HIV and AIDS
Revision of a Professional Policy Statement
SECOND ROUND POLICY PANEL REVISION

BACKGROUND

HIV and AIDS are serious global public health concerns with biological social and economic ramifications. Throughout the world HIV and AIDS disproportionately impacts marginalized and disempowered populations throughout the world. Today one in three people infected with HIV do not know they are living with HIV or AIDS (AAWH 2001b). The key areas of concern are prevention, testing, treatment, and the impact of HIV on individuals, families and communities.

In the United States HIV and AIDS prevention and treatment services available today are the result of significant biomedical and social advocacy efforts by many groups over a long period of time (Wheeler 2007). However, effectiveness of some prevention programs has been hindered by racism, sexism, heterosexism, and homophobia (Ferrales 2003).

Limited government response resulted in the establishment of many community-based AIDS service organizations (ASO), and many are still in existence today. The design of AIDS prevention strategies largely occurred on a small scale due to limited funding options. Not only has there been a failure to develop effective programs, there
has been a governmental and societal hindrance to the development of effective
programs, such as needle exchange programs or sex education for young adults.

**Testing**

Testing is an important component of HIV prevention. Research has shown that people
who are aware of being HIV-infected may be more likely to take steps to prevent
transmitting the virus to others. In addition when a positive test result is obtained,
appropriate medical treatment can be initiated to slow the disease process (Zúñiga, M.A.,
et al, 2007). The availability of testing on an anonymous or confidential basis is thought
to maximize the number of people who choose to get tested. To protect confidentiality of
HIV status, all states apply confidentiality laws to HIV test results. Throughout the
pandemic, there have been many struggles over federal and state policies on imposing
mandatory testing or mandatory reporting of test results for certain populations, including
prisoners, pregnant women, and child care workers. In addition, a number of states have
criminalized the potential transmission of HIV through sex, needle sharing, breast-
feeding, or organ donation by a person who is HIV-positive or diagnosed with AIDS
(American Civil Liberties Union, 2000). Unlike HIV serostatus, all diagnoses of AIDS
must be reported to state public health departments.

The Center for Disease Control (CDC) Revised Recommendations for HIV
Testing in Health Care Settings recommends that HIV testing be voluntary and
recommended for patients in all health care settings after the patient is notified that
testing will be performed unless the patient declines (or “opts-out” of screening) (CDC
This recommendation replaces the practice of “informed, written consent.” These recommendations notwithstanding, many people obtain HIV tests without pre- or post-test counseling, especially when they test in a physician’s office or at the client’s home.

**Treatment**

The emergence of antiretroviral therapies (ART), and increased access through private insurance, Medicare, and AIDS Drug Assistance Programs (ADAPs), has resulted in a positive, dramatic change for many people living with HIV/AIDS (PLWH/As). For many, living with HIV or AIDS has transitioned to living with a lifelong, chronic illness, often with a renewed sense of hope and challenges (Tomaszewski, 2001). For others, however, the complexities of a strict medication regimen cannot be sustained over extended periods of time, because adherence is not as simple as taking medications. An increasing number of people living with AIDS are unable to tolerate the toxicity and severe side effects that are common with the medications (ART and prophylaxis treatments); others experience unexpected and unexplained health deterioration, or the drugs simply “fail the patient.”

Economic issues continue to affect access to care. Few people can afford the drugs unless they are enrolled in a private health insurance plan with prescription drug benefits or state-administered Medicaid or ADAPs for those who are underinsured and uninsured. Although ADAP funding is available nationwide, some state ADAP programs limit coverage of certain medications, resulting in access and adherence problems, or have waitlisted or capped enrollment (NASTAD, 2007).

**Impact of HIV/AIDS on Individuals, Families and Communities**
HIV/AIDS can have devastating consequences on affected individuals and members of their families and support systems. HIV and AIDS are highly stigmatized conditions (Fullilove & Fullilove, 1999), and people living with HIV/AIDS are likely to experience stigmatization and discrimination related to it (Diaz & Ayala, 2001) in areas such as education, employment, housing, insurance, and health care. Although the federal Americans with Disabilities Act of 1990 (P.L. 101-336) has provided legal protection for such people, its scope has been reduced by subsequent court rulings. In addition, state laws regarding HIV/AIDS discrimination vary considerably, with some states allowing certain forms of discrimination (Gostin, Feldblum, & Webber, 1999). In too many cases PLWH/As continue to be denied basic civil and human rights. They may face discrimination in employment, military service, housing, child care, access to health care services, and social and community support programs.

**ISSUE STATEMENT**

Social workers increasingly encounter HIV/AIDS, either directly or indirectly, regardless of their area of practice, geographic location, or practice setting. Because of its ecological perspective and commitment to social justice, social work is particularly well suited for addressing the complex problems associated with the epidemic, including those experienced by PLWH/As, their friends, and their families. Globally, HIV/AIDS continues to have catastrophic impact on communities, particularly resource poor countries where people cannot afford medications or access treatments.
Heterosexism and homophobia contribute to the spread of HIV in other populations as well. For example, HIV prevention and care programs for gay men that include explicit sexual information or language continue to be threatened periodically with loss of federal funding (Erickson, 2001). Also, the increase in HIV infection among African American men who have sex with men (MSM) may be due in part to these attitudes among African American communities and the continuing belief that AIDS is a “gay disease” (Fullilove & Fullilove, 1999). In addition, women may often contract HIV because their male sexual partners cannot admit that they also engage in high-risk sex with other men.

Racism contributes to the spread of HIV. For example, MSM of color might not benefit from prevention resources distributed within predominantly white gay and lesbian communities because of actual and perceived racism within them (Diaz & Ayala, 2001). Also, many of the strategies that have effectively prevented spread in the white gay community are not effective among men of color because these programs lack in cultural context. In addition, racism is an important link to disempowerment and the lack of financial and other resources among communities of color, which prevents such communities from responding to the epidemic as effectively as the predominantly white gay community. Sexism contributes to the spread of HIV. For many years, virtually no attention was given to women’s risks or needs with respect to prevention or treatment of HIV/AIDS. Consequently, knowledge about the specific ways in which HIV affected women, and the best ways to treat it, lagged far behind such knowledge in relation to men. Women may not feel empowered in relationships to insist that their sexual partners
use condoms, or may use sexual practices (such as anal sex) in efforts to prevent pregnancy but are considered high-risk for HIV transmission. Also, women who are impoverished are more likely to prioritize daily survival issues over safer sex (Kline, Kline, & Oken, 1992). Educational, occupational, and economic discrimination may lead some women into high-risk sex work and IV drug use. Finally, the lack of funding for female-specific microbicides is rooted in the historical lack of recognition for women’s sexuality, reproductive health of women and girls, and the right to control one’s body. Discrimination against transgender people may lead to at-risk behaviors that increase risk for HIV and other STDs. Factors such as mental health concerns, physical abuse, social isolation, economic marginalization, and unmet transgender-specific healthcare needs can potentially lead to increased HIV risk. (Herbst, J., Jacobs, E., et.al 2008). In addition, the inability to obtain or pay for hormone therapy drives some transgender people to seek hormones illegally and to inject them with shared needles (Clements-Nolle, Marx, Guzman, & Katz, 2001).

Discrimination towards people who use street drugs also contributes to the spread of HIV. Federal policy continues to oppose clean needle exchanges (National Minority AIDS Council, 2002). Although research shows that needle exchange programs can reduce the transmission of HIV, federal policies and laws in many states and localities prevent the access of IV drug users to sterile syringes (Vertefeuille et al., 2000).

Prevention efforts continue to be under funded and excessively influenced by moralistic politics instead of empirical research. Limitations created by federal and state
policies, and funding levels and regulations, hamper the efforts of community-based organizations to reduce HIV/AIDS incidence in populations at high risk.

The CDC Revised Recommendations for HIV Testing in Health Care Settings (CDC 2006) recommends that HIV testing be voluntary and recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening). These recommendations remove the requirement for pretest and posttest counseling, a critical step in helping individuals prepare for a positive test result and providing the context for exploring behavioral risk regardless of test results. HIV antibody testing also provides an important opportunity for health professionals to elicit important information about partners of the person testing. Such information can be used to help patients communicate to partners their risk for HIV infection. Partner notification laws, however, limit the confidentiality of testing results in some states.

HIV testing and counseling are important components of a comprehensive public health approach to reducing the devastation of HIV and AIDS, however, services for infected persons, and treatments for co morbidities (e.g., other sexually transmitted diseases, and substance abuse) must be available to persons after they receive their HIV testing results.

The advent of HAART has greatly changed the quality of life for many people living with HIV/AIDS. Yet there is evidence that the effectiveness of HIV medications
may cause some people to believe that HIV is no longer a threat, leading to an increase in risky sexual or drug-taking behaviors (Halkitis & Wilton, 1999). In addition to the high cost of medications, other medical care for people living with HIV/AIDS is exorbitant and unevenly available. Coverage for emergency room visits, hospital stays, diagnostic tests, physicians’ fees, and nursing care may be inadequate for many people. Those enrolled in public health plans are unlikely to be able to obtain the same quality of care available to those with private insurance. The quality of HIV/AIDS-related medical care may depend on where people are living, given that specialized HIV/AIDS services are not universally available, especially in rural areas.

**POLICY STATEMENT**

Across fields of practice, social workers provide services to HIV-positive clients, their families, and clients who are at risk of becoming infected with HIV. Given the high incidence of HIV/AIDS, and the rapid spread of the pandemic over the last two decades, the social work profession should take an active stand to mitigate the overwhelming psychological and social effects, including the inequality of access to health and mental health care and the lack of education and prevention in the United States and internationally.

**NASW supports:**

**Prevention and Education**

- Professional cooperation with existing HIV and AIDS educational, treatment, and research organizations to develop and implement programs that include
educational and prevention strategies that meet the needs of all segments of our society.

- Prevention programs designed and implemented to ensure they are tailored to the specific needs and risks of diverse populations. Programs must be culturally appropriate, taking into account the language, culture, ethnicity, sexual orientation, gender and gender identity, religion, and age of the target population.

- The implementation of prevention strategies that focuses on harm reduction.

- Evidence-based prevention efforts that target children and adolescents in both public and private school systems and comprehensive sexuality education programs for youths and adults.

- The establishment of both publicly and privately funded needle exchange programs and efforts to increase the quantity and quality of drug abuse treatment, in order to reduce HIV incidence among IV drug users.

**SW Education**

- The education of all social workers so they are knowledgeable about behavioral strategies to prevent the transmission of HIV, including safer sex and harm reduction. Use of assessment tools that assess all clients for HIV risk, and they should educate clients about ways to reduce their risk.

- Social workers take responsibility to continuously update their knowledge about all aspects of HIV disease, including new prevention strategies, treatment models, medication regimens, and policies.

- Social work education programs should include curricula that examine the ramifications of HIV/AIDS from the perspective of the profession’s core values.
Content should cover the range of health and mental health issues of PLWH/As and their families, support systems, and communities and interventions at all levels of practice.

Testing

**NASW supports:**

- The education of all practitioners about both the availability and the accessibility aspects of HIV antibody testing and referrals related to living with HIV and AIDS.
- Voluntary and confidential testing which is available on an anonymous basis, and includes prior informed consent,
- Pre- and post-test counseling programs, provided by trained caregivers,
- Rapid testing conducted only by people trained and certified to do so, and implemented only when consent is granted by the client or patient.
- Access to competent professional counseling by phone for people using home-testing kits at no additional charge, and referral to a formal HIV testing site.
- Informed consent of pregnant and birthing mothers prior to mandatory HIV testing of themselves and their newborn child or children.
- Prior consent for release of clients’ test results Social workers with HIV-positive clients who have not informed sexual or needle-sharing partners about their sero status should use their clinical skills to encourage them to do so.

Service Delivery, Care and Treatment
NASW supports:

1. The right of people living with HIV/AIDS to the highest quality care including those confined in correctional institutions.

2. A comprehensive services delivery system based on a quality case management model that includes access to suitable and affordable housing, mental and health care services, adult and child foster care, home health care, nursing home care, legal services, and transportation.

3. Comprehensive bio-psychosocial spiritual support for people with HIV/AIDS and those affected should be readily available. Service programs that are culturally competent, linguistically appropriate, and client and patient centered.

- 4. Elimination of the inequities or obstacles in access to medication, clinical trials, and HIV care specialists; or services that ensure psychological, social, cultural, and economic wellbeing.

5. Policies that facilitate access to affordable pharmaceuticals worldwide. Clients should have sufficient supports to help them maintain difficult medication regimens.

6. The right to confidentiality relating to HIV/AIDS status. Clients should be informed of the limits of confidentiality, including the existence of partner notification and record keeping. Social workers should be familiar with applicable state laws, regulations, and federal guidelines.

Political Action and Advocacy

NASW supports:
Continued public and private funding and advocacy for health and mental health care provider programs that address HIV/AIDS and related health and mental health issues, including as well as state, local, national, and international HIV/AIDS prevention and treatment programs.

- Domestic and international initiatives that address structural factors such as poverty, community disinvestment, and interpersonal violence to curtail the HIV/AIDS epidemic.

- Leadership in advocacy efforts at the local, state, and federal levels to improve the quality of life of all PLWH/As and to protect their civil liberties, including maximum access to confidential testing, diagnosis, and treatment.

- Advocacy for adequate funding of research on all aspects of HIV/AIDS, including prevention, clinical interventions, and vaccine development.

**Research**

NASW supports:

- Research, including epidemiological, clinical, and comprehensive, biopsychosocial-spiritual studies, funded at appropriate levels by the federal government.

- Research protocols that address the unique biomedical needs of women, children and adolescents, and the psycho-social-spiritual needs of all people affected by HIV/AIDS.

- Funding for research in order to accurately assess the effectiveness of primary and secondary prevention and educational strategies, service delivery models, and the impact of related policies. Research protocols must include the bio-psycho-social-
spiritual issues of people living with and affected by HIV/AIDS, and the unique needs of women, children and adolescents, and the needs of all people affected by HIV/AIDS.

REFERENCES


States: A Systematic Review. Retrieved on June 30, 2008 from


