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SOCIAL JUSTICE AND HIV

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[video transcript]

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Shani Wilson is our speaker today for this course on social justice and HIV. Shani Wilson is a board certified physician's assistant with areas of expertise in LGBTQ plus health, medicated opioid addiction therapy, sexual health, Minority Health Disparities with emphasis on mental health, trauma informed care and vaccine preventable diseases. Community engagement and activism have been especially important to Shani. She has a passion she is passionate about giving a voice to the underserved community here in Rochester. She also works closely with local LGBTQ plus organizations such as the Rochester black pride, where she currently serves as one of the CO organizers in the Greater Rochester LGBTQ Political Caucus, and is currently chairing the police accountability board. Shani is also a CI regional champion for the restaurant in New York region. Thank you so much for joining us today, Shani. And now I will turn it over to you.

01:02
Thank you so much. This has been a really, really great talk, I've given this talk before. And the last time I did, we had a lot of folks that reached out to me just about social justice, within medicine, you know, we have a lot of a lot of folks in the community that are now you know, really starting to respond to the idea of all black lives mattering. And all you know, all black and black, all black and brown lives matter. And so I'm really hoping especially in the clinician world that we can start to really take a really take a look at what it means to think of social justice, and HIV, and really how these disease states, especially HIV affect the lives of our patients and some of the other topics that I'm going to touch on today as well. So Are we all set with the with the slides, folks? Okay. All right. So I'm going to go ahead and start my slides. Right, so the learning objectives today. So we're going to identify the social determinants of health definitions and describe how they disproportionately affect African Americans were going to shut discuss the shame and stigma of illnesses, especially in HIV, are going to challenge recognize the challenges of HIV outreach, discuss new ways of outreach to the communities affected, and review HIV as a social justice issue, to win the war on HIV disease in disproportionately affected populations. And I also want to say, we're gonna identify social determinants of health, but we want to encompass African Americans and Latino Latin X folks, folks have a different experiences than white folks. So any of those black and brown folks within within whoever fits into that category? Really, the thing is, too, is that we want to talk about how to fight back and make headway into averting new infections, which we're seeing now in the community. And we haven't stopped in these communities. And we must stop working to only solve the problem halfway. You know, we want to want to start with saturate our communities with HIV messaging that does just not just speak to the harsh realities of what our communities face, but take a comprehensive and cohesive approach that invokes political and institutional change that brings us that brings us closer to achieving health equity and social social inclusion here. So we're going to start with the first question. Okay, next slide, please. Next slide, please. Thank you. Okay, first question being. Okay, what percent of HIV new HIV diagnosis were from the southern United States in 2017? To 2018. Okay, so that actually, so the next slide actually talks

about 52%. And so I thought that that was really poignant. I mean, I don't think it's a surprise to anybody I am, I'm I know, you're not shocked because you actually pick 60%. So the fact that like, half of new new diagnoses is from a southern half of the country in which we live in, it makes up 52% of the population is pretty staggering. So we're gonna go to the next slide. next polling question. What percentage of African Americans did African Americans report on average being harassed or stopped by police? Okay, nice job, everybody. So you are correct the answer to the next slide. Okay, is 60%. So, you know, I wonder and I want you all to think about this, when you're thinking about what would your answer, what would your answer have been for some of the folks on this on this webinar? Four years ago, five years ago, would you have still picked 60% And if you have picked 60% Is it because you now have a wider knowledge of what it is like to be over policed in this country, especially if you're a black and brown person. So just an interesting, interesting question to put forward. Next slide, please. Right, Rian? There we go. So don't cheat. I know you all saw the answer, though. But according to a 2017 center, a Center for American Progress poll, what percentage of transgendered individuals reported a doctor or other health care provider? Refusing to see them because of their actual or perceived gender identity? Sir, so the answer is actually next slide. 29% So, discrimination reported by transgender patients declined significantly over a six year study period with the Center for American Progress poll.

05:55
But you know, by a by far, you know, that the that racial discrimination and discrimination against transgendered individuals were cited by transgendered individuals, including black and brown, transgender individuals receiving poor service or treatments from doctors and hospitals. Next slide, please. Okay, nearly blank percent of LGBTQ plus individuals reported postponing or avoiding medical care when they're sick, injured or injured due to discrimination and disrespect and over blank percent delayed or did not try to get preventative care. So there is one answer there is one, ABC or D, the the percentage is the same. Okay, so you all are correct. So the answer is 30%. I think that's really interesting that you got that answer. So yes, that's correct. So, alright, so let's move on to the next slide. Alright, so folks, we're going to now talk about social determinants of health. Next slide, please. So here is the model from the Centers for Disease Control, we have the five tiers of social determinants of health. Next slide. Okay, so we're done. The definition is a social determinants of health care conditions in the environments in which people are born, live, work and play, they worship and age and that affect a ride, wide range of health functioning and quality of life outcomes and risks, conditions like socio economic and physical, these various environments and settings, like school church workplace have been referred to as place. Next slide. So I'm not going to go through all these examples of social determinants of health. But I did want to just highlight some of these since these are ones that we deal with on an annual basis, individual basis here with our with within our practices, but you know, the ones that we see most daily are, can you how do you meet your local needs? Do you have a safe house to go to local food markets are close to your house within walking distance or within bus distance, access to education, economic job opportunities, access to health care services that are reasonable to get to or even reasonable to get an appointment on time, quality of education and job training? Public safety, we talked about that transportation options, ability, ability to community based resources in support of community based community living and opportunities, do you do you have a chance to rest and relax within your workspace or within

your space? Next slide, please. Right. Social norms and attitudes like are you constantly subjected to racism, discrimination, distrust of government? Is there an exposure to crime violence and disorder? socio economic conditions, like concentrated poverty or stressful conditions that accompanied racial segregation language and literacy? Do you when you go to the doctor's office, can does your provider or nurse or both have a way to speak to you that you can understand and they can properly say things back to you that your that your patients can also understand? Is there proper dialogue because there's access access to language and literacy? You know, can we use mass media or emerging technologies in order to can they use cell phones so they have a phone and then just culture in culture as well? Next slide. Okay, so folks, racism, poverty, poor housing, unemployment, high crime rates, various education, political inequality robs communities of color, the opportunity to live long, healthy lives, by creating barriers and accessing services such as HIV testing, chronic care management and routine medical care. We know these are all vital in preventing disease. So don't with a No, the thing that I add on is, which is what we want to get into the social justice aspect of this and get a little deeper is dealing with political potential consequences of bias and discrimination. You know, job loss, homelessness, lack of health care insurance often results in individuals that are affected to engage in behaviors that facilitate that The spread of HIV and also contribute to undiagnosed undertreated and effectively managed chronic conditions. We're going to talk about that right now with perceived discrimination. Next slide. Okay. So perceived perceived discrimination, by perception is discrimination against someone because he or she or they are wrongly perceived to have certain certain protected characteristic. For example, an employer believes that his employee is gay or a particular race, and treats him or him less favorably as a result. So we already know that discrimination is a social stressor and has a psychological effect on individuals, right, that has a physiological effect rather, it can be in compounded over time and to leave can negative health outcomes. Next slide.

10:52
So discrimination in the medical office of perceived discrimination is known to contribute to higher rates of psychological distress found among socially disadvantaged populations. You know, remember, if you have if somebody from the population or even just a regular are just a person in the doctor's office, they have another negative experience with a provider or nurse than they're going to tell their friends and then their friends tell their friends until the community knows to stay away from the center because they have, what does it look like as a medical professional to have, you know, a uncomfortable or a conversation that did not go the way that you wished, and then add on the perceived discrimination, which in turn is actual, you know, discrimination because of just the lack of knowledge avoidance will minimize interactions in order to avoid trauma from discrimination. So, again, you know, the patient provider relationship is destroyed because of perceived discrimination, and also just outright discrimination. So, next slide, please. Okay, hyper vigilance or a heightened awareness and anticipation of protecting oneself against additional trauma is a key feature of post traumatic stress disorders. And one of the proposed pathways in which trauma leads to poor outcomes. You know, we talk about anticipatory stress and vigilance. So if I don't go to the doctor's office, then I can't be discriminated against if we continuously see that being reinforced in the doctor's office that every time I go, I mean, they've been discriminated against my because of my gender identity, my sexual preferences my skin color, or even my even just, even just like just regularly just

having like a sex talk about sex in the office. You know, if I if I anticipate because of repeated experiences that I will not go back. Next slide, please. So here is a study in perceived discrimination that was done in Chicago, all parts of Chicago 2015 2016, Mount Sinai did a health survey, talk to talk to black, Caucasian Mexican, Puerto Rican, other adults that were surveyed in these face to face interviews talked about all of Chicago, participating in different roles across the city or neighborhoods. Questionnaires included 369 questions and 160 questions for children. So they made it quite broad. They had a multistage sampling design interviews were conducted in English and Spanish dependent on the preference of the respondents. Next slide, please. Okay, so proceed discrimination in medical settings. So here was the outcome of so I guess I want to just just talk about the very top, the top overall percentage of type of discrimination in medical settings was 40% overall. So that means that in a black, Mexican and Puerto Rican folks, like in black in black folks, the perceived discrimination in any medical setting was 56%. So in every every interaction that they had had, those 56% of those that participated said that they had had a negative experience or perceived discrimination or overall discrimination. 39% in Mexican, and 44% in Puerto Rican folks, it's really it's devastating. Okay, next slide, please. So, this is where an HIV we kind of are circling back to the idea of shame and stigma. We know, we want to talk about shame as a powerful force in the clinical encounter. The researchers argue that it can be included in the social determinants of health category, I most certainly think it should be, especially when we know that shame is such a threat to our patients. It can really drive whether or not a patient comes to the office, right? We have it can have a significant impact on health, illness levels engagement, you know, we have to think about as healthcare providers, how does the impact of shame How does that affect our patients when they engage with us? It must be incorporated into our treatment plan. When we encounter patients that are having issues engaging in care, you know, it imprisons people, folks, psychologically and physically it makes living with HIV difficult and makes living with other other disease states difficult. Think about mental health. Think about diabetes, you know, think about, you know, how does it affect your patient when a patient is not engaging with you? What does that look like to you and start thinking about talking about shame.

15:29

I will give an example. I had a issue in an office I was working in, um, where I had some folks that were being lied to 18 year old girls that were coming in for a sexual health treatment, or just just STI checks. And I had some, some employees that were working with me, you know, talking and saying, oh, you know, they're, you know, why they're here, right? And kind of snickering to themselves. And it just, and I had to take them aside and say, you know, we want to thank them for being here. Right? You want to talk about stigma, like having a conversation with some folks that just, that was uncomfortable. And so, you know, there were two sisters that came in? One sister, one, the 18 year old sister that came in, came with the other sister and said, hey, you know, I wanted to come for my first STI check. I just started having sex. And I was like, thank you so much for coming here. You know, thank you for coming to see me. Thank well, how can I answer your questions, right? You're talking about a population of folks that do not have enough health literacy. So we are literally starting from ground zero a lot of times and I really want to take the time to make sure that we ask as many questions as possible, make them feel as comfortable as possible. But think about even the perceived perceived stigma and shame around getting tested in general. Next slide. Okay, so feeling shame for just what we are, right?

We were just talking about being queer in this country being queer around, you know, different different religious organizations. Like if you grew up Christian, if you grew up, Jehovah's Witness, if you grew up, Mormon, if you grew up in another, and another religious, religious institution, or you know, even family dynamic that was just really, really hard to live in. So I really liked this quote, just talking about, you know, how shame just follows them. It's like a specter in their lives, you know, puts in, puts to bed at night. whispers whispers to us while we're having sex, traveling, our every move as we dressed to go out, telling us lies as we sit in job interviews, or stand in line for welfare, shame visits us in the bedroom and at the beach, and the medical exam room. And at the therapists office, shame was in the mirror and the camera. The impact is hugely due from self esteem to addiction and ignoring our needs and driving us to commit suicide. And so we need to take a better look at what shame is and how it affects our patients. Next slide. Okay, so now we're going to talk about biomedical bias and pain. All right, so here's another study that was done in 2019. And we did some emergency medicine research. So research examined 14 previously published studies from pain management in emergency medical emergency rooms across the country. They included about 7000 White patients, 1500 Hispanic patients, 3100 black patients, and they talked about acute pain and medication getting medication. And so the study showed that compared to white patients, black patients were 40% less likely to receive medication to ease acute pain, and Hispanic patients were 25%. Less likely. The reasons for these disparities are likely complex, and multifactorial and may include factors as implicit bias, language barriers, cultural differences in perception of pain, and institutional differences in ers that serve mostly black and Hispanic patients. That was what that was what the conclusion came to. So next slide, please. Okay, so this is the I'm sure you folks have probably heard of this pain bias study in 2016. They talked about studying folks that white folks, white, white, and medical students that were going in and getting training to become doctors. And so this study talked about white adults with or without medical training to investigate beliefs about biological differences. Look for false beliefs and stereotypes. Like for instance, you know, black people have denser nerve endings. Black people's blood is thicker than white blood 121 White adults without medical training, and foreign nga teen white adults with medical training medical students and residents and then they base the pain ratings just on race. Next slide.

19:57

So then, so then what they did was they took The 14th and 15th medical students and ask their thoughts on common, commonly stereotypical beliefs and said, Do you believe this black people's nerve endings are less sensitive than white people's nerve endings, a and whites are less likely to have a stroke than black people, they were given a same scenario as the other group. So the scenario was that they had a an orthopedic injury. So somebody presented to the ER to their primary care office with a with a fracture, either a broken bone or a broken femur, something really, really drastic, or maybe they just broke like a toe, like a fifth digit or something like that. And then they were asked to suggest treatments for the patient in the scenario. Next slide. So with both control groups, those with individuals, white individuals with with no medical training, and some and the ones with training, that they it was found that there were some incorrect beliefs found about there were stereotypical that were between black people and white people's perception of pain, while the groups that had perceptions of how, while groups had perceptions of how black and white folks experienced pain, the group that was

disproportionately affected by by the stereotype were black people and how and especially how their pain was managed. Next slide, please. Okay. All right. So. So really, folks, really, at the end of the day, patient experiences matter, right? In the study, it found that discrimination in health care was most strongly associated with quality outcomes for black and Hispanic individuals, discrimination in health care was significantly ly links to failed adherence to screening guidelines and fewer provider visits for serious illnesses. You know, we see that every day in our office, you know, we are we have to be, you know, racism, medical bias, you know, some of these, you know, some of the, the Black and Brown percept perception of pain goes back to slavery, right? You know, that, you know, that, you know, when J Marion Sims were experimenting on black women to perfect the speculum into perfect fistula repair, he did so without any any type of any type of analgesic, or any type of any type of ether or any type of any type of thing that would have helped out his his people that he experimented on, because the perception was that they didn't feel pain the same way white women did, so they could take more, some of these women had been subjected to dozens of surgeries to perfect this fistula repair right to perfect this types of surgery. So we have to be teaching our students about racism and medical bias, you know, and we understand to that, because, you know, a positive patient experience is essential for high quality care, that we really have to be making sure that our, our provider patient relationships are strong, that we go the extra mile to meet our patients needed to understand them. And we have to make sure that we are listening to and addressing biases in the medical profession, and especially in our offices, and how patients perceive versus what patients perceive a bias versus what we what we're actually being taught in the classroom. Next slide, please. Okay, so, so we're gonna move on to queer folks, LGBTQ plus individuals in HIV. Next slide. So this is just CDC, 2015 to 2019. These you already, probably some of you know, by, by race, by ethnicity, you know, estimated 44%, black African American, transgendered or transgendered experienced folks 44% African American 26%, Hispanic Latinx. And of the 3 million testing events that reported to the CDC in 2017, the percentage of transgendered folks who received a new HIV diagnosis was three times the national average, which is why I chose to, which is why I chose to have this slide be about transgender individuals in this next couple of slides will be about that as well. Nearly two thirds of the transgendered women and men surveyed by the paper risk factor in 2014, and 2015 20. Jurisdictions never reported reported never been tested for HIV. Never. So even if they had had an experience where they could get testing, folks, were not getting tested. That's what that is, again. Next slide, please. So here is a just a CDC breakdown of new HIV infections, I think in the same year category 2015 to 2019. So transgendered folks, Black and African American, as you can see, it's just so disproportionate to other other groups.

24:47

You know, when we talk about having, you know, persistent discrimination and what does that look like and how does it reverberate through, you know, queer, queer individuals and transgender native joules and their experiences, you know, for instance, you know, the, you know, we know the rate of diagnosis was five times higher than those, that those are in survival sex work, right, that we see these higher diagnosis rates, and they're five times higher within those that participated than those that did not participate in sex work. But when you talk about persistent employment discrimination, what opportunities are there? Next slide. So barriers to trans to transgendered care. And this is something that, you know, I know, that we are working

on, I know that there are different groups in New York State that are really trying to tackle this, but, you know, we talk about transgendered individuals are folks experiencing stigma, discrimination, social rejection, and exclusion, transgendered sexual health, especially men's sexual health has not been studied. Lack of knowledge about transgender issues, transgendered women and men might not fully engage in medical care because of socio economic issues, issues with employment, just dynamics within family, certain behaviors and still get socio economic funk founders are factors can affect outcomes. So, remember, it's not about us and what we're doing in the office, you know, you we are just a very small part of the lives of our patients. And we have to understand that if I if my patient can't find a job and is engaging in survival sex work, or just is overwhelmed with their lives or just busy, you know, how do I get them to engage in health care, right? It goes back to that strong, strong provider relationship, and then a knowledge, a working knowledge about what it is like to live within that sphere, because you have a direct impact on the patient's lives, meaning that if they experience social economic stress, how are we able to help them with that? How are we able to talk to them on that level, and get them to engage, knowing that we can identify or at least have some have some empathy about where they're at, right? Not sympathy, empathy is active. Next slide, please. So we just another barriers to care, we talked about discrimination. We talked about survival sex, just now, anti LGBTQ bias. This discourages those in the community from consistently getting tested, not just getting tested once a year, but consistently getting tested and treated and staying in treatment for HIV, for fear of getting harassed or outed, especially on social media. I work in urgent care right now you would be I don't think you all would be very surprised. But I think you'd be somewhat surprised about how many of the folks I see are community members that are queer that come to see me for, for testing frantic because somebody tried to out them on Facebook, and said that they knew their HIV or they had an STD. And lastly, HIV criminalization laws exist still in this country and keep HIV infected individuals living in secret. Next slide. So this is a really, really interesting and important topic. So federal issues and state issues and discrimination. So in most states, folks, it is perfectly legal to discriminate against those who because of their sexual orientation, or gender identity, and one or more aspects of their life, including employment, housing and public accommodations. Explicit non discrimination protections based on sexual orientation or gender identity do not exist at the federal level. HIV programs such as the wind right program have not seen an increase in federal funding in over a decade. Next slide. Okay, so do you also know too, that there's a lack of training on chins, gender issues that contribute to these the lack the knowledge at the state and federal level? They're, by healthcare providers are seen as a barrier for transgender folks or queer folks looking for them who are receiving HIV diagnosis and are seeking quality treatment and care services. If there's no money for services? How can we give them quality treatment? Youth Care, few health care providers actually receive proper training, and are knowledgeable about queer health issues and unique needs. This can be limited to this can lead lead to limited health care access, and negative health care encounters like we talked about? So one of the things I wanted to highlight two, which I felt was interesting, and sorry, I just want my slide was that we talk about medical students, a PA students, nurse practitioner students, how much education are they getting at the that is mandated by the state level or federal level human, or by our certifying bodies, the extent of LGBTQ medical education varies greatly. And I know it's increased, but I still think it's not enough. 2011 study found that the median time on LGBTQ plus health was five hours that medical students receive.

29:45
And I'm, I'm wondering how much has increased since then I know that I can talk to some folks across the state but I would say probably about five to 10 Still not enough. The you know, so that really will. I think that really is our up to our state in order to figure out what that looks like for making sure that we actually are able to deliver care effectively. Next slide. Next slide please. So community based outreach strategies, we talk about outreach strategies have changed the needs for our communities and our communities have started their own outreach programs, and that have started to D stigmatize HIV testing and living with HIV. You know, I here in Rochester, Rochester black pride, which I'm now which I'm on the board of directors now sort of starting to phase into our 501 C three land. One of the things I'm a huge a huge fan of and will continue to be at the table over is that community knows how to reach out to community. And we literally just have to figure out how we can support community in order to get them to do what, what, in order to reach out to folks effectively, we have to engage community and community has to be at the front of that conversation, not at the back. So for instance, we have the, you know, the balls the balls seen, I know everybody's seen TV and pose on television on Fox, but the largest annual ball of international ball and community where people can feel safe about their gender identity, and sexual expression and learn about HIV prevention was started in 1989. And that was at the peak of the HIV epidemic, leaders from the house and ballroom scene developed several outreach programs called the latex project, one of the largest ballroom competitions in the world, and 1000s go to this ball, which is a latex ball that happens every year in New York City. They also have different balls across the country, but they all have that same same HIV STD, STI STI, focus, some minor cities as well and medical to the community and comfort those who have also lost folks to the HIV AIDS epidemic and bring awareness to HIV and safe, safe sex practices. Next slide. So now I'm just going to dig deeper into HIV criminalization, and how medicine have played a role into that conversation. How does the legal system discriminated against those living with HIV? You know, black, gay and bisexual men still make up the largest single category of people with HIV in this country. This is further complicated do their criminalization based on their skin color and sexual orientation. Coming from socially politically vulnerable communities, many black and brown people face multiple intersections of discriminate of discrimination and stigma. This is already a very tense history with public health and police even before the emergence of HIV. Next slide. So the origin of the HIV criminalization laws at the very beginning of the HIV epidemic, public fear of the disease led many states to pass laws that established criminal penalties for failing to disclose infection, for exposing other citizens to the disease, and for transmitting the disease intentionally or unintentionally. In many cases across the US, these laws had been applied to a person of regardless of the protection measures of the HIV positive person may take and I'll give you some examples. Okay, next slide. Kind of a busy slide. But as of 2020 37, states have laws that criminalize HIV exposure, and only five states have modernized their laws base of now based on now what we know about HIV. The laws for 50 states and the District District of Columbia were assessed and categorized into four categories, HIV specific laws that criminalize or control behaviors that can potentially expose another person to HIV is categorized as sexually transmitted diseases, communicable contagious, and infectious disease, these laws criminalizing control behaviors, they are they have sentence enhancement based on HIV exposure or STD exposure. So they so if you have a law where, for instance, they have a

general criminal statute such as reckless endangerment, so if you have if you have HIV disease, or HIV infection, and or they enhance that, that charge with this specific law based on if you have HIV or not, that makes sense. And it can be such as it can be reckless endangerment, or can go as far as attempted murder. And these can be used to criminalize behavior that can expose another to HIV disease. Many states have laws that fall into more than one category of those listed above. Go to the next slide, please. Think that's a repeated slide. We go through we just jump to the next slide.

34:42
Thank you. So these are the cities that have that now have criminalization laws on the books that are from 2020. Okay, as you can see, we talked about sentence enhancement. Right. So when you have somebody that's charged with reckless endangerment because they've had sex with somebody that has HIV But some of these are criminalized control behaviors, though sentence enhancement statutes, the purple, they have criminalized control behaviors through specific. Like, for instance, if you have, if you have gonorrhea, and you normally infect somebody else, and they, you know, become infected, does that mean that you'll be charged with an additional charge, doesn't mean you'll go to jail. So some of these, some of these folks are these some of these things are meant to regulate people's sexual behavior without really understanding the knowledge of the disease that they're speaking of. And so next slide. Okay, so these are the ones that are the types of behaviors that are criminalized or controlled in these jurisdictions that we that on the previous slide were the the, the this color green, so donation of blood fluid and tissues, we have sharing needles, prostitution is solicitation, biting, spitting, or placing, placing Okay, sharing sex objects, oral sex, vaginal sex, and anal sex are all listed here. So, so we do know that, you know that with our new with our new knowledge that, you know, I don't know if many people are gonna get, you know, HIV disease from some of the things that they're stating. But, you know, these, these some of these, some of these have not changed in a decade. Some of these have not changed more than a decade. And so that is why some of these folks are subjected to these harsher sentences just because of just being infected with HIV, no matter if their viral load negative or not. Next slide, please. So here's an example of that case. In state versus Gambella. A person with HIV was convicted of an intentional HPV exposure, despite his testimony that he disclosed HIV status to his girlfriend and work condoms during sex. On the man's girlfriend testified that as as after she became pregnant by the defendant from condom failure, they engaged in unprotected sexual intercourse and multiple occasions, she testified she didn't know his HIV status or your relationship. The defendant was convicted and sentenced to 10 years in prison at hard labor. So really, at the at the state and federal level, folks, this is a huge said versus she said, right? It is not about in a lot of in a lot of ways not about science, but really just about stigma. Next slide. So some cases around the United States. So in 2009, we had an HIV positive individual that was charged with attempted intentional exposure to AIDS after failing to disclose the HIV status to an undercover police officer during a prostitution bust. 23 year old with an HIV positive individual was charged intentional exposure after he was engaging essentially ship without disclosing his HIV status 2010 individual charged with HIV or intentional exposure to the AIDS virus after engaging in unprotected sex with a man without disclosing her HIV status. And 2017, a 37 year old HIV positive individual was charged with intentional exposure after allegedly failing to disclose his

status to a sexual partner who he met on Facebook and had sex with on one occasion. Next slide. So then we're going to talk about moving forward.

38:21
So we have, you know, with all of this knowledge, and you know, we know that we have these, we have these, these federal and state guidelines, we have all these different issues, you know, what are we doing to take action in our individual communities at the state and federal level to engage and get these get these things changed? Right? You know, these are the things that we honestly are asking you to ask ourselves, when we talk about how to engage our patients, how do we engage our society? You know, how do we educate ourselves? How do we advocate for those that do not look like us? How do we take action? You know, one of the things I, I constantly say, when I'm giving talks, because I deal with policing here in the city of Rochester, is you know, Ally ship will always cost you something. And if it doesn't cost you something, then it's not ally ship. And I know that's not very, not very popular, but it's true. You know, we have everybody that you know, we have, you know, racism, we have medical disparity or healthcare disparities, we have people that are getting HIV, and it's like a burning building. You know, we've gotten so good in the country in the state of just looking at a burning building, trying to figure out like, why is this why is this burning? Where's this building burning? What can we do to put it out but let's say let's examine it first to make sure that we know how it started in the first place. What does the color of the flame look like? You know, what kind of house is it and we're all standing there with our pencils and our pens just being like, Hmm, what can we do? How can we you know, instead of just literally taking some water and just literally putting out the fire? No, that is where we are in In this country as far as like, getting people to see how much of an emergency this is, it is literally we are in a lifeboat folks, we are pulling people out of the water. And that is the type of urgency that I'm desperate for people to see. That type of urgency we need to have we are advocating for our patients were advocating for those who do not look like us. Right? That even goes for me as a sis, as he says heteronormative or sis normative person, right. I also wanted to say that for the next slide. So reframing HIV discrimination, racism and shame is a social justice issue. And it is imperative to winning the war with HIV and other health care issues, especially in these effective, especially in these proportionally affected populations. You know, I think that a lot of our issues will get better until we have a we are had these really crucial conversations at the level that is not just provider wise, but with our leadership and with the leadership's leadership and that we demand change because we know that when we demand change up here at the top, then it disseminates to the bottom. But it is an anti racist approach. It is an anti it is a anti discrimination approach. It is not just a diversity, equity and inclusion approach. It is a an emergent approach. So thank you so much, everyone. For your questions.

41:30
And thank you so much for that presentation. Shani. If there's any questions at this time, you can put them into the q&a function, or you can put them into the chat.

41:49

And know, Shani, this was a topic that was very prominent in our conference this year, which took place on June 25. And we also discussed the overlap between COVID-19 and HIV, would you be able to speak to those intersections just briefly?

42:07
Yeah, so we talked about HIV. And a couple things, I guess I'll mention two things. The first was the the access, the lack of access to care, that was seen leapt IV disease in the beginning of the 80s. And still today, and COVID, right, we saw that those were those that were black and brown, or just from just affected affected populations that were already decimated by chronic disease and illness were just wiped out, or at least had a significant impact on those populations for COVID. Right? HIV disease, it's the same, you know, we had these populations, just like I spoke of that have the smoke, that's these factors that contribute to infection, you know, isolation, shame, stigma, lack of resources, that are contributing to these, these explosions of HIV disease infections. And so that was the correlation. And then also, just the, just the, even the stigma behind getting COVID. Right? No, we had folks that were put in, put in situations that of course, they were going to end up in, in getting getting infected because of just working they were first line workers, they were health workers, they were people working in, in nursing homes, right, there are people working, as you know, nurses on the floor, but also working as janitors working as cleaners and rooms. So those with HIV that were directly affected were, you know, those that were engaged in relationships that didn't have a lot of access to resources, you know, engaged in sex work, engaged in just having just general relationships with folks that just didn't know enough or, or just didn't have enough care or enough access to just like our PrEP or PEP, I'm not even talking about 1980 and talking about today, right? Just even just health knowledge, just knowledge about health and access to health consistently. So those are sorts of Joseph, those were just the two things that we spoke of, during the conference.

44:02
Absolutely. We have in the chat box. I'd like to thank the presenter for this information. They learned a wealth of information. We also have in the q&a how this presentation was awesome. Thank you for taking us to school. Thank you so much. So we have a long thing here. Awesome presentation. I have a question regarding the 2009 case of HIV positive individual charged with attempted intentional exposure to AIDS after allegedly failing to disclose their HIV status to an undercover police officer during the prostitution bust. Why the charge? Is it exposure to potential clients or the police officer who was doing the arrest? If it was the police officer, how are they exposed? I'm not understanding the exposure to whom that would commit to a charge.

44:51
Sure. So So good question. So when I was reading the case, and I should have put this in there, but I also think that I liked the question the way that it is because it kind of leaves it ambiguous. I can tell you this that I doubt that it was because of the person that that was engaged in sex work with John. Right. It was probably the probably the sex worker. Right. And it was probably an altercation with a police officer. And maybe that police officer was subjected to fluids or was bitten or something else. Because just in studying, unfortunately, studying police, police conduct and police policy and procedure, I doubt that it was because this person had subjected their actual John's to HIV disease, I think was probably the officer that was either bitten or something

else happened during the arrest? And I'm not sure that it would. Yes. So. So really, again, it's like, if they're being arrested, you know, and they're getting read, hopefully getting read their Miranda rights, you know, they're they're alleging that this person should have, you know, disclosed their HIV status or done something because of what happened during the arrestee. Which, you know, when you're getting arrested, and it's a high stress, high, high issue situation, I doubt that would happen. But that's why

46:06
I think it also speaks to the fact that many of these laws are outdated, and they don't take into account the fact that undetectable equals on transmittable. And so they they're just very outdated. And so you're able to charge folks with things that no longer makes sense given the current science that's available. Correct? Yeah. Are there any other questions for our speaker at this time? I think we have one here. Another person saying fantastic presentation. This is necessarily an eye opening delivery of knowledge and they appreciate the work that you're doing. Thank you so much. And once again, I would just like to thank Shani Wilson for this phenomenal presentation.

[End Transcript]