 20 states have implemented such laws, as have a number of cities.

4. Policies that Preserve the Dignity of Transgender People in Prisons

When people of transgender experience are incarcerated, their gender identity puts them at increased risk of assault, violence, and harassment from both incarcerated people and correctional officers. Additionally, transgender women in particular are more likely to be housed in non-gender-affirming facilities where they are then repeatedly placed in isolation units for extended periods of time. This is supposedly done to protect incarcerated transgender individuals, but is a dehumanizing and trauma-inducing practice. California has recently introduced legislation (SB 990) that would implement guidelines on the intake and subsequent treatment of transgender people who are incarcerated. This legislation would allow them to register their gender identity and name and require that correctional staff use their correct name and pronouns.

Additionally, transgender individuals who have been removed from the general population for safety concerns would maintain access to programming and work opportunities. Other states should pass legislation that supports and protects people of trans experience who are incarcerated.

At the State Level, We Oppose:

1. State and Local “Bathroom Bills” Requiring Individuals to Use the Bathroom That Matches Their Sex Assigned at Birth

People of trans experience, gender non-conforming and non-binary individuals should be able to use the facilities that are safest and most comfortable for them. No one should have to fear violence and harassment in restrooms.

Restricting people of trans experience to private or separate bathrooms only feeds into the malicious narrative that transgender people are different and should be segregated. According to the National Center for Transgender Equality’s 2015 nationwide survey on discrimination against transgender people, 59% of respondents reported that they sometimes or always avoided public bathrooms. 32% avoided drinking or eating so that they would not need to use the restroom, and 8% reported having a urinary tract infection or kidney related medical problem from avoiding restrooms.

Policing the most basic bodily functions of people of trans experience undermines their autonomy, safety, dignity and health. These laws must be repealed and anti-discrimination protections installed in their place.

ENDING VIOLENCE AGAINST WOMEN LIVING WITH HIV

OUR VISION

PWN envisions a world where women living with HIV are free from interpersonal, community, and structural violence, safe to report interpersonal violence when it occurs, and supported in healing from trauma that results from violence experienced in this lifetime and by past generations.

Current State of Play:

Some research has focused on intimate partner violence (IPV) as a risk factor for women in relation to HIV acquisition. This is important – studies show that over 60% of women living with HIV in the U.S. may have experienced intimate partner violence at some point in our lives. What's less researched and less understood are the many ways that violence at all levels impacts the daily lives of women who are living with HIV.

Some studies show that living with HIV in itself may be a risk factor for violence and emotional abuse in relationships. Partners and even family members may use HIV status, the threat of public disclosure or the threat of prosecution under HIV criminalization laws as tools for coercion, abuse and control. Research has shown that exposure to violence can affect the immune system both before and after HIV diagnosis and that emotional abuse can increase the rate of CD4 decline. For WLHIV who are immigrants, reporting domestic violence to authorities may place them at risk of losing their immigration status, being detained, or even being deported, while also threatening the immigration status of their partners.

In addition to interpersonal violence, WLHIV in the U.S. are disproportionately affected by community-level violence and structural violence. Gun violence and violence against women of trans experience are forms of community violence that have personally impacted many of our members and their loved ones. Structural violence refers to the harm inflicted by social institutions and social structures, which prevents people from meeting their basic needs. Forms of structural violence that directly harm the majority of women living with HIV in the U.S. include but are not limited to racism, HIV stigma, transphobia, the historical linking of access to health care to employment and a safety net system that requires people to be poor or sick in order to qualify for lifesaving medical care and other benefits. Because most WLHIV in the U.S. are Black and Latinx, racist policing practices and targeted attacks on immigrants, including those which threaten the ability of immigrants to access health care, are also forms of structural violence that harm U.S. WLHIV. Immigrants who try to report crimes to law enforcement may face threats to their immigration

status or immigration status of their loved ones. Thus, many health care, service delivery and law enforcement institutions allegedly in place to protect and serve have and continue to directly harm our communities, perpetrating further trauma.

Preventing or intervening in the epidemic of violence against WLHIV at the interpersonal, community and structural levels is critically important and our policy agenda reflects this priority. Equally, PWN's policy priorities address the need to prevent further traumatization and to support WLHIV in healing from the trauma that results from these experiences of violence, which often span a lifetime and may be intergenerational. In particular, Black Americans and Indigenous people in this country are still suffering from massive community-level trauma resulting from our violent history of genocide, slavery, Jim Crow laws and mass incarceration of people of color.

At the Federal Level, We Support:

1. Maintaining and Fully Funding the Violence Against Women Act (VAWA)

Initially passed in 1994, VAWA has dramatically improved and expanded services for survivors of domestic violence, stalking and sexual assault. The most recent reauthorization of VAWA in 2013 expanded protections for immigrant women; gay, lesbian and transgender individuals; and Native Americans. Any future versions of VAWA should continue to include:

- Comprehensive protections for immigrants reporting domestic violence, including confidentiality protections;
- designation of courthouses as prohibited locations for immigration enforcement;
- full protections for LGBT and Indigenous communities.

2. Removing the Annual Cap on U-Visas

U-Visas are special visas reserved for immigrant survivors of crime or abuse who are helpful to law enforcement; they provide a critical lifeline for individuals fleeing

dangerous or abusive situations. As of fiscal year 2016, 150,064 U-Visa applications were pending. Under current law, only 10,000 U-Visas can be granted annually, creating a bottleneck that places immigrant survivors at risk.

3. Integrating Trauma-Informed Care and Intimate Partner Violence Screening and Response into HIV Health Care and Service Delivery Settings:

Research shows that the majority of WLHIV are survivors of multiple forms of violence. Rates of post-traumatic stress disorder (PTSD), sexual abuse as a child, and experience of intimate partner violence (IPV) among WLHIV are particularly high. IPV has been shown to negatively affect engagement in health care and ability to take HIV medication as prescribed. Health care and service delivery settings may further traumatize WLHIV, through any combination of HIV stigma, cultural insensitivity, racism, transphobia and failure to account for past experiences of sexual assault when conducting screenings and examinations. Trauma-informed care—the provision of medical care through practices that actively seek to reduce retraumatization, seek to intervene in current danger, and promote healing from past trauma—should become the standard of care for all people living with HIV. As such, we recommend:

- Ryan White programs should be required to collect and report data about rates of IPV, PTSD symptoms, substance use, depression, stigma and social isolation. This data should be included in the annual Ryan White Services Report.
- The Health Resources and Services Administration should create guidance to support Ryan White clinics in becoming trauma-informed and provide funding opportunities to help them transform their institutions.
- HRSA should prioritize funding clinical and community-based grantees who can demonstrate their commitment to addressing trauma, PTSD and intimate partner violence.
- AIDS Education Training Centers (AETCs) should provide training for case managers, social workers, nurses, administrators, doctors and other clinic professionals at Ryan White service delivery sites to use trauma-informed approaches with clients and among staff.
- HIV providers should be trained not to perpetrate further trauma in health care settings.

- HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) should support and advance collaborations between community-based IPV organizations, trauma recovery centers, HIV and primary care clinics and AIDS service organizations.
- This should include integrating interventions that have been shown to reduce symptoms of PTSD into existing funded clinical services for PLHIV, including therapy, psychiatry, medication adherence, and substance abuse treatment.

At the Federal Level, We Oppose:

Any Attempt to Weaken, Undermine or Reduce Funding for the Violence Against Women Act (VAWA), Which Provides Federal Resources to Support Survivors of Domestic Violence and Sexual Assault.

This includes any attempts to restrict populations that can be served through VAWA funding. VAWA is currently up for reauthorization and we support maintaining all protections currently in VAWA, including all protections for undocumented immigrants, LGBTQ individuals, and maintaining full funding for VAWA.

At the State and Local Levels, We Support:

Incorporating into State and Local Getting to Zero/End the Epidemic Plans and State HIV/AIDS Strategies:

- goals and metrics which encourage integration of screening and referrals for intimate partner violence services into HIV prevention, care and service delivery settings.
- goals and metrics for integrating mental health, healing justice, and trauma-informed services and programs into HIV medical care systems
- collaboration between state agencies responsible for HIV and violence prevention and services.
- funding to train HIV care and service delivery providers in becoming trauma-informed.

Passing Sanctuary City and Sanctuary State Legislation

Sanctuary policies are generally those which restrict or discourage cooperation and data sharing between ICE

and law enforcement. They also include legislation such as SB 54 passed in California in 2017, which requires employers to ask for a warrant before granting ICE with access to a workplace and prevents employers from voluntarily sharing employee information.

Take Action!

Contact your members of Congress to let them know you support federal Sanctuary legislation and VAWA reauthorization.

Is your city a sanctuary city? Find out how you can support local sanctuary efforts. Contact a local immigration rights organization and contact your mayor's office to find out if they have taken a position on protecting immigrants from ICE.