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**2007 National HIV Prevention Conference - Day 2  
Plenary Session: Impact on Communities of Color  
CDC  
December 3, 2007**

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**JOCELYN DORSEY:** Good morning. Good morning. I'm Jocelyn Dorsey, Director of Editorials and Public Affairs for WSB-TV, Channel 2 here in Atlanta. Community coverage you can count on as we say. So I hope when you all go back to your rooms you turn to three I think it is on the cable, but I welcome you.

And it is my privilege to be a moderator of sorts this morning, we've had some distinguished panelists that you are going to want to hear about and we're going to try to have a lively discussion, which I'm sure will happen with all the different speakers that we have. And it is my pleasure to begin introducing them.

First we have Dr. Robert Fulilove, he is the Associate Dean for Community and Minority Affairs and Professor of Clinical Sociomedical Sciences at Mailman School of Public Health, Columbia University. During his 18 years with Columbia, Dr. Fulilove has conducted extensive research into the impact of HIV/AIDS in communities of color here in the US and has been published widely regarding the impact of HIV/AIDS among African Americans. Dr. Fulilove's current research focuses on the population of men who are reentering poor communities after jail or prison and the degree to which access to healthcare impacts health outcomes ranging from HIV to cardiovascular disease.

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Dr. Valerie Stone is the Director of Women's HIV/AIDS program at Massachusetts General Hospital, an Associate Professor at Harvard Medical School. She devotes substantial time to HIV/AIDS patient care and research. Her HIV/AIDS research focuses on the studies in the care provided to minorities and women with HIV/AIDS, barriers to treatment for HIV and adherence to the anti-retroviral therapy for HIV/AIDS. Dr. Stone is the author of numerous scientific abstracts and publications ranging regarding the care of the persons with HIV/AIDS. Dr. Stone has more than 20 years of experience as an AIDS physician, much of which has focused on providing political care for minorities and women.

Dr. Rafael Diaz is the Director of the Cesar Chavez Institute, better known as CCI at San Francisco State University, guided by principles a community participatory research. The CCI conducts research programs pertaining to the impact of social oppression on the health, education and well being disenfranchised communities in the United States. Dr. Diaz has conducted extensive research regarding the impact of social discrimination and social oppression on the risk for HIV among Latino gay men. His studies demonstrate that the risk for HIV is not simply an outcome of individual behavior but rather a property of context created by oppressive structural and socio-cultural factors such as poverty, racism, homophobia and forced migration.

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Dr. Cynthia Gomez is the Founding Director of the Health Equity Initiative in San Francisco State University. Where she leads efforts to enhance and integrate campus research, curriculum, community service and training programs that address health disparities and/or promote health equity in the United States. Dr. Gomez is considered a pioneer in the areas that cultural determinants and sexual behaviors among Latinos in the role of power dynamics in sexual risk among women. And in the development of HIV prevention interventions, including interventions for people living with HIV.

ManChui Leung is Director for the HIV program at the Asian and Pacific Islander American Health Forum, or APIAHF. A national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well being of Asian American and Pacific Islander communities. ManChui's current policy in advocacy work is grounded in community experiences and grassroots organizing efforts. Her advocacy is focused on making sure that Asian Americans and Pacific Islanders are included in the national response to HIV/AIDS and that the issues such as the need for culturally appropriate interventions and linguistically appropriate services for a community that speaks over 50 different languages are addressed.

Dr. Bonnie Duran is an Associate Professor at the School of Public Health and one of the Directors at the

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Indigenous Wellness Research Institute, better known as IWRI, at the University of Washington. Dr. Duran has worked in public health prevention services, research and education among Native Americans and other community of color for 33 years. Dr. Duran's research projects and interests include alcohol and mental health epidemiology, barriers to care, violence and other social determinants, and cultural protective factors. Dr. Duran is currently working with colleagues in New Mexico and nationally to determine the elements of authentic community partnerships in research and on alcohol screening and interventions for people with HIV, primary care populations, and college students.

Please welcome all of our panelists. [Applause] And as you can see we have an awful lot of ground to cover. So what we will do first is allow our panelists to give brief opening remarks and then we will try to cover as many subject areas as time allows us in this session. Dr. Fulilove.

**ROBERT FULILOVE, ED.D.:** Good morning everyone. I am terrifically impressed as I heard the introductions of each of the panelists. With the degree to which all of us are trained in science but are increasingly focusing our efforts on the understanding structural barriers that exist in our society that promote the transmission of HIV. Fundamentally what, I think all of us are discovering is that if we are to be saved with respect to the ravages that this epidemic is really

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reeking upon American society and throughout the world, it will not so much be through the efforts of our science, it will be through the efforts of those of us who have seen the human rights dimension and all the work that we have been doing.

I first came to Atlanta in 1964 to work with the Student Non-Violent Coordinating Committee, the civil rights organization that has more or less been lost in the dim past. But it's interesting to see that in 22 years in working with HIV/AIDS I'm increasingly confronted by the fact that the issues that I worked on in 1964 with so many young people of my generation, are precisely the issues that we're confronting in trying to understand and prevent HIV.

As you heard from the introduction, a lot of the work that I do currently focuses on the incarcerated population in the United States. As a guy who worked in Mississippi in 1964 trying to assure that black folk had the right to vote, it's interesting that in the year 2007 there are seven states in the United States where one out of every four African American males has permanently lost the right to vote because he's been convicted of a felony. Therefore it's not surprising that prisons are increasingly the machine driving not only HIV transmission in many poor communities of color, it's also the machine driving structural inequalities throughout society. HIV is simply a symptom of a much larger problem that I think prisons embody. Because they reflect our inability as a

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society to deal with issues of race, poverty, stigma, inequality and segregation. It's segregated communities that contribute so much to our prisons. It's segregated communities that bear the heaviest burden of HIV infection in American society at present.

And it's for this reason I'm really pleased that in addition to having an extensive dialogue this morning and throughout this conference about the advances that we've made in our science. There are also a significant number of people out there in the audience who are advocates, who are equally impressed with and passionate about and committed to making sure the human rights dimension in what we do is not lost.

I really want to particularly applaud the work of CHAMP, which has done so much to remind us through demonstrations, through teachings, through individual advocacy work that what we do in science cannot be implemented unless we're also forcing the American public to understand how much of HIV is being driven. Not simply by a virus but our own inability to care for those amongst us who are disadvantaged and who are continually oppressed by structural factors that so many of my colleagues have been studying throughout their careers.

My hope is that those of us who do science, those of us who do advocacy, those of us who are concerned about human rights, will continue to use the dialogue that's made possible

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by this conference to advance our ability to talk to each other and to the American people about what we see as a growing threat. That doesn't just represent itself in the form of this virus, but is also creating, in the words of the riot commission of 1968, two societies in America, one white, the other non-white, separate and unequal. It's that inequality that is driving this epidemic and it is that inequality that has to be the work of both scientists and advocates alike. Thank you. [Applause]

**JOCELYN DORSEY:** Thank you Dr. Fulilove.

**VALERIE STONE, M.D.:** Good morning everyone. It is an honor for me to be here with you on this panel of HIV prevention experts. I am actually an AIDS doctor and have been providing medical care for people living with HIV/AIDS for over 20 years now. Currently, as you heard, I'm at Massachusetts General Hospital where I direct the women's AIDS program. In our program we try to have a program that delivers not just medical care but helps people living with AIDS with some of the other structural issues that they are facing. Sometimes lack of insurance, lack of a job, homelessness and mental health, and substance abuse challenges.

In addition I also do research focusing on disparities on HIV care by raising gender in treatment issues that particular affect minority and poor people living with HIV as well as women. So as you can see, I'm basically a treatment

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expert, not a prevention expert but I believe there is an integral relationship between HIV prevention and treatment. Prevention and testing messages are only as effective as we communicate them and they are greatly influenced in terms of whether people accept these messages, particularly in minority communities, depending on the stigma that they feel around them, depending on how willing they are to find out their status or not. If HIV is experienced and perceived as a asymptomatic but heavily stigmatized disease then people won't want to find out and identify their serial status.

Thus I think that current efforts to make HIV testing routine is a rational strategy for decreasing HIV transmission from the 25-percent of people who don't know their infected. Yet its only a strategy that will work if people perceive that there's any benefit to finding out that they have HIV. And if by so doing they become part of a group that they perceive as terribly stigmatized then they won't perceive a benefit. So I see one of our largest challenges in prevention is to find strategies that work for de-stigmatizing HIV, particularly in minority communities but throughout the United States.

For somehow finding a way to make it a disease that people care about in a broad sense in the same way that we care about people who have cancer and diabetes and that isn't a disease that isolates people. So I really think that's our challenge. Thank you. [Applause]

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**RAFAEL DIAZ, PH.D.:** I want to start this morning by thanking you all for the opportunity to give this opening statement and particularly in the context of this group of exciting colleagues and this magnificent audience.

We're here this morning to acknowledge that HIV infection is not equally distributed in the population. We're here to recognize that HIV is spreading at a faster case within communities of color and in particular within groups and communities that face multiple force of oppression and social discrimination.

Indeed HIV is increasingly located within pockets of powerlessness that are created by chronic poverty, racial and sexual discrimination, forced migration and unequal access to resources and services. The data are very clear, the AIDS epidemic has a social shape. AIDS is not only a medical emergency but also a window, a mirror, to the reality of socially and structurally produced inequalities in our midst.

It is important to remember that within this focus of powerlessness individual choice is greatly constrained and reduced. In this context individuals are not simply choosing freely how to act or how to behave, more often than not in this complex people are in a survival mode, in a reactive mode. Reacting to immediate life challenges to find food, shelter, some kind of life stability and a sense of safety from the virus that cuts their life short.

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In this context people are trying to maintain a sense of self-worth in the face of daily threats to their dignity and wellbeing. In this context people are trying, and often through sex and comforting substances, to find some relief from this sense of helplessness and hopelessness, [speaks a phrase in Spanish] as the day laborers that we study say, that is the daily bread of the poor.

We must also face the fact that in communities of color and among those who are at greatest risk for HIV, HIV prevention is not their most pressing issue or concern. And that the members of this community have accepted HIV infection as an inevitable outcome, yet another toxic ingredient within the poverty landscape they must live in. Often there is exhaustion and burn out among many prevention workers who serve these communities and at times there is a pessimistic sense of the battle that has been lost.

Where our data show that the risk of HIV transmission is socially produced within oppressive context and situations, our prevention science and most of our models of behavior change as still seeing the individual as the main factor, where individual behavior is the outcome that needs to be changed. Most prevention programs are aimed at changing the behavioral individual participants rather helping change their social context and situations that constrain their ability to make healthy choices. We have often heard that it is behavior what

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you do that puts people at risk for HIV and that's certainly true, but we forget that what you can and can not do is determined by your social situation vies a vie all these forces of oppression and discrimination. [Applause]

I believe that the data on HIV in communities of color argue for community organizing approaches to prevention rather than for behavior change workshops based on social cognitive theory whose affects we know to be short lived. We must assist communities to organize themselves to create contexts that are for choice and self determination where health priorities and the means to achieve them are determined by members of the local community. In this approach, community members are seen and treated as powerful factors rather than deficient victims. In this approach there is a vision of the future and a quality of life beyond survival from HIV.

This approach is focused on enhancing the existing strength and result in renewed community activism against the forces that oppress them. The bottom line is that HIV prevention in communities of color is a matter of social justice and in order to be effective, prevention efforts must also engage in social action towards a more just and equitable society. [Applause]

**CYNTHIA GOMEZ:** Good morning. I am glad to be here my great colleagues and the pleasure to see many friends and also new faces that have joined in this amazing effort. I wanted to

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speak about the program title, the synergy between science and program as a key piece in what we need to actually be doing in our action. As scientists many of us have been working on developing what is an effective intervention, what is it composed of, what are the key elements, and we have worked very closely with our community partners in thinking about that.

Many of you know I started in the community, I ran the community programs. When the epidemic hit I was in a community based organization. And yet many of the science that has been developed is done to find the cognitive issues or the cognitive barriers and is it not really helped by the innovation that community offers. And I think that this is an opportunity now to acknowledge that the science has given us a very strong base but program, the innovation of community now needs to lead the way in how that science is implemented. [Applause]

Critical in this relationship is that from here forward any new research on intervention has to be a partnership between community and science. One cannot really be without the other. It is critical for us to work together. Why is this? Well I don't know about you but most communities HIV, as Rafael mentioned, is not people's priority. People are not knocking at the door of our HIV agency saying I would like to be part of an HIV prevention program. It used to be that way, when the epidemic started we were all scared, everybody ran anywhere to find out information but that was very short lived.

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We don't live with fear for very long or we wouldn't exist, it's sort of a human instinct, survival instinct.

And so now we are much more challenged about where do we create messages around prevention that our communities want to hear. As you know I now direct a health equity initiative and part of my own learning is the importance of the integration of HIV as part of our overall health model. Now what does this mean, because I'm not saying not to emphasis and not to continue to focus on the specific issues of HIV but we can no longer pretend that it is an isolation. We need to learn from other areas of STD's where in doing that we sort of lost the importance of what we were trying to do, it became diffused.

So how do we both integrate HIV into health but keep it on the front burner? And I think that's a challenge and I really challenge all of you to think about this. Is the integration into testing as a medical procedure that happens automatically mean that we forget thinking about the fact that we're being tested for HIV. And what does that mean for the individual. Or is there a way in which our prevention services need to take on not only HIV but all other prevention models, STD's, pregnancy prevention, maybe even broader, the diabetes prevention, cardiovascular disease. Again, how do we do that but stay focused on our intent to stop the epidemic.

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It's a new time for us, it's 25 years and we have to deal with the complexity of how to keep what is still a crisis changing while integrating so that people can accept it in their daily lives. So I order just to continue to get the innovation from the community that is really going to lead us into the best way to reach our communities. To use the science to know what works. I believe, quite honestly, that we have so much evidence of what works and so few resources to implement them that that is one of our biggest issues today. Most agencies are not given the resources [applause] that they need to implement the programs. We can hand them all the divvy you want, [laughter] 49, 52, 105 [applause] but they are not matched with the resources that it takes. Scientists are given the resources that it takes to test out an intervention, programs are not given the equal resource to implement them, even more challenging. [Applause]

So again as we move forward I urge us to study together the process of implementation in the community and to study it in a way of product development. In the corporate world, product development is a very specific theory where a product peaks and then becomes less interesting. Our prevention programs go through this peak very quickly in our communities, that product development changing the color of the toothpaste happens very quickly in marketing, we do not do it in prevention and I think again that is a huge problem for us. We

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need to find a way to immediately change our interventions to make them more interesting, more exciting, new colors, new tastes, so that the community feels that there's newness in everything that we do.

So it will require a much faster turnaround time. Scientists have to find a way to do that, we can't spend five years creating an intervention that by the time it gets into a divvy it's outdated. We need a much quicker turnaround time. [Applause] And so I will end by saying let's do this together, something that is so dependent on social change means that we have to link together. If we don't link together that social change will never happen. So thank you and I hope and look forward to working with you. [Applause]

**MANHUI LEUNG:** Thank you. Good morning. I want to start off with a quote from Martin Luther King Jr. that I heard when I started my community activism during the first Gulf War. "True peace is not nearly the absence of war, it is the presence of justice."

In our context now at this conference, in seeing the increasing numbers of HIV infection in communities of color globally and domestically, I rework the quote that helps me focus my energy in the fight against AIDS. True wellness is not nearly an absence of disease or infection, but it is the presence of empowerment.

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I say this because my approach in the fight against AIDS is about an investment in powering and mobilizing the Asian and Pacific Islander community to adjust the social issues that fuel HIV disease such as racism, sexism, poverty, end to immigrant sentiment, ageism, homophobia and violence.

Asian and Pacific Islanders are one of the fastest growing populations in the US. We're extremely diverse with over 60 ethnicities and nationalities, over 100 different languages and dialects. Some of indigenous people, such as the Pacific Islanders and Native Hawaiians, some have been here in the US for many generations and some are new immigrants and refugees. This diversity is our strength but it does also give us unique challenges in making sure that HIV prevention is delivered with cultural and linguistic competency and acknowledges and respects the specific ethnic differences within the Asian Pacific Islander community.

So what are the challenges for the Asian and Pacific Islander community? I'm sure we share a lot with my other communities of color, I'll highlight three. Invisibility, silence and discrimination. And we often think of these on the individual level but I want to highlight to you how they actually manifest on a systematic re-structural level and how it impacts the Asian and Pacific Islander community specifically.

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Invisibility is the major issue for Asian and Pacific Islanders. We are not seen to have health problems. We are not seen to be impacted by AIDS, in fact sometimes we are not seen at all. This is particular to when it comes to data. In a time when data is so important, there continues to be significant gaps in data collection and reporting. In many health departments and in CDC reports, Asian and Pacific Islanders and Native Americans are still classified as other. Not only does that make us invisible but more importantly it does not give us the information to have an accurate picture of the impact of AIDS that reflects what people in our community are really seeing.

In a time when surveillance technology and systems are becoming more advanced, there is no reason for there to be data gaps or to be relegated to a category that deems us invisible and insignificant. This lack of acknowledgment [applause], this lack of acknowledgement and invisibility also makes our work on the ground so much harder and more importantly it actually is what fuels the HIV stigma within our community.

Since the beginning of the epidemic there were Asians and Pacific Islanders being affected by HIV/AIDS. We have seen our brothers and sisters die, often alone and without the quality care we all deserve. We also see similar issues in other communities of color. A disproportionate impact on gay and bisexual men, rising rates among women and the use of

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crystal meth, the increasing HIV positive cases in the Asian and Pacific Islanders.

There's a need to analyze the problem to ask the hard questions and more importantly to develop interventions and solutions but this is difficult because Asians and Pacific Islanders are under funded across the board in health disparities research, including HIV behavioral research. There continues to be no Asian Pacific Islander and I must add no Native American intervention in the CDC menu of affective behavioral interventions. So as we have more questions and increasing problems, the response cannot be silenced because of the lack of government and university investment in community based research.

Finally Asian and Pacific Islander women are also facing rising HIV infection rates. I think there needs to be a comprehensive agenda that really addresses this issue of gender based violence, sexism, homophobia, and other forms of discrimination that produce HIV risk among women, especially women of color but also affect all of us. For example the prevalence of violence among HIV positive women and HIV positive gay and bisexual men of color are higher than the general population.

I know these are big issues, violence, HIV, racism, sexism, but I think they have to be addressed in order to stop AIDS. We don't have a choice. We will be hearing soon about

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an increase in estimates in rates in new infections. We cannot save the problems or issues are too big or impossible to change when we are dealing with the lives of people in our communities and in our families. So I hope this panel and this whole conference not only highlights what the issues are such as silence, invisibility and discrimination, but I also hope it creates opportunities that foster community empowerment, grassroots advocacy and social justice that overcomes these challenges. Thank you. [Applause]

**DR. BONNIE DURAN:** Good morning everyone. First I'd like to say I absolutely agree with and can support both from the evidence and from a lived experience everything that all of my colleagues have said on the panel. Most of what you've said is also true for Native American, American Indian populations, Alaskan Native, and other indigenous populations of the US. And I would just like to reiterate and say again that HIV risk for American Indian and indigenous peoples in the United States has a huge structural component. The HIV risk is embedded in larger systems of social inequities, stigma, economic, cultural and political root causes of disparities.

HIV risk also has a huge behavioral component as well. As you know my wonderful colleagues said there is not Native American specific divvy or hardly any Native American specific educational materials. I would love to know that the healthful league model or the special cognitive theory doesn't work for

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Natives, but we don't even know that yet because we have never tested evidence based interventions specifically on Native American populations. We don't have any to test so we definitely need to go there.

I think on huge issue for Native American communities, and it might be true for other communities of color, is that Native communities, Native people's, a lot of Native people's have a very different relationship to the field of medicine and public health than mainstream US people. Native American people have been exposed to medicine and public health as a huge tool of colonialism and because of that we have a lot of distrust, a lot of wariness when a public health of medicine comes into communities of color. For example in the 1980's the federal government was routinely taking Native children out of their homes and putting them into boarding schools where they weren't allowed to speak their language, they weren't allowed to practice their culture, they were absolutely forbidden to practice their religion. In the 1880's, up until the 1950's, or actually up until the 1970's some Native American religions in the US were banned, they were outlawed. And where does the culture have it's sense of what's right and wrong behavior, it's in the culture and it's in the religion. And if the US federal government decided that they were going to ban Native American culture, Native American religion, well I think the

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chickens are coming home to roost in the night and what's happening right now because people are not. [Applause]

So I think that that means for all of our communities we need to embed, or HIV prevention with the revitalization of our cultural systems and our religious systems in order for them to be implemented in our communities, in order for communities to recognize themselves in the public health endeavors, and the medical endeavors. And in order for our traditional medicine and western medicine to finally be integrated so people don't have to choose between one and the other in order to be recognized as Native American in this culture. That's all I'll say. [Applause] Thank you.

**JOCELYN DORSEY:** As you can see our panelists are not going to be shy and the microphones will all be open and I've encouraged them to have a conversation rather than be polite, jump in when you have something to say. And I only direct questions initially to get things going.

We talked about a lot of issues, I think the biggest thing is to start with, what are the prevention barriers? And Dr. Stone I'd start with you on some of the prevention barriers and what you feel needs to be done to overcome some of those barriers.

**VALERIE STONE, M.D.:** Well, I spoke about it already. I think that Dr. Fulilove had a wonderful article several years ago called "The Elephant in the Room" that talked about stigma

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as the elephant in the room when it comes to African Americans in particular and HIV. Stigma is such a big deal that it causes many people to not want to get tested, but then in addition, once people do know they're HIV infected and they're doing their best to come to care, they also feel tremendously isolated. And despite our saying that people can live the same quality of life, if they are not able to successfully negotiate the stigma situation then they're not able to thrive and they're not able to benefit from their better medical condition.

So I think one of the greatest barriers we need to overcome is real structural and social work, almost sociologic work, particularly in the African American community on de-stigmatizing HIV. Making it a mainstream issue that belongs to all of us, that is not one that some people are blamed for and others are victims of. And I think once we are able to do that then we can have more open dialogues about people having safe sex, about protecting themselves, about seeing condom ads, things that people can do as behaviors once they think those behaviors are worth doing because it's not a negative thing to find out that they have HIV.

**JOCELYN DORSEY:** One thing I remember you saying, Dr. Diaz though, is it's not an individual. It's society that is creating this so it seems like it's going to be difficult to

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get rid of the stigma because, in truth, we have to look at ourselves as a society to do that. Wouldn't you think?

**RAFAEL DIAZ, PH.D.:** Well, I think that my main point is that all of our models of behavior change as soon that people are out there acting and deciding well should I do this, should I not, should I take a risk or not take a risk. Assuming that people's lives are enacted by creating tensions where there is for this kind of behavior, that kind of behavior and then enacting them.

But when you go and you study people that are at risk, and I'm going to speak a lot about Latino gay men which is a population I have studies, particularly immigrants and you see their conditions, you see their situations, the risk of course, you really see men trying to respond to the fact that they 15 of them have to live in one apartment because sometimes [inaudible] and not be paid with the salaries that some undocumented person can afford. And you see that these men have broken hearts or they have to leave their families, they have histories of sexual abuse, they're actually trying to participate in the gay community that really objectifies them and then leaves them out when it comes to participation in more integrated activities. So these men are actually reacting to a lot of situations where positions that are threats to their wellbeing, to their safety, to their sense of dignity, and therefore to when sex happens you should be, it is the time for

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an oasis. And they regard sex as it happens under the influence of substances because these men are using substances to create an oasis of relief and respite.

So to think that this man is deciding to act this way or that way and to change or to creating them some kind of cognitive apparatus to make decisions without making any attempts to change those for strength, for me it's misguided. So the issue, I have come to define operation as the narrowing of choice. And a situation is oppressive is that you cannot choose, so your just responding to whatever is needed. And I think HIV is not a poor, or HIV risk is not the poor choices it's actually a reflection of the lack of choices, and therefore our task is not just to increase the ability to choose, our task is to open the possibility for choice. And for me empowerment is the property of context that afford that kind of choice and that kind of determination. And then we can actually talk about what is needed to make choices but it's impossible with that kind of constraint to really focus our ability in changing an individuals choices or cognitive structures that this person can actually choose to invest. It is about, it is about defining risk not as the property of the individual, risk is the property of the situations that do not allow people to act according to their health choices.

**CYNTHIA GOMEZ:** If I can jump in here.

**JOCELYN DORSEY:** Please.

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**CYNTHIA GOMEZ:** You know I think our challenge is that HIV transmission is about sex and we're in a society where sex, for whatever reason, is something that people cannot talk about. Is something that is hidden and is judged upon. And there are other parts of the world where there is much more openness around sexuality and I think, I totally agree Rafael that it is that context that creates the underground reaction.

So if we can't talk about sex, if we cannot educate our children about sex, then there is no way for us to help an individual make decisions without struggling still with those voices in their head about the sex. If we didn't have those little voices there would be more room to think about I want to stay healthy, I want to be in a situation that I make choices that keep me healthy, but we really don't come from that place. We come from the place of I'm having sex, is it okay, is it not okay, am I a bad person because I'm having sex.

I mean, I think it's really at the core and in that sense I'll credit Freud that I really do think that sometimes while a cigar is a cigar, it is a lot about sex. [Laughter]

**JOCELYN DORSEY:** I see you nodding.

**MANHUI LEUNG:** I think in terms of expanding the options, it's also focusing on that what we don't want, or what we want to prevent, but also what we want to build, what protects us, what makes us feel good. So in terms of focusing on community organizing efforts, building identity, groups

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like, a lot of our organizing efforts, like Dr. Fulilove mentioned, since way back, it was a real solidarity movement and I think that really was a strong way to build a reaction against racism. It wasn't just fighting racism it was building community, it was building solidarity.

And I think in HIV we really need to really not just focus our research and our resources on fighting a virus, but really actually building community, building people to feel empowered, to feel affiliation with each other. And I think that's really key to the fight against HIV.

**ROBERT FULILOVE, ED.D.:** If I can add. I think it's absolutely critical that we not lose our focus on the degree to which HIV is about sex, but let's be clear as well that drug abuse also figures prominently. And in the '90s, the intersection between what people were doing sexually and what they were doing with sex in order to get drugs drove a lot of the epidemics in our respective communities.

I have been myself amazed at the capacity of other countries, I'm thinking particularly about the Netherlands, to have not only open discussions about sex, but open discussions about drug use that doesn't stigmatize you [applause], that often recognizes the degree to which it's much more complicated than a poor choice made by the individual and is often driven by a variety of factors that the individual has little control over.

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Thinking about this intersection, and thinking about how much the dialogue that we have in HIV seems to separate us into camps, exposure factors, risk groups, is one of the things that keeps us from creating the kind of solidarity that you just spoke of. And understanding how much we are all in this together I believe is one of the battles that we constantly face. Those of us in public health will, over the course of the last 20 years, really have been worried about how much of our work goes into silos, folk who do STD's, often don't talk to people who are dealing with HIV. Folk who do drug treatment often don't talk to the folk who are doing STD's and HIV.

It's not just that we have to organize our communities to become more conscious to the threat that we face, it's also that we have to think about organizing ourselves so that we can work in solidarity as we try to promote that solidarity in the communities that we're a part of. [Applause]

**JOCELYN DORSEY:** As we look towards solutions, what would you suggest be the first step for folks out here who are trying to build communities? Where do you begin?

**ROBERT FULILOVE, ED.D.:** I, it could just be that I'll be 64 next month and I'm sort of stuck, [laughter] you're all supposed to remark about how good I look. [Laughter]

**JOCELYN DORSEY:** You look good. [Laughter]

**ROBERT FULILOVE, ED.D.:** That I'm stuck by the more things change the more they stay the same. That so many of us

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are going back to our roots and human rights and civil rights that we really aren't talking about organizing. That scientists are saying what we need to do is organize our communities. That community organizing disk forces increasingly a part of what we're talking about I think is critical.

We have created over the course of the 25 years that we have been, 26 years that we have been fighting this epidemic, a notion that if we don't have the money from the feds or from the state, from the city to do this job the job won't get done. I think that's one of the reasons why we're very likely to face a future in which the numbers are going to spike terrifically and our colleagues who have pointed out we just don't have the resources to, Cynthia, Cynthia pointed out, we just don't have the resource to do that means that we can no longer look to the check, to the cash as being a way for us to become effective in this.

Part of this whole time with the civil rights movement is that it didn't get funded by the federal government. [Applause] I think we cannot lose site of the fact that we have the capacity and the power and the potential to do so much more. And I think having people start to look back at the history of mobilization, not just in this country but all over the world, it is one of the ways in which we're going to find

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some new directions and some new ways of thinking about HIV prevention.

**RAFAEL DIAZ, PH.D.:** I wanted to add that I, one of the things I really, that keeps me going is that I have seen so much strength. Strength in the mist of what, of the situations that I've been, now it's very oppressive. And I also have witness a lot of possibilities and I wanted to share some of those experiences.

For example, in one of my research projects I was asking a young Latino man what helps you protect yourself? And I remember this guy from New York at the moment, was saying I respect myself, he said. And I said, "Well, what do you mean by that?" As a good interviewer I said well what do you mean by I respect myself. And he said, I remember him looking kind of out there and said, "You know, I cannot just come to my mom and tell my mom, mom, I'm infected." And I would say oh my God, this man has replied to a question about self respect by saying I have a special relationship, I have someone who might matter too that really sustains my desire to live, my desire to protect.

And when I see the programs that really work in a particular example of this is that I have worked with in San Francisco with Latino gay men with black gay men. What I see is that this process for me that a sense of community, where you matter, we are family, what you say here, who you are, and

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that becomes that community is organizing is not just organizing that happens to agree, which does happen for housing and for better neighborhoods and for against violence, what it gives is a sense I do matter to other people which is basically the message that we humans need to live. That's what families are about correct. That we're not alone, that people matter to one another. [Applause] And that's the best message that the poor, that differentiates that disability that individuals get. You do not get, you do not matter, you do not matter and we actually get that to the very last fiber of ourselves and therefore are expected to act with this sense of strength which we don't have.

So prevention is to be, again, by bringing people together in a family, in a true family atmosphere, really giving them the real experience that they do matter, that they're worth. And that's where we need to begin. And that's actually happening in our communities. I'm not sure if our divvy's really allow for that experience to the extent that we need to because when I studied the programs that work, these are programs that have been long lived, these are not programs that men attend to, these are organizations belong to. That's very important fact that I have been studying prevention.

A prevention program that works is [inaudible] subjectively not as the program I attended to but that's a group of people I belong. And that I come in and out as needed

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and that I know it's there when I need it, I should stay. So a lot of prevention has that flavor of community organizing, you know that we have organized context, what I [inaudible] the sense of worthiness and support and where I can actually find the openness of respect and self-worth that I can begin to feel I can make choices rather than be in a desperate mode to try to survive, to try to feel good, to try to get a sense of wellbeing.

**CYNTHIA GOMEZ:** This is the complexity that we're talking about, which I think that it's, we're talking both about individual level change and social level change. And I think that we have to acknowledge that both of those need to be happening at the same time. Because it is, at the end of the day, an individual choice often, whether it be a choice or not I think is something that we can talk about, but it is an individual behavior that exposes people to HIV. And so is there a way for us to create the environment, which is what I think you're both saying, to create the environment through which an individual can in fact say I'm going to respect myself, I'm loved and I love myself, and therefore staying healthy is something that I want to do.

But you know, this will come naturally from any of us, to stay healthy. Preventative behavior, I'm sorry, of any kind is not our first choice. And until we can make, for example, condom use be a sexual enhancer so that the reason we're using

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condoms isn't because we want to prevent disease but because we want better sex, it probably is going to be a challenge. And I think that's where we need to head is sex is good, sex is pleasurable, finding ways to treat substance use in a way that is not punitive, that is not judgmental. But that social change and individual change cannot be unlinked, it's tempting, it's tempting to say we've done all the individual level change, we need to change our structural problems. And I agree with that 100-percent but I would feel that even if we change all of our structures, again, at the end of the day, somebody's in the bedroom having sex and they're making a decision. So I think if we can link those continuously it will improve our efforts.

**RAFAEL DIAZ, PH.D.:** Can I follow up with that for a moment? I just wanted to say that for me, we cannot see social individual change as separate. And actually that indeed the change that many of us want to see, which is people making choices that are healthier, are driven by social change and that's the point. That the way to really create the change that we need is by changing the social structures that prevent that change from happening.

So in a way, the more that I think about it and the older I get, I realize that this distinction between the social and the psychic, the cultural and the structural, they all are so intertwined but that it is really misguided to try to, well

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first of all it's really misguided to try to say when this all happens let's change this individual without really taking into account that this, what this individual is doing is of this, is determined in many ways by this kind of social context.

And what I have witnessed of social organizing events is the incredible changes in the individuals involved. So in a way I am, I'm advocating for community organizing precisely because that's a source of individual empowerment that you don't see in this kind of individual mediated models aimed at the individual. And I think that we need a language that integrates the psychological and the social and structural theories. We need more integrated models but the, it's basically, what needs to happen now because the emphasis has been on changing individual, it's really the realization that what individuals do is to [inaudible] on our social context. We can not understand individual actions outside of that context and we know that HIV prevention is hampered now by the social context we have just described, the publics are powerless.

**VALERIE STONE, M.D.:** Could I make a comment to change the focus to women a little bit. Because I acknowledge that much of the epidemic in communities of color is among men who have sex with men, and a smaller proportion is among drug users. And it seems so feasible to pull them together into a social network of people who know they have those behaviors,

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who know they're at risk, and begin to work together to develop community, family, and a common social change that may change behavior.

What I find is difficult regarding women who are at risk is that they don't perceive that they are at risk. Particularly in cities like Atlanta and other southern cities, many, many heterosexual women are getting infected who would never go to an HIV prevention program because they don't know that they should go to one. They don't know that they belong at one, they don't know that the next partner that they may have has HIV. What are our challenges in trying to structure programs to prevent those women from getting HIV when they aren't unified by an identifiable risk factor? [Applause]

**JOCELYN DORSEY:** That's a great question.

**DR. BONNIE DURAN:** I'd like to say, I'd like to weigh in on the issue of structural versus behavioral. And that's what we're talking about is HIV risk, HIV risk and HIV prevention, should we concentrate on the structural. I've heard Barack Obama said a few days ago, he said when the United States gets a cold people of color get pneumonia. [Laughter] That was, I thought that was so great and it's a great analogy for when times get hard we're having a particular bad economic times in the US right now, we have exposure to our young people going off to war, people of color are at disproportionately affected by that. Both by economic conditions and the social

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conditions and our lack of diplomacy and that is absolutely, and I love the way Dr. Diaz said that oppression means a lack of choices. So that oppression absolutely manifests in individual behavior, people not having a choice of, or not having the knowledge that they need.

For example, we just finished a study at the Navajo Nation where we looked at the knowledge attitudes and behavior of people who were incarcerated because we're having a little bit of an STD epidemic there and we were looking at the knowledge and attitudes of people in the jail system. And we found that less than half of the people realized what STD's that they were at risk, at increased risk for because they didn't understand the increased, the little bit of epidemic they were having out on the reservation.

So I think that even though we absolutely have to look at the pneumonia's, the social pneumonia that's happening in our communities of color, we do have a responsibility to make sure people have the right knowledge to make those individual choices. Because people of color were not, one thing that I know about Native communities is that we're really tired of being victims. We really want to use our agency and use our power both for structural change but also to educate our communities as well. So the two really go hand in hand.

I wanted to follow up maybe on the question of women.

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**JOCELYN DORSEY:** Good because I was going there.

[Laughter]

**CYNTHIA GOMEZ:** I've recently had the opportunity through the National AIDS Fund to work with many community organizations around the country, many of you are here funded through the National AIDS Fund on initiatives for women.

And I think what's critical is we've worked together in partnership with the community agencies as recognizing what will bring women in, number one, and number two, how do you overcome that sense of denial, if you will. I mean I don't think it ultimately is because in a recent study that I did of 600 women of color 95-percent of them knew that their casual partners probably were either having sex with other women or having sex with men, or using drugs. So they knew it, but only 30-percent of them were using condoms. So I think there is also sort of going beyond that knowledge sort of what then helps them decide they're going to actually protect themselves.

But going back to the agency experience, I think what we've been learning together is that until you create programs that deal with broader issues for women, we're not going to bring them into the agency. So important to really create a different way of doing it, either going out to them, I know folks here from Chicago who work in beauty salons, you go to where women are to try to provide them information, provide them with testing. But also it goes to the empowerment piece,

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I mean in a project that we did with a small organization in San Francisco, the women who were better able to improve their demand of condom use with their partners were the women who had been trained to advocate for themselves at city hall. Not the HIV workshop.

So I think it really goes back to it's about the empowerment of women. And what does that mean though, I think yesterday there was some very important points, education of women is really where it starts but also to feel that you can be empowered as a woman and demand a certain thing from your partner, which is not easy to do and will take a lot of resources and a lot of social support. The sense that you have a family in a community which many women do not feel that they have.

**JOCELYN DORSEY:** And I imagine that it gets even worse when in the Asian Pacific community.

**MANCHUI LEUNG:** Yes, I think also folks who know women, and we talked earlier about breaking of the silos, it's so important, especially with women, women of color, Asian Pacific Islander women to break out of the just HIV silo. I think there's a whole anti-violence movement, which really started from the feminist movement that really is addressing women's health, women's safety, women's empowerment, and there needs to be a way to bring those two together. Because I think the impact of violence on women's choices, talking about narrowing

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the choices around condom use, around access to testing, around immobility, I think the impact for violence on women really does structure their limited choices around HIV prevention.

And I think the other thing is also, it's not just the immediate personal, interpersonal violence, but it's the long term violence, whether it's in the community, violence outside, but it's also long term like the history of child abuse, child sexual abuse, really has an impact on somebody's choices in the present. And so we have to also think about HIV prevention in the long term, not just in this one moment of time. Really how it impacts in terms of distally and really up close, and so structurally and then individual, we're kind of going all around but I think it's important. I think we can't dismiss that, we can't, it's our communities that are really being impacted. It's our neighbors, our friends and we can't save the issue just, we can only focus on this one part or that's too big an issue, or I can't deal with racism, today is sexism. We deal with it all the time and I think that, also we need to name it more. We don't name, it's not being a woman, it's sexism that is the problem. We need to name it and own it as a community, own it as a society [applause] and we need to do things about it.

And I think there is things, it's not just a race, class and gender, its racism, classism, and sexism that really cause health disparities. It's not just because we're unlucky

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or if you get, I think we're all on the same page here around what really needs to be done to really change HIV prevention in this country. [Applause]

**CYNTHIA GOMEZ:** Can I ask you a question?

**JOCELYN DORSEY:** Yes.

**CYNTHIA GOMEZ:** Where does the media come in? Because we really need [laughter], yeah. We need help. We need help in making sure that after the erectile dysfunction commercial [laughter] we get to have the condom commercial. The stations will not allow condom manufacturers to purchase ad time, they're willing to give them the money but it put it on.

**JOCELYN DORSEY:** We have run, we have run public service announcements.

**CYNTHIA GOMEZ:** I'm not talking about public service announcements, I'm talking about condom commercials.

[Applause] And then this, I don't want to put you on the spot but I really think that we-

**JOCELYN DORSEY:** Not that's okay, you can put me on the spot.

**CYNTHIA GOMEZ:** - but I really think that we need, we need the help of the media because sex is out there continuously but we don't have the message about how to do it in a responsible, healthy way, in a way that it raises sexuality. [Applause]

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**JOCELYN DORSEY:** You know it's funny you ask me that because I was thinking of what the media's role is. And I'm not sure about the condom ads, I definitely will ask when I go back. I'm not in the sales department so, but generally television stations don't allow issue advertising at all. So that's an issue. But I thought about what partnering with drug companies that manufacture the products that people use and getting them to actually buy airtime to talk about prevention and to talk about treatment. I mean, that's what a lot of other organizations do, they go directly to the people who have the vested interest in it and they get the money from them to put this on prime time. I mean, the advertising council does it, in fact very powerful organizations like the Susan G. Koman Foundation for breast cancer does it, they go to Ford. They go to the people who would have vested interest, and that is one strategy that I think could be done fairly quickly and working with the television stations to really get that message out.

**CYNTHIA GOMEZ:** Well I'll appreciate you going back because Church and Dwight, who owns Trojan condoms, has tried over and over again to put the evolved campaign on prime time television, has tried to buy that commercial time, and they will not allow him to do it. So it's, and again, it's a product advertisement to really, again, try to match it with some of the erectile dysfunctions. So I think really, if you would be an advocate for us we'd appreciate it.

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**JOCELYN DORSEY:** Well the other thing that people don't realize is that not, I getting to this question of where is the outrage. Because if people are outraged enough it will get done. But the problem I see now is that we have lost the outrage and we have turned to apathy as far as HIV and AIDS, wouldn't you agree? And how do we create this outrage?

**ROBERT FULILOVE, ED.D.:** Well I think it's important to point out that this panel represents itself one of our most critical problems. I believe that one of the most fundamental aspects of human behavior is our capacity to see the world as us and them. Now that this has become a black and brown epidemic mainstream America is increasingly going to say that's your problem, that's not my problem, and lot of them have outrage but then have invisibility. [Applause]

It's sort of interesting that one of the most important books written in the 20<sup>th</sup> Century, voted as one of the important books in the 20<sup>th</sup> Century was the Invisible Man. I think we're about to have an invisible epidemic. It's going to unbelievably hijack the nature of healthcare expenses and cost in the United States, it's going to contribute to a whole host of social ills, but as long as its perceived as their problem, and as long as media treatment of it, for example, paints it as their problem it will provide people with a certain level of comfort. It's not my problem and therefore I don't have to do anything about it. So rather than outrage I worry about

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continuing to maintain a level of consciousness about how long we've had to endure the ravages of this epidemic so that it stays in the forefront of public opinion.

Cynthia talked very appropriately about the fact that products had a certain kind of a life cycle. Well so do public issues. Public policy issues typically last four, five years and then they are forgotten. Well we've been around for 26, 27 years now and we're still fighting to get people to understand that the all clear has not been sounded. Just because we do have effective anti-retroviral doesn't mean that the, doesn't mean that the battle is over now. And trying to make sure that folks maintain the notion that this is one of our number one priorities, HIV prevention has got to be at the very top of the list that our politicians, our leaders, our community organizations talk about and I think that's the real battle that we face.

I'd be happy with outrage but for the moment I would just like to have people continue to pay attention [inaudible].  
[Applause]

**RAFAEL DIAZ, PH.D.:** I think one of the things that we have to face about the history of the epidemic is that prevention at one point was basically born out of the outrage of community members that took on in responding to the epidemic in a way and actually the greatest reductions of HIV risk, and increases of safer sex happened at the beginning when

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prevention was a community response to AIDS. And as we became, as prevention became a professional endeavor that we, with disguise of [inaudible], with disguise of education, do to the others who are at risk to that point actually, the exhaustion, the separation of the [inaudible] happened.

So one of the issues that we need to face is actually the fact that we need to put prevention back in the hands of the community, not the professional thing to do. And actually [applause] what I'm very worried, and actually I'm sitting here in the city where the CDC is and I'm very grateful for the enormous work that the CDC does and I believe that there's divvy initiative is a very well founded but there's some very, very strong problems with that. One of them is for example that because we now want to implement this top model, kind of top down kinds of interventions, the creativity of community organizers workers are these, I used to see the young men that were recruited in the community based organizations that were created that were screened, not it's about fidelity to a protocol. [Laughter] The connectivity that has been shifted away and actually people that are the true outreach ones get fired because they're not producing the [applause] fidelity to the protocols that are effort. So the [inaudible], and not to mention that now evidence is what comes from randomized control trials. How many community organizations can conduct this randomized control trials, so it basically silenced the

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knowledge and expertise and not wanting to consider why a lot of communities are doing as true evidence that can impact the larger picture.

So we have [applause], we have to see that there is actually, I don't want to use the word but I will that a conspiracy against outrage out there. We actually have a whole system of professionalized prevention that really without the outrage workers, that are the ones that we need now in the epidemic. So we need to actually, and that is because our fundings are tied to government fundings and that's because science has an over-privilege, versus a community knowledge. So there's a lot of systemic problems that really reduces the outrage and creates HIV prevention as a bureaucratic endeavor. And that's what I'm outraged about because I think [laughter], I think we need to actually be very critical and respectfully so but we need to come to, bring the CDC and the federal governments and the funders to task about do not silence the communities in the name of science. [Applause] Okay, they need to be out there.

**VALERIE STONE, M.D.:** I agree that the main stream is very quite about the issue. But I also don't every underestimate the power and resiliency in our communities, especially in communities of color. And we are always outraged, I think we aren't seen as outraged, but we are always outraged. And I also feel that we also need to expand what, if

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we're looking at structural issues, we have to expand in a HIV field to look at what is really helping our, in the fight against HIV.

So when I saw hundreds of thousands of immigrants marching against anti-immigrant policies, that's really helping our movement. And these are undocumented people who really took a chance, a risk to be out on the streets, to say that those things can't be done to them. When women march for reproductive rights in Washington, that helps the HIV movement. I think at the same time we want people to focus on our movement around HIV, there needs to also be recognition that there's every movements that are really building to strengthen power but also they are outraged as well.

And I think I'd never underestimate the power of our community to really fight back and then fight back in different ways to. Sometimes in smaller quieter ways, but a lot of times out on the street in the public, in the cultural consciousness, in the media, I think that needs to be recognized and valued in our communities but also in the government and also been as a legitimate source of resistance.

**DR. BONNIE DURAN:** I'd like to put a plug in for science. [Laughter] There is a recent series of articles published about the relationship between unfairness and Medabout [sounds like] Syndrome. So I think that our field, public health and our science has a place to do to look at

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social inequities in our absolute direct impact on our bodies. I mean our health inequities are manifest in our bodies, that's how health disparities and the unequal distribution of HIV and heart disease and cancers, I mean, its manifested, inequalities are manifested in our body and there's a way for our science to get at that. And I think, Bob said earlier, people just, NIH and other places, just don't want to fund that kind of research. And I think that's another place where advocacy needs to get at is realizing that NIH, we need to pressure them to do more research on social inequities, on the impact of violence on HIV risk and risk of all other chronic diseases. That absolutely needs to happen. And so let's not totally give up on science, there's something there to be learned.

One other point is that the other thing about public health is that we know that our policies and our public policy is absolutely just not based on evidence, but it's also based on constituency building. And in public health that's why all of the people doing the HIV advocacy work and all of the advocacy work are crucial to the field of public health. And you know that's what we need to be training our masters and doctoral level people to do too is figuring out how to increase advocacy and get that public health constituency for the health of disadvantaged people.

**MANCHUI LEUNG:** And I want to add also that researchers need to be advocates, our doctors need to be advocates. All

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the professionals in our community need to be advocates as well, it's not just [applause] leaving it up to the people in the community, we all need to really step up and be stronger advocates for the issue in our communities.

**RAFAEL DIAZ, PH.D.:** I just wanted to say that, I don't want to make all this to be interpreted as putting down science, but I think maybe putting down is actually interesting, putting down what, getting them at the table, getting, getting us and the scientists and I think that it is about, that I remember actually that when I was learning to be a scientist a basic thing was that the scientific experience is a spirit of humility. You go into problems not knowing what the outcome it is, but we have turned now science to be the dictate, if it's not this then it cannot be done. And actually we need to, science needs to be gunned out that not only with internal validity but with ecological validity. That what we do can be replicated, that the work that we do can be accepted and feasible, it has to be in dialogue art. And I think we need more of this idealiphic spirit but not this powerful science that basically silence people because when we start throwing out our statistics and our, this on ideas and so on, it silences a lot of people at the table.

So it is about returning to the true spirit of science, which is we need to, we know that in many ways we have succeeded, we know many ways we have failed, we know what are

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the issues and work together in an open, but open mindedness is not really what is correct, the reason that most of the scientists are dictating, this on the contrary side very forced models. So it's about reclaiming science as one of our greatest tools but ours referring the communities that need to have prevention in health.

**CYNTHIA GOMEZ:** And speaking of spirit though, I want to go back to Bob's mention of the civil rights movement because it's also about our religious leaders and that the leadership [applause] in this country of our religious leaders. We have to, we are the people that are in church, we should have a say with our church leaders about the type of advocacy and promotion of health that exists in our churches. We are spiritual people, in case people didn't know that about those of us doing HIV work, we are spiritual people [applause], we're religious people and we cannot do this without linking all of these different parts of our society and religion is a very, very important part. I mean, I can still remember in developing intervention where we wanted to assess the roles of spirituality in people's lives and people said to me, "Oh, we don't want to ask about that, we're talking about sexual behaviors, we don't want to ask about that." I was like how can we not ask about that? It's our soul, [applause] it's our soul.

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And so again, I think that it's also a real request to have our religious leaders take the risk, you won't lose your constituents, take the risk and do the right thing. [Applause]

**VALERIE STONE, M.D.:** I was just going to add, I do think there is a role for some of the new scientific technical prevention methods that we have and I have patients and partners who need them. So, for example, one of the largest places we can do prevention is prevention with positives. And of our patients who, people who know they're living with HIV many cases have partners who are not adequately protecting themselves and are knowingly getting exposed to HIV by their own choice, if those are women, the women don't want to force the men sometimes to use condoms but if they have microbicides that were effective, if they had pre-exposure prophylaxis medications that they knew worked, these things could really make a difference in having that whole cope work of partners of people living with HIV be much safer.

So I really would encourage our microbicide research to move forward despite the failures we've had [applause] in the current year, and our research on how well pre-exposure prophylaxis works, what are the downsides of it, what are the toxicities, but these are important technologies that I think do need to be further researched and brought to the community.

**RAFAEL DIAZ, PH.D.:** I just wanted to say that this afternoon at around 6:00 I think we're going to have, or 5:00,

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I don't remember, is a panel that is going to be organized by the San Francisco AIDS Foundation on, talking about the notion of evidence and what does it mean. And you are inviting people, I think there's a flyer in your packages, and these issues about scientific evidence vies a vie the prevention realities are going to be discussed. So I wanted you to know about it.

**JOCELYN DORSEY:** Great. We were talking about invisible populations and I do not want to ignore the prison population. I think we need to talk about that [applause] because it's my understanding that the, probably the largest group of prisoners will be coming our very soon. Almost like the baby boomer generation, they're going to be coming back into the community. What is, what do you see is the impact of that layered with HIV and AIDS, treatment barriers or any other thing that you might want to talk about with regard to that population.

**ROBERT FULILOVE, ED.D.:** Well I'm very impressed with the statistic that has been cited increasingly over the course of the last year and a half or so that's states that one out of every three black men in the United States is going to do time in prison at some point in his life. That's not an invisible population, a third of our community constitutes an incredible burden in any number of ways, especially since the experience of jail or prison is often one which people go in ill and come

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out even sicker than they were when they went in. Linking, for example, those who are HIV positive and being treated in prison through services that are available in the community, I think it's going to be absolutely critical. The large numbers of ex-prisoners who go on forced drug holidays because they can't connect immediately to service means that we're going to start to see some variance of the virus created, not because people haven't been adherent, but because they are in a system that simply cannot meet their needs.

At a time when the dollar is getting smaller and smaller in terms of it's worth, when it's not buying as much and when we're seeing, as you pointed out, maybe as many as 600,000 people a year being released into the community that we have not made adequate provisions to really see how, and HIV prevention agenda, this is going to impact. I'm talking about issues that Dr. Stone talked about with respect to women, I think this is probably one of the most pressing issues of the day and I'm very impressed with how many of us here on the panel are now including working with inmates and ex-inmates as part of what we're doing because increasingly that's the face of the epidemic.

**DR. BONNIE DURAN:** I just want to point out that even though federal prisoners get really bad healthcare, I think the per capita expenditure for federal prisoners are for prisoners is like 38 or 40 thousand dollars a year, per capita. Indian

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health services is less than half that. The federal expenditures for American Indian for healthcare under Indian Health Service is half of what it is for federal prisoners, just need to go on record to say that. And the issue of resources is huge and is fundamental to all of our communities.

**ROBERT FULILOVE, ED.D.:** And I think one of the greatest ironies of all, as was pointed out by groups of researchers who described the phenomena of the million dollar block. A million dollar block is a block in a poor neighborhood that has so many inmates living there that the cost of keeping these men and women incarcerated is in excess of a million dollars. Recent story in the Times talked about one in Texas where I think it's about 11 million dollars is being spent on one block just to keep the men and women in that community locked up. One of the poorest neighborhoods in the city yet an enormous amount of money is being spent to keep open out of the city. And the question to all of us is what would happen to our work if those dollars were available to us to provide healthcare and to fund the HIV prevention [applause] that we're talking about today.

I think it's one of the greatest tragedies that we face and it's one of the reasons why I like you're question about outrage because if there's ever a reason for outrage it has to be the imbalances that are created socially by having our

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dollars go for something that is basically ruining our communities. [Applause]

**JOCELYN DORSEY:** I hate to tell you this but we are within a minute thirty of wrapping up this wonderful session. I would like for you to go ahead and make some-

**MANCHUI LEUNG:** I just want to say that our communities deserve the best quality prevention and the best quality care out there. There's no excuse for anything less. And I think that the need for cultural and linguistic competency, especially in a community like the Asian Pacific Islander community where there's so many different cultures and you just can't interchange, so many languages, I think that's so important to get the message across. But cultural linguistic services isn't, should not be an afterthought. It's central part of quality prevention and essential part of quality care. I think we really need to reshape how we see care in our communities and the kind of funding that we get for our communities and not just sort of accept small pieces but really demand the best that we deserve because in our, you're right, in our bodies we are really living the levels of oppression that are really coming on us.

**CYNTHIA GOMEZ:** If I could just add one more thing is, and then let's not replicate the segregation among ourselves. We really need to work together. [Applause] We really need to

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work together. The us and them should not happen in here,  
we're really, really trying to do this together.

**JOCELYN DORSEY:** Thank you so much. Any final  
comments? I certainly appreciate Dr. Fulilove, Dr. Stone, Dr.  
Diaz, and Dr. Gomez, Ms. Leung and Dr. Duran. Thank you so  
much, I hope you all [applause]-

[END RECORDING]