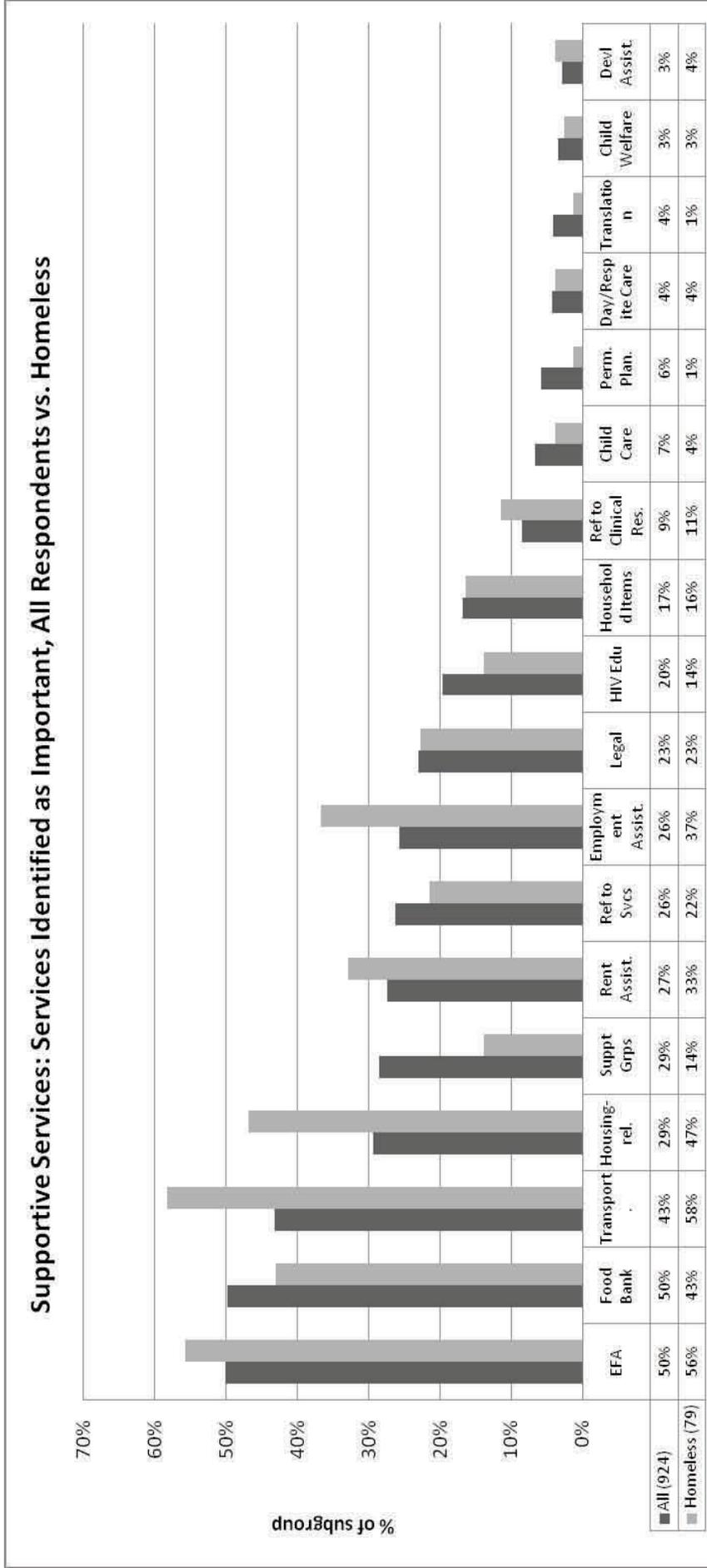


Homeless

Access to Supportive Services

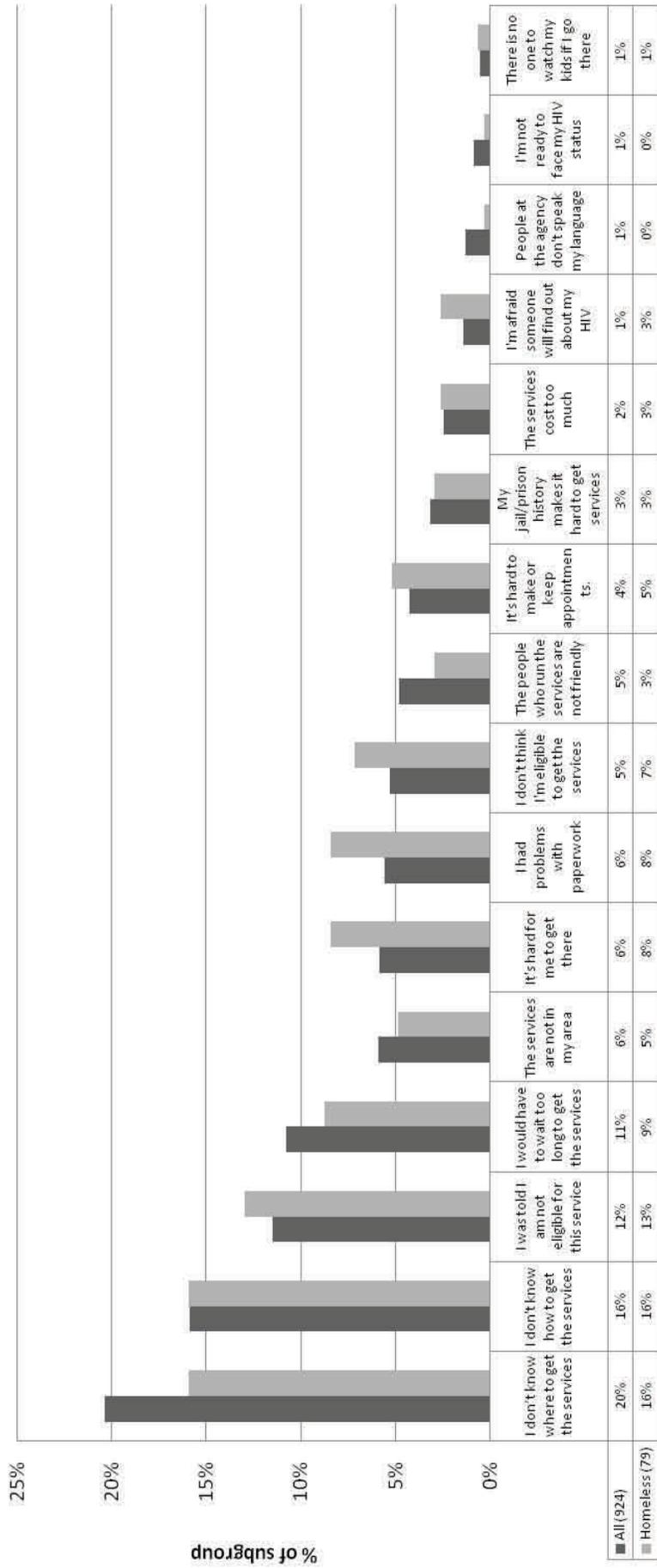


The chart above shows the supportive services reported as useful or helpful by Homeless respondents compared to the overall sample of 924 respondents.

- Compared to the overall sample, this subgroup was more likely to report emergency financial assistance, transportation, housing-related services, rental assistance, employment assistance and referral to clinical research as important supportive services.

Barriers to Supportive Services

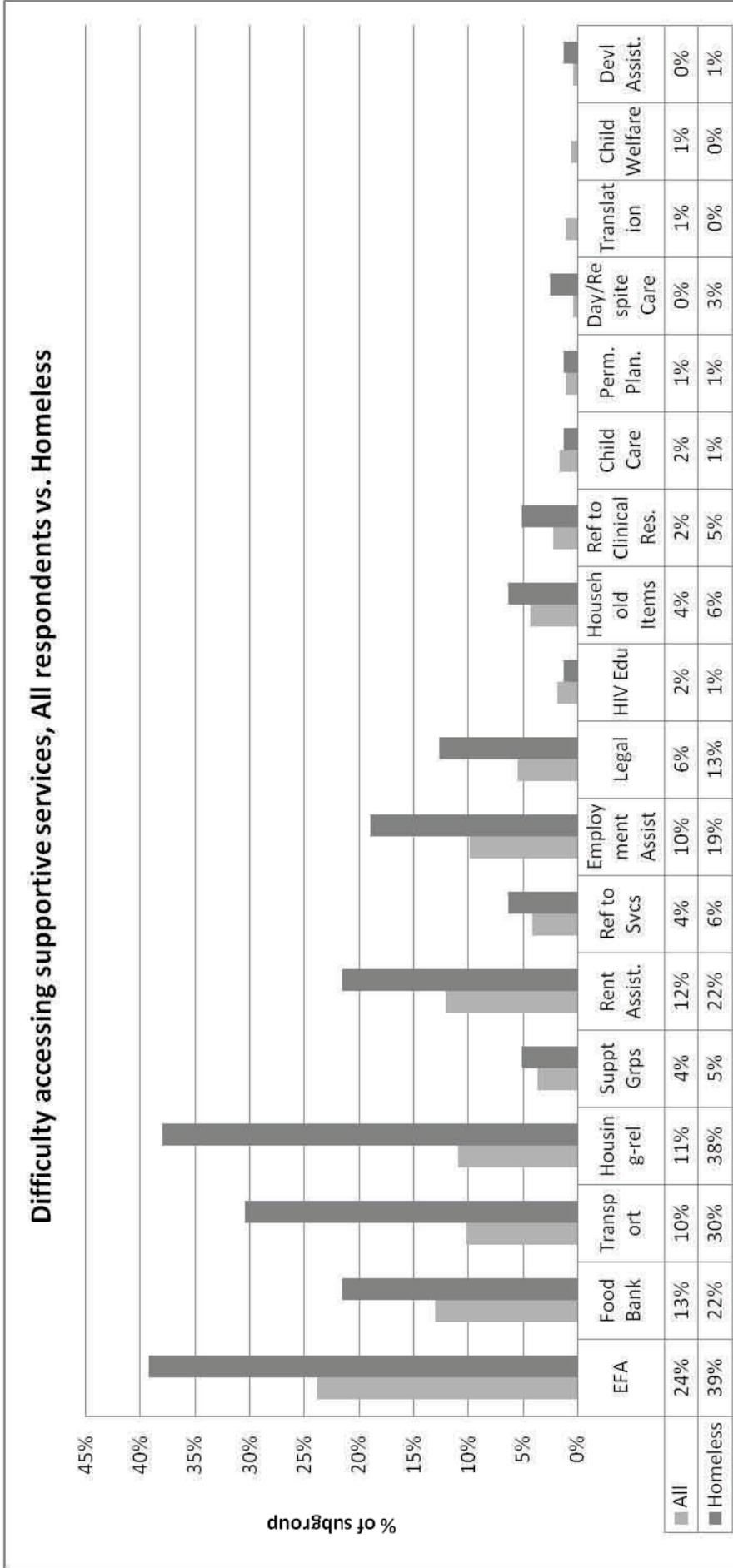
Supportive Services: Overall Reported Barriers, Homeless



The chart above shows the proportion of barriers reported by Homeless respondents compared to the overall sample of 924 respondents.

- Compared to the overall sample, this subgroup was more likely to report being ineligible for services, difficulty getting to services, having problems with paperwork, being unsure about eligibility, difficulty making or keeping appointments and fearing HIV disclosure as barriers to supportive services.

Difficulty Accessing Supportive Services



The chart above shows the proportion of Homeless respondents that experienced difficulties accessing each supportive service, compared to the overall sample of respondents.

- Similar to the overall sample of respondents, this subgroup had the most difficulties accessing emergency financial assistance.
- In addition to emergency financial assistance, other difficult to access services were transportation and housing-related services.

Homeless

A point-in-time (PIT) count of homeless persons is conducted annually in most major cities and towns across the country.¹ The purpose of the count is to approximate the number of homeless individuals in a defined geographic area according to the Department of Housing and Urban Development (HUD) definition of homelessness, which is: persons staying in emergency shelter, transitional housing, or safe haven with beds dedicated for homeless persons; plus those persons who are unsheltered (i.e., staying in a place not meant for human habitation).¹ Commonly referred to as a homeless enumeration, the last PIT count for the Houston Area took place in January 2012 in Harris and Fort Bend Counties.¹

According to the Harris and Fort Bend Counties PIT count, there were 7,356 homeless individuals in Harris and Fort Bend Counties in 2012.¹ This calculates into 0.16% of the total population of the two counties, or 1 out of every 636 residents, being homeless in 2012.¹ The number of homeless persons in the two counties decreased from 2011 by 13.8% or 1,182 fewer homeless individuals according to the HUD definition.¹

Of those currently homeless in Harris and Fort Bend Counties, it is estimated that 1 out of every 12, or 8.9%, has been diagnosed with HIV.² In addition, 1.6% of homeless persons report that they were triggered into homelessness by an HIV diagnosis.²

(Table 1) In 2011, 476 persons who received HIV care through the Ryan White HIV/AIDS Program in the Houston EMA were indicated as homeless. Of these, 75.0% were male, 23.7% were female, and 1.3% was transgender. In addition, 15.3% were White, 55.7% were African American, and 27.3% were Hispanic/Latino. About two-thirds (66.4%) were age 35 and older, and one-third (33.6%) was under age 35; 7.4% were age 13 to 24. About one quarter (25.2%) indicated male-to-male sexual activity (MSM), 33.4% indicated heterosexual contact, and 33.6% reported no known risk or other risk.

Compared to the proportions of all persons in HIV care in the Houston EMA in 2011, homeless persons who are in care are more male (+2.0%), more African American and Hispanic/Latino (+6.2% and +5.1%, respectively), and younger (+10.5% more persons under age 35) than in the general in care population in the EMA. Due to differences in data calculation methodology, reported risk cannot be compared.

¹Houston/Harris County/Fort Bend County Point-in-Time Enumeration 2012 Executive Summary. Prepared by Catherine Troisi, Ph.D., Enumerator, and the Coalition for the Homeless of Houston/Harris County, May 2012

²Troisi, CL, et al., Perceived Needs of Homeless Persons in Houston/Harris County. Prepared for the Coalition for the Homeless of Houston/Harris County, 2012

HOMELESS TABLE 1-Persons Receiving HIV Care in the Houston EMA by Sex, Race/Ethnicity, Age, Risk, and Homeless Status, 2011				
		Homeless Persons in the Ryan White HIV/AIDS Program ^a		All Persons in HIV Care ^b
		Cases	%	%
Total		476	100.0%	100.0%
Sex				
	Male	357	75.0%	73.0%
	Female	113	23.7%	27.0%
	Transgender	6	1.3%	^c
Race/Ethnicity				
	White	73	15.3%	26.4%
	Black/African American	265	55.7%	49.5%
	Hispanic/Latino	130	27.3%	22.2%
	Other/Multiple Races	8	1.7%	2.0%
Age				
	0 - 12	0	0.0%	0.4%
	13 - 24	35	7.4%	5.2%
	25 - 34	125	26.3%	17.5%
	35 - 44	147	30.9%	27.6%
	45 - 54	122	25.6%	32.2%
	55+	47	9.9%	17.1%
Risk Category^d				
	Male-to-male sexual activity (MSM)	120	25.2%	52.1%
	Injection drug use (IDU)	24	5.0%	10.6%
	Heterosexual contact	159	33.4%	30.9%
	Other/unknown	173	36.3%	6.5%

^aSource: Harris County Public Health Services, Ryan White Grant Administration. Centralized Patient Care Data Management System (CPCDMS) Reporting Period: January 1, 2011 - December 31, 2011

^bSource: Texas Department of State Health Services, Number & Proportion of PLWHA with Unmet Need for Medical Care by EMA/TGA, 2011. Released 8/17/12. Data reflect persons in HIV care not limited to the Ryan White HIV/AIDS Program.

^cTransgender is not collected for the denominator of all persons in HIV care in the Houston EMA

^dCases with unknown risk have been redistributed for the denominator of all persons in HIV care only

IN FOCUS

A Quarterly Research Review of the National HCH Council

December 2012

HIV/AIDS among Persons Experiencing Homelessness: Risk Factors, Predictors of Testing, and Promising Testing Strategies

The October issue of *In Focus* provides a synthesis of recent literature on HIV/AIDS among persons experiencing homelessness in the United States. Special attention is given to literature on HIV risk behaviors, predictors of HIV testing utilization, and promising HIV testing strategies for both youth and adult populations experiencing homelessness.

Prevalence of HIV/AIDS in Homeless Population

In 2009, an estimated 784,701 individuals were living with a diagnosis of HIV infection in the United States.^[1] According to a 2010 study, HIV infection was more prevalent in urban poverty areas¹ in the U.S. (2.1%) than in the general population (<1%); in these urban poverty areas, homeless status was significantly associated with and a predictor of HIV prevalence.^[2] Persons experiencing homelessness are disproportionately infected with HIV/AIDS at a rate 3-9 times higher than the stably housed population.^[3-5] Among youth experiencing homelessness, HIV prevalence is estimated to be between 2-11%.^[6]

High-Risk Behaviors among Persons Experiencing Homelessness

HIV risk behavior is prevalent among the homeless population. Individuals experiencing homelessness are more likely than other subpopulations to engage in behaviors associated with HIV risk, including risky sexual practices, injection drug use and needle sharing, and trading sexual acts for money, drugs, or a place to stay.^[5]

An emerging topic within HIV/AIDS literature is that of high-risk behaviors and HIV prevalence among homeless youth. The country's estimated two million runaway and homeless youth (RHY) are disproportionately affected by HIV and other sexually transmitted infections in comparison to stably housed youth.^[6, 7] Unstably housed youth are at 2-10 times greater risk of HIV infection than stably housed adolescents in the U.S.^[6] This elevated rate of HIV infection could be the result of the small networks of social support that exist among RHY, in which high-risk behaviors are normalized, including unprotected sexual intercourse and injection drug use.^[8] A study of homeless youth found that the longer adolescents had been homeless, the less motivated they were to reduce HIV risk behaviors.^[9]

Unstably housed
youth are at
2 to 10X
Greater Risk
of HIV infection

Online social networking—used by over 96% of youth experiencing homelessness—can play a significant facilitative and preventative role in high-risk behavior, depending on how it is used.^[6] For example, online social networking

¹ Urban poverty area defined as a census tract where $\geq 20\%$ of residents had household incomes below the U.S. Poverty level in one of 23 cities included in the study.

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by youth who are homeless has shown to be a tool for identifying sexual partners and establishing exchanges of sex for food, drugs, or places to stay, while it has also been used to discuss safe sex practices and build knowledge about HIV/STI prevention behaviors.^[6, 10]

Factors Associated with Utilization of HIV Testing

According to Wenzel et al. (2012): “HIV testing is an effective tool for reducing HIV transmission and for combating poor HIV/AIDS health outcomes that disproportionately affect homeless persons” (p. 270).^[4] If routine HIV testing became widespread, it could extend survival rates by 1.5 years for the average HIV-infected individual who seeks care.^[11] However, HIV testing has yet to become a widespread practice, as more than one-fifth of HIV positive persons in the United States are unaware they are infected.^[1]

1 in 5
People infected with HIV
in U.S. is unaware
he or she is infected

Testing rates among youth experiencing homelessness are higher than youth in the general population.^[6, 7] In a study of sexually active youth experiencing homelessness in Los Angeles, 85% had ever been tested, while 47% had been tested in the past three months.^[7] The factors significantly associated with increased likelihood of testing included youth who self-identified as gay or had been to a drop-in center in the past month; factors marginally associated included youth who were of older age, Hispanic

ethnicity, had more depressive symptoms, injected drugs in the past six months, and had two or more casual or need-based sexual partners in the past three months. Sexual risk behavior had no associations with testing likelihood.

Predictors of HIV testing vary for adults. A study of heterosexually active homeless men explored the individual and structural predictors of HIV testing.^[4] The study found that structural factors related to service access and use—including recent access to medical or dental services or past U.S. military service—were significantly associated with a greater likelihood of past-year HIV testing. Conversely, individual factors—including demographic factors and HIV risk behavior—were not associated with a greater likelihood of past-year HIV testing. As Wenzel et al. (2012) state, these findings are supported by past research, which identifies access to medical services as a predictor of utilizing HIV testing.^[12]

A study of women in shelters and low-income housing units, however, found both individual and structural factors to be associated with testing likelihood.^[13] HIV testing was more likely among women who: lived in a shelter, were younger, lived with a child, had a regular source of medical care, had drug or alcohol dependence within the past year, experienced sexual violence, and were at low risk for mental health problems.

Promising Practices in HIV Testing

The increased likelihood of HIV testing utilization among unstably housed men who had recent access to medical or dental services and unstably housed women who had a regular source of medical care presents an opportunity to improve testing rates across the board. In the aforementioned study of women in shelters and low-income housing units, the most common location for testing was a clinic or physician’s office.^[13] Implementing routine and universal testing at medical and dental appointments regardless of individual factors such as demographic characteristics or HIV risk behavior has proven more effective

**Recent access to
medical services =
greater likelihood of
HIV testing utilization**

HIV/AIDS among Persons Experiencing Homelessness

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than targeted, risk-based testing practices that rely on individual factors, which Wenzel et al. found to be ineffective predictors of testing.^[4, 14] This is consistent with the Centers for Disease Control's (CDC) revised testing recommendations, which endorse "routine voluntary HIV screening as a normal part of medical practice, similar to screening for other treatable conditions."^[14]

Health Center Program grantees, including Health Care for the Homeless (HCH) projects, can provide integral HIV testing locations for unstably housed consumers due to their roles as primary care medical homes for the country's most vulnerable populations, regardless of insurance status or ability to pay.^[15] Incorporating universal HIV testing into the primary care setting could increase the prevalence of HIV testing utilization among persons experiencing homelessness, potentially leading to "...earlier HIV diagnosis, improved linkage to care, and reduced transmission of HIV infection."^[16] This primary care testing approach is reiterated in the National HIV/AIDS Strategy released in 2010, which states that all health care settings should be utilized for HIV testing.^[17]

The dental care setting—found at some HCH projects—is also gaining attention for its suitability for rapid HIV testing.^[18] Rapid HIV testing is a quick and cost-effective method for HIV screening that can be conducted by non-laboratorians in a variety of settings, although reactive-positive results must be followed up with traditional testing.^[19] Even though exploration of HIV testing practices in the dental setting remains limited, dental clinics offer a promising venue for HIV rapid testing using oral fluid. Dentists already offer screening tests that are not focused on oral health, including tests for high blood pressure and elevated glucose, so incorporating routine HIV testing could become a standard component of dental exams.^[18]

40%

of unstably housed youth
received HIV testing in
non-clinical setting

Rapid HIV testing is also being implemented in outreach and community settings—including mobile medical units, homeless shelters, public parks, needle exchange programs, bathhouses, community events, bars, social service organizations, and drug treatment facilities—to reach minority groups and others at high risk for HIV infection.^[19] In a study of rapid HIV testing in non-clinical settings, which included over 24,000 participants, 98% of those tested by participating community-based organizations indicated that they believed the non-clinical venues were appropriate settings for testing.^[19]

Testing in non-clinical venues, especially bathhouses and community special events, successfully reached those who had not been previously tested.

Non-clinical testing venues—including outreach settings and community-based organizations—may also be more effective in reaching unstably housed youth than conventional medical settings.^[20] In particular, unstably housed youth have shown a preference for drop-in centers over other service sites, and the use of drop-in centers was significantly associated with testing among this population.^[7] In a study of youth experiencing homelessness in New York City, 40% of participants had received rapid and conventional testing in non-clinical venues.^[20] Considering that the majority of adolescents in a community sample were willing to take a free rapid HIV test when offered, routine rapid testing in drop-in centers and other non-clinical settings could be an effective way to increase testing rates among youth.^[21]

Discussion

Given the prevalence of HIV infection and high-risk behavior among persons experiencing homelessness, particularly unstably housed youth, a better understanding of HIV testing utilization predictors and innovative testing practices is essential. The educational potential of online social networking could be utilized as a

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prevention strategy for RHY, whom are generally well-connected to online social media. Additionally, the use of promising rapid HIV testing strategies, including in primary care, dental, and non-clinical settings, can reach individuals who have never been tested, such as minorities, youth, and those with high-risk behaviors.

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Social, Structural and Behavioral Determinants of Overall Health Status in a Cohort of Homeless and Unstably Housed HIV-Infected Men

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Abstract

Background: Previous studies indicate multiple influences on the overall health of HIV-infected persons; however, few assess and rank longitudinal changes in social and structural barriers that are disproportionately found in impoverished populations. We empirically ranked factors that longitudinally impact the overall health status of HIV-infected homeless and unstably housed men.

Methods and Findings: Between 2002 and 2008, a cohort of 288 HIV+ homeless and unstably housed men was recruited and followed over time. The population was 60% non-Caucasian and the median age was 41 years; 67% of study participants reported recent drug use and 20% reported recent homelessness. At baseline, the median CD4 cell count was 349 cells/ μ l and 18% of eligible persons (CD4<350) took antiretroviral therapy (ART). Marginal structural models were used to estimate the population-level effects of behavioral, social, and structural factors on overall physical and mental health status (measured by the SF-36), and targeted variable importance (tVIM) was used to empirically rank factors by their influence. After adjusting for confounding, and in order of their influence, the three factors with the strongest negative effects on physical health were unmet subsistence needs, Caucasian race, and no reported source of instrumental support. The three factors with the strongest negative effects on mental health were unmet subsistence needs, not having a close friend/confidant, and drug use. ART adherence >90% ranked 5th for its positive influence on mental health, and viral load ranked 4th for its negative influence on physical health.

Conclusions: The inability to meet food, hygiene, and housing needs was the most powerful predictor of poor physical and mental health among homeless and unstably housed HIV-infected men in an urban setting. Impoverished persons will not fully benefit from progress in HIV medicine until these barriers are overcome, a situation that is likely to continue fueling the US HIV epidemic.

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Introduction

Homeless persons disproportionately suffer from serious mental and physical health problems [1] and are disproportionately infected with HIV [2]. The added burden of HIV-infection introduces further risks to overall health [3,4] compounded by structural barriers to receiving consistent care [5,6]. While improved antiretroviral medications have led to an era in which HIV is considered a manageable chronic condition for many individuals [7], the benefits have not been realized equally across populations due to barriers to medical care, treatment adherence and optimal health among homeless persons [2,8,9,10,11].

Few studies have examined the relative contributions of behavioral, social and structural factors influencing health outcomes over time, and even fewer have done so exclusively among community-recruited unstably housed persons. Structural factors are the policies, practices, environment and context that

directly or indirectly affect an individual's options and behavior [12]. Given a variety of competing needs that are uncommon in general populations [13] and change over time, the broad economic influence of structural factors are important components of risk and risk environment among unstably housed persons. We recently reported that unmet subsistence needs had the strongest negative effect on the mental and gynecological health of HIV-infected unstably housed women, while drug use had the strongest influence on physical health (as measured by the SF-36) [14]. The aims of the current study were to determine the extent to which changing risk factors (i.e., exposure and contexts of risk) influence the physical and mental health status of HIV-infected homeless and unstably housed men over time, empirically rank risk factors by their level of influence and determine whether the most influential variables previously found among women were also the most influential variables among men.

Methods

Ethics Statement

All study procedures were conducted with the approval of the Committee on Human Research at the University of California, San Francisco. No funding bodies had any role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Sample Population

In order to include a sample of individuals who reflect San Francisco's larger population of homeless adults, methods developed by Burnam and Koegel were employed to recruit a probability sample of persons transitioning through homeless and unstably housed situations [15,16]. From July 2002 to September 2008 a mobile outreach team recruited adults from all San Francisco homeless shelters, free food programs serving over 100 persons per day, and a random sample of single room occupancy (SRO) hotels in three neighborhoods selected with probability proportional to the number of people residing in that hotel. At small venues, all persons present on recruitment days were invited to participate in screening activities; at large venues, a subsample of individuals present (e.g., every third person) was invited to participate. Individuals who were over 18 years of age and tested HIV antibody positive were invited to enroll in the current study. Eligible individuals gave written informed consent to participate in study activities. During consent interviews, individuals were asked to answer questions regarding study procedures to address any issues of illiteracy and ensure understanding. Participants were asked to make quarterly visits (i.e., every 90 days) to a community-based field site where they provided blood for CD4 cell count and viral load assessment, and completed an interviewer-administered questionnaire to assess factors that might influence health status.

The current analysis is restricted to biological men. Restricting the population to unstably housed men allowed a focus on structural barriers that are relevant and limit options within this population. Thus, by its design, the study recognized the importance of gender inequalities and poverty as structural factors inherent to HIV and risk [17].

Outcome Variables: Health Status

All study measures pertained to the 90 days prior to the interview. Outcome measures of self-reported health such as physical functioning and mental health are important indicators of overall health status [18]. Such self-rated health measurements offer information not consistently captured by clinical assessment [19], provide a comprehensive assessment of health status that accounts for co-occurring conditions and interactions between conditions [20], and provides significant predictors of survival [21]. The Medical Outcome Study's Short Form (SF)-36 [22] uses self-reported information to offer a reliable and valid assessment of overall health status among unstably housed individuals [23]. Two composite scores were employed in the current study, a Mental Composite Score (MCS) and a Physical Composite Score (PCS), both ranging from 0 to 100 where higher scores indicated better health.

Main Effects: Health risks

Variables considered as having potential influence on health status included behavioral, social and structural determinants of health that have been previously established as important factors in predicting health. These factors included sociodemographic variables, including homelessness (slept on the street or in a homeless shelter); unmet subsistence needs (difficulties gaining

access to housing, a bathroom, place to wash, clothing or food) [24]; social/instrumental support (having a friend who would lend the respondent money or give him a place to sleep) [25]; alcohol use (>2 drinks/day [26]); any use of heroin, crack cocaine or methamphetamine; symptoms of withdrawal from heroin, crack cocaine and alcohol, as detected in the Diagnostic Interview Schedule-IV [27]; CD4 cell count, viral load and self-reported adherence to antiretroviral therapy (ART). ART adherence was defined as 0% among persons who were ART eligible (i.e., CD4 cell count ≤ 350 by clinical guidelines in place during the study period [28]), but not currently taking ART. Health services were not adjusted in the current study, as service use may be a consequence of poor health and not a risk factor.

Statistical Methods

Marginal structural models and targeted variable importance (tVIM) have been used previously to rank influences of social and structural factors on the overall health status of HIV-infected impoverished persons [14], and were employed in the current study. This approach is uniquely suited to handle time-dependent confounding of variables that are more commonly found in impoverished populations (e.g., drug use may lead to poor health, but poor health may lead to subsequent self-medicating drug use [29]).

tVIM assesses the effects of a large number of variables with unknown or diverse correlation structures; it more accurately assesses effects when compared to techniques that rely on parametric regression models [30,31,32,33]. tVIM estimates the effect of one variable at a time, which tailors the estimation approach towards the specific effect of interest, thereby providing a more accurate effect and assessment of uncertainty. This approach is important for analyses described herein because different data types and a broad spectrum of variables were analyzed, thus a single multivariable regression model approach was untenable. tVIM involves two steps: First, to ensure that the exposure preceded the outcome (an assumption of risk and the statistical models that estimate it) and then fit a marginal structural model to estimate the target parameter. The marginal structural model estimated the population-level effect [34] of each risk factor in the previous quarter on health status of the current quarter (i.e., a 1 unit change for MCS or PCS), adjusting for potential confounding [35]. Variables were considered as potential confounders in all models for which they were not being considered as a primary effect, and confounders were assessed separately for each model estimating a primary effect.

Second, tVIM techniques were applied such that the risk factor-specific effects were ranked by p-value, which was appropriate for the current study due to the fact that exposure variables (i.e., risk factors) had different units of measure. Because the population and sample size were consistent between models, ranking variables based on p-value was a standardized approach to ranking effect estimates (i.e., signal to noise ratio). Thus, ranking is not from the most negative to the most positive effect, it is from the variable with the largest population-level effect on the outcome to that with the smallest.

Results

A 3% refusal rate for study enrollment resulted in a cohort of 288 HIV-infected men. The median age of study participants at baseline was 41 years (IQR = 35–46). Less than 40% of study participants had graduated from high school, almost 60% were of non-Caucasian race/ethnicity and 23% reported the recent use of crack cocaine (Table 1). Regarding structural factors reported at

baseline, 20% of study participants had slept on the street or in a homeless shelter, 8% had been incarcerated and 26% had unmet subsistence needs during the 90 days prior to baseline (Table 1). Considering a 2% annual loss to follow up and 0.5% annual mortality rate, the median follow-up time was 15 months per person.

Physical Health

At baseline, the median viral load in this sample population was 7200 copies/ml, the median CD4 cell count was 349 cells/ μ l and 18% of eligible persons (CD4<350) took antiretroviral therapy. Over one-third of study participants reported current symptoms of chronic illness (Table 1). The population median for overall physical health (PCS) was 43 (out of 100 possible). Adjusting for all

significant study confounders, unmet subsistence needs was the most important explanatory variable (i.e., had the largest effect) among the study's estimated effects on the overall physical health of men in this sample (Table 2). On average, men reporting unmet subsistence needs had PCS scores that were 3.8% lower ($p = 3.4e-05$) than those who did not, after adjusting for all other significant study confounders. In separate models, and in order of their adjusted population effect on physical health status scores, Caucasian participants had PCS scores that were 3.7% lower ($p = 1.2e-03$) than other racial/ethnic categories; those with no instrumental support had scores that were 1.6% lower ($p = 2.2e-02$), and for every unit increase in viral load, PCS scores decreased $-1.8e-05\%$ ($p = 4.1e-02$).

Table 1. Baseline Characteristics of HIV-Infected Homeless and Marginally Housed Men living in San Francisco, CA, USA, 2002–2008 (N = 288).

SOCIOECONOMIC	
Age	Median = 41 (IQR = 35–46)
Graduated from high school	38%
Race/ethnicity	
African American	38.4%
Caucasian	41.2%
Latino	7.4%
Other	13%
Any minor children living at home (past 90 days)	0.36%
Incarcerated (past 90 days)	8%
Slept on the street or in a homeless shelter (past 90 days)	20%
SUBSISTENCE NEEDS AND SOCIAL SUPPORT (past 90 days)	
Employed	7%
Any income from SSI, SSDI	65%
Current monthly income	Median = \$815 (IQR = 690–878)
Unmet subsistence needs [□]	26%
Has close friend/confidant	68%
No reported instrumental support	28%
DRUG AND ALCOHOL USE (past 90 days)	
Crack cocaine	23%
Heroin	12%
Methamphetamine	2%
Alcohol use (>2 drink/day)	9%
MENTAL HEALTH	
CD4 cell count	Median = 349 cells/ μ l (IQR = 178–546)
Viral load	Median = 7,200 copies/ml (IQR = 15–43,250)
Current symptoms of any chronic health condition [‡]	33%
Overall Physical Health score (PCS) [◇]	Median = 43 (IQR = 33–50)
MENTAL HEALTH	
History of depression	35%
History of schizophrenia	3%
History of manic episodes	22%
History of PTSD	16%
Overall Mental Health Score (MCS) [◇]	Median = 46 (IQR = 33–55)

[□]Access to a bathroom, place to wash, clothing, food and a safe place to sleep.

[‡]Asthma, diabetes, heart disease, high blood pressure or emphysema.

[◇]Out of 100 where a higher score indicates better health.

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Table 2. Ranked Influence of a Unit Increase in Competing Needs during the past 90 Days on the Overall Physical Health (Score 0–100)* of HIV-Positive Homeless and Unstably housed Men, 2002–2008 (N = 288)[†].

Main Effect	Crude Population Effect	Crude 95% Confidence Interval	Crude p-value	Adjusted Population Effect	Adjusted 95% Confidence Interval	Adjusted p-value	tVIM Rank
Unmet subsistence needs	-4.33	(-6.06, -2.59)	1.4e-06	-3.83	(-5.27, -1.6)	3.4e-05	1
Caucasian race/ethnicity	-3.71	(-6.08, -1.31)	2.2e-03	-3.71	(-6.03, -1.29)	1.2e-03	2
No source of instrumental support	-1.74	(-2.94, -0.56)	4.2e-03	-1.56	(-2.88, -0.21)	2.2e-02	3
Viral load	-1.8e-05	(-3.8e-05, -3.1e-06)	4.5e-02	-1.8e-05	(-3.8e-05, -3.1e-06)	4.1e-02	4

*SF-36 Physical Health Composite Score (PCS) in which a higher score indicates better health.

[†]Each line represents a separate model in which a single main linear effect is estimated, adjusting for the potential confounding of all other significant study variables.
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Mental Health

Regarding individual mental health conditions, 35% of the population had a history of major depression, 22% experienced manic episodes and 16% had a history of post-traumatic stress disorder (PTSD) (Table 1). The population median for overall mental health (MCS) was 46 (out of 100 possible). Adjusting for all significant study confounders, unmet subsistence needs was the most important explanatory variable among the study's estimated effects on the overall mental health of men in this sample (Table 3). On average, men reporting unmet subsistence needs had MCS scores that were 3.5% lower than those who did not ($p = 3.6e-05$), after adjusting for all other significant study confounders. In separate models, and in order of their adjusted population effect on MCS, individuals reporting a close friend/confidant had MCS scores that were 3.2% higher ($p = 4.5e-05$), while MCS scores were 3.7% lower ($p = 2.0e-04$) among drug users, 2.2% lower ($p = 1.2e-03$) for those with no instrumental support and 1.7% higher ($p = 4.3e-02$) for those with $\geq 90\%$ ART adherence.

After adjusting for all significant confounders, variables that were not among the strongest predictors of overall mental and physical health included age, race, income and CD4 cell count.

Discussion

Among HIV-infected homeless and unstably housed men who were aware of their HIV status and eligible for treatment in a resource-rich environment, only 18% took ART at baseline. Moreover, while ART adherence and viral load were among the most important predictors of overall health, unmet subsistence needs and social support had even larger influences in this population. These results are based on six years of follow-up, during which time detailed longitudinal data were obtained on a probability sample of 288 individuals, making it one of the most thorough and extensive data sets of its kind. Every exposure examined was established in previous research as important to the health of unstably housed individuals. With overwhelming burdens of illness experienced by homeless persons and limited resources to address these issues, health care and social service providers are often left with the responsibility of choosing which important factor to prioritize. Results presented here suggest that addressing basic subsistence needs first (i.e., ensuring access to housing, food, clothing and hygiene needs) will have the most impact on the health of HIV-positive unstably housed persons. Thus, advances in medical science that are saving, lengthening and improving the quality of life for many people living with HIV/AIDS will not fully benefit unstably housed persons until their basic subsistence needs are met.

Results presented here expand implications from a recent CDC report showing that poverty is the single most important demographic factor associated with HIV infection among inner-city heterosexuals living in the United States [36]. Taken together, these observations indicate that unmet subsistence needs are having critical influences on the health of impoverished persons both infected with and at risk for HIV/AIDS, which is consistent with findings from multiple HIV outcomes studies. For instance, homelessness is a risk factor for both HIV acquisition [37] and delayed diagnosis among men who have sex with men [38], a strong predictor of initiating injection drug use [39,40] as well as unsafe syringe acquisition and disposal [41], a significant correlate of transactional sex [42,43] and unprotected sex among high-risk heterosexual women [44]. It is clear that the influences of poverty on the US HIV epidemic are not confined to exceptional cases, nor are they confined to sub-groups. Poverty is a pervasive force driving the epidemic and its influences on health.

Table 3. Ranked Influence of a Unit Increase in Competing Needs during the past 90 Days on the Overall Mental Health (Score 0–100)* of HIV-Positive Homeless and Unstably housed Men, 2002–2008 (N = 288)[†].

Main Effect	Crude Population Effect	Crude 95% Confidence Interval	Crude p-value	Adjusted Population Effect	Adjusted 95% Confidence Interval	Adjusted p-value	tVIM Rank
Unmet subsistence needs	-5.35	(-7.25, -3.42)	4.9e-08	-3.51	(-5.08, -1.29)	3.6e-05	1
Has a close friend/confidant	2.36	(0.91, 3.82)	1.6e-03	3.19	(1.64, 4.72)	4.5e-05	2
Any drug use	-4.45	(-6.41, -2.45)	1.2e-05	-3.67	(-5.53, -1.8)	2.0e-04	3
No reported sources of instrumental support	-1.81	(-3.11, -0.53)	7.0e-03	-2.2	(-3.62, -0.89)	1.2e-03	4
≥90% ART adherence	3.32	(1.37, 5.18)	7.3e-04	1.66	(0.07, 3.27)	4.3e-02	5

*SF-36 Mental Health Composite Score (MCS) in which a higher score indicates better health.

[†]Each line represents a separate model in which a single main linear effect is estimated, adjusting for the potential confounding of all other significant study variables. doi:10.1371/journal.pone.0035207.t003

How to address poverty as a leading cause of morbidity is a source for ongoing debate worldwide, including resource-rich countries like the United States [45]. While research is rarely able to measure moral dimensions of homelessness such as dehumanization, diminished capacity to actualize basic societal rights and privileges, and susceptibility to victimization [46], a variety of studies have shown measurable health improvements from structural interventions. Specifically, studies evaluating the effects of housing and case management have demonstrated significant reductions in medical care utilization and improvements in physical and mental health [47,48,49]. Such interventions have also been shown to offset costs of acute care and significantly decrease overall costs [46,50,51,52]. In short, while regional variations exist, homelessness is more expensive to society than the costs of permanent housing [46]. Similarly, research has shown that the Supplemental Nutrition Assistance Program (SNAP) decreases food insecurity by 20–50% [53], and the Expanded Food and Nutrition Education Program (EFNEP) translates into a positive cost-benefit based on potential prevention of diet-related chronic diseases and conditions [54]. Considered in association with results presented here, these studies suggest that subsistence needs such as housing and food insecurity have the most influence on the overall health of HIV-positive unstably housed persons and can be successfully intervened upon. Taken together, this body of empirical evidence suggests that social programs addressing subsistence needs are fiscally sound.

The low level of ART use and strong influence of ART adherence on health in the current study are particularly relevant in light of recent dialogues regarding expanded HIV treatment. Theoretical decreases in HIV incidence from expanded treatment [55] have been interpreted with caution in the social context of the US HIV epidemic [56] on the grounds that ART availability and use are determined by a multi-faceted and interrelated array of clinical, epidemiological, biological, social and behavioral factors. In this context, the use of ART may be lower than expected and thus theoretical reductions in HIV incidence from expanded treatment may be limited in certain populations such as those experiencing extreme poverty. Findings presented here support and extend this position as follows: the use of ART is a multi-faceted phenomenon; the overall health of HIV-infected impoverished persons is also a multifaceted phenomenon and relies neither exclusively nor primarily on ART.

Strong connections exist between poverty, structural factors, poor health and non-Caucasian race/ethnicity in the United States. The finding that Caucasian race/ethnicity predicted worse health was thus unexpected and contradicts medical research conducted in the general US population [57,58] as well as the general US HIV/AIDS population [59]. However, contrary to the general US HIV epidemic, the recent CDC analysis found no significant differences in HIV prevalence by race/ethnicity when data were considered from exclusively low-income areas [36]. Data reported here do not only apply to low-income individuals, but individuals who live in such extreme poverty as to be without stable housing. These results thus extend CDC findings and suggest that, when data are restricted to extremely impoverished persons, effects of race/ethnicity may not only be diminished relative to the general US HIV epidemic, but there may be situations in which effects are in the opposite direction. The mechanism by which HIV-infected unstably housed men of color experience better overall health compared to Caucasian HIV-infected unstably housed men cannot be established with these data and warrants additional inquiry. In particular, future studies that assess associations between race and length of time living with

HIV, and the mediation of these influences by health services use, would facilitate a better understanding of this effect.

Comparing results from the current analysis to our previous work regarding the health status of HIV-infected unstably housed women, there are two main points of divergence. First, race/ethnicity was not among the most influential predictors of health status among women [60]. Second, after adjusting for basic subsistence needs, street homelessness was among the strongest predictors of worse overall health among women [60], while this effect was not as strong for men in the current study. On the other hand, the most influential variable in both gender-specific cohorts is basic subsistence needs. The consistency and strength of this finding provides evidence that prioritizing basic subsistence needs (i.e., housing, food, clothing and the use of a bathroom) would lead to the largest population-level health improvements among extremely impoverished HIV-infected persons living in the US.

The results of this study should be considered in light of potential limitations. First, study participants may have underreported behaviors such as drug use, due to social desirability; however, this would have biased results toward the null, indicating that effect sizes are at least as extreme as those reported. Second, data were taken from a single well-resourced metropolitan area and generalizability may be limited. There is, however, evidence suggesting similar findings regarding influences of poverty and housing on health in other metropolitan areas [11,61,62,63,64], thus, influences of location are likely minimal. Third, models used in this study assumed that there were no unmeasured confounders related to health status, and it is possible that residual confounding existed from unmeasured effects. This limitation is inherent to all traditional modeling techniques and our inclusion of factors that have been found by previous studies to be important correlates of health status was intended to minimize this potential limitation. Fourth, results suggesting that ART adherence positively influences mental health may not represent the true causal pathway (e.g., baseline mental health influences adherence and not the other way around); however, a marginal structural model approach was chosen specifically to address these complicated associations. With IPTW estimation, weights create a pseudo-population in which the previous mental health outcomes are no longer confounders, which allows the construction of an unbiased estimator for the parameter of interest. Results presented here therefore indicate that, after accounting for influences of mental health on ART adherence, individuals with high levels of

adherence had overall mental health scores that were an average of 3% higher.

Results presented here and in our earlier women's study [60] indicate that unmet subsistence needs have the largest population-level effects on the mental and physical health of unstably housed HIV-positive individuals and that the biggest population-wide impact on health would be made by focusing on these issues. Given that the influences of poverty and housing instability on the US HIV epidemic are pervasive throughout major risk groups [37,38,39,40,41,42,43,44], addressing subsistence needs stands to have broad impact on overall health. Furthermore, given the US Census Bureau's recent report indicating that the nation's poverty rate rose more than 15% last year, resulting in 46 million impoverished people living in the United States [65], this impact is likely growing.

While a combination of behavioral, biomedical and structural interventions is expected to provide the most effective approach to HIV prevention [66,67] and HIV treatment, advances in HIV medicine will not be fully realized by unstably housed persons until opportunity and choice limited by social and structural barriers are overcome. Moreover, the social and structural barriers inherent in poverty are not only likely to continue fueling the US HIV epidemic until they are overcome, but they now have opportunity to do so at a faster rate with currently increasing rates of US poverty.

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Author Contributions

Conceived and designed the experiments: EDR TBN JC DRB. Performed the experiments: JC. Analyzed the data: KM. Contributed reagents/materials/analysis tools: EDR TBN KM. Wrote the paper: EDR TBN KM JC DRB DH.

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THE BODY PRO

The HIV Resource for Health Professionals

Access to Stable Housing and Other Basic Necessities Huge Factor for People Living With HIV/AIDS

By Kellee Terrell

May 4, 2012

Last November, the Centers for Disease Control and Prevention released what the HIV/AIDS community already knew to be true: Only 25 percent of people living with HIV/AIDS in the U.S. have their disease under control. Lack of access to medication and cost of meds were among the main contributing barriers.

But a [new study from the University of California-San Francisco](#) provides some other reasons. By studying 288 men living with HIV/AIDS who were homeless or in unstable housing situations, researchers found that basic necessities such as food, housing and clean clothes had the largest effect on mental and physical health -- topping drug abuse, viral load and lack of access to meds. Other findings included:

- Researchers gave participants physical and mental health scores based on a scale of 0 to 100. The median physical health score was 43 and the median mental health score was 46.
- Researchers then determined the effects of various positive and negative influences on the participants' health. Not having basic needs had the biggest impact, lowering the physical health score by 3.8 percent and mental health score by 3.5 percent. Regular use of antiretroviral drugs improved the mental health score by 1.7 percent but had a negligible effect on the physical health score.

[The San Francisco Gate reported on the study:](#)

[For] many very poor patients, being homeless keeps them from getting consistent drug treatment at all.

Basic human needs must be addressed in parallel with HIV treatment if patients are going to stay healthy, said Elise Riley, lead author of the study. And until these needs are addressed, and the poorest HIV-positive patients are able to manage their illness, the virus will continue to circulate in the United States, she added.

"We're willing to spend all this money on medication, but it's not going to be doing as much good if we don't have more opportunities for housing or other needs," said Riley, an associate professor in the UCSF HIV/AIDS division at San Francisco General Hospital.

Brad Hare, M.D. and medical director of San Francisco General Hospital's HIV clinic, told the *Gate*, "We're always struggling with people who need to be on HIV treatment for their health but that's not the priority. This study validates what we've seen. It recognizes just how important the structural barriers are to HIV care."

Kellee Terrell is the former news editor for TheBody.com and TheBodyPRO.com.

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Code-Red Homophobia: Homelessness, HIV, and Black Religiosity

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By Guest Contributor [Sikivu Hutchinson](#); originally published at [Feminist Wire](#)

(Excerpt from the forthcoming book *Godless Americana: Race and Religious Rebels*)

For the past several months, Crenshaw Boulevard, in predominantly black South Los Angeles, has featured a series of striking

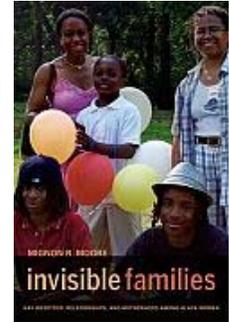


billboards condemning homophobia and its role in the HIV/AIDS epidemic. The billboards are the work of the black gay activist [group](#) In the Meantime Men, headed by Jeffrey King. Sounding a “code red alarm” on the raging HIV/AIDS epidemic among African Americans, King said, “The staggering rates of [increased teen suicides](#) in the last five years, and the uncontrollable increase of teen homelessness in America have awakened our senses to the damaging effects of homophobia in the Black community. Every year, thousands of Black LGBT people are displaced from their homes, families, churches, and communities due to their sexuality, gender, gender identity, and gender expression. This has resulted in a mass influx of homeless youth on the streets of Los Angeles and other cities throughout the nation.” [King will be a panelist at the upcoming “Confronting Homophobia in the Black Church” roundtable hosted by Black Skeptics Los Angeles at Zion Hill Baptist Church on February 27th] With

African Americans comprising the majority of new HIV cases in the U.S., the epidemic has devastated black communities nationwide. Yet the refusal of mainstream black America to seriously confront how homophobia and black religiosity drive homelessness and HIV only deepens the killing fields.

In her book *Invisible Families* Mignon Moore notes that “some in the Black gay community use religion to [validate](#) their

identities as same-gender loving people.”^[i] Rejecting the Bible’s condemnation of homosexuality, gay African American Christians focus instead on what they believe to be the loving, compassionate, universalist message of Jesus. As one respondent in Mignon’s book says, “I do believe God loves me and even though they may not agree with what I am I think that this is between me and God.”^[ii] For many African American LGBT folk, faith is intimately tied to cultural identity and is not easily shorn even in light of the social conservatism and heterosexism of mainstream black America. Indeed, according to a [study](#) by UCLA’s Williams Institute, when compared with their white counterparts, African American LGBT folk are more likely “to attend religious services, to engage in prayer, and to self-identify with a religious affiliation.”^[iii] Straight, gay, bi, and trans African Americans live together in segregated communities where racism, white supremacy, and criminalization shape their shared lived experiences. Save for the drumbeat of white normalcy portrayed in TV, film, and advertising, our worlds are overwhelmingly black and brown. Thus, it is not surprising that gay African Americans are invested in the same religious cultural traditions that prop up straight normalcy yet may afford them with a sense of community. Despite the overall increase in secular Americans, people of color have not embraced secularism in significant numbers.



Yet, countering the homophobic dogma of organized religion is only one aspect of LGBTQ enfranchisement. And it is for this reason that existing humanist organizations are inadequate for queer youth of color. The needs of LGBTQ youth of color can’t be adequately addressed by culturally homogeneous or colorblind approaches that don’t acknowledge the intersection of heterosexism, white supremacy, and racism. For example, queer youth of color are especially vulnerable to becoming homeless. Family economic instability, sexual abuse, religious dogma, and discrimination at school and in [local neighborhoods](#) often precipitate homelessness among African American queer youth. The nexus of foster care and mass incarceration has also dramatically increased homelessness amongst youth of color. Youth who age out of foster care have few resources to fall back on, putting them at risk of becoming homeless.^[iv] Youth who come out of the juvenile or adult prison systems may be unable to [find jobs](#) or housing due to employment applications that require criminal felony disclosures.

With its illusion of glamour and accessibility, the city of Hollywood is a popular magnet for runaways and homeless youth. The majority of Hollywood’s homeless youth are African American. Forty percent of all homeless youth in the community identify as LGBTQ.^[v] Floating spectrally in the hills above the workaday traffic, the old Hollywood sign is a faded beacon and gilded promise for the klieg-lit dreams of youth everywhere. It’s purported that thousands of young people used to dam up at the now desolate Vine Street Greyhound terminal off of Sunset Boulevard every year. Many sought refuge from personal trauma and upheaval, hungry for a new beginning, a semblance of family, home, and, true to the cliché, a shot at fifteen minutes of fame. Hollywood is home to a network of homeless youth shelters run by organizations like the L.A. Gay and Lesbian Center and Covenant House. As the largest privately funded homeless youth shelter in the nation, the faith-based Covenant House has historically been averse to the needs of LGBTQ youth.^[vi] After years of discrimination against trans and genderqueer youth, Covenant House Texas implemented culturally responsive policy that specifically addressed the targeting of trans youth.^[vii] According to Houston’s *Out Smart* magazine: “Since the leaders who followed its founder were Catholic nuns, its service has always included a religious component. With little official acceptance of gay people coming from the Catholic Church, Covenant House has not been encouraged to focus on LGBT-specific programs and training.”^[viii] Writer Rachel Aviv echoed this view in a *New Yorker* article on queer homeless youth. She noted that the organization’s “Catholic underpinnings have complicated the shelter’s response to increasing numbers of gay residents.”^[ix] One young lesbian Aviv interviewed complained that she felt pressured to go to church. After she objected to a staff member’s heavy proselytizing “they sent the pastor to talk to” her.^[x] Promoting a new book about several inspirational homeless teens, the head of Covenant House has said that “we are each made in the image and likeness of a loving God.”^[xi] But having been despised and demonized by “God” for so long, when the script is flipped and an authority deems that God is suddenly loving and forgiving—why is God necessary at all?

When my colleague Josh Parr and I ran a homeless youth leadership group at Covenant House California in Hollywood from 2009 to 2012, some youth struggled to be housed according to their gender identity. Conflicts about sexuality and gender often played out in our group. Amber*, one of our female transgender interns, got into fights with a cisgender female youth leader who had “problems” with having her as a roommate. In the general population of the facility there was clear tension between the “hard” bangers, and so-called gang-related males (who had come directly from the juvenile system), and openly queer and questioning youth. Both groups navigated public identities that had been demonized as criminal, “other,” and threatening. Being both homeless and of color already made them vulnerable to racist police who often roust and profile homeless people of color on the streets with impunity. According to the Center for American Progress, of the “approximately 300,000 gay and transgender youth who are arrested and/or detained each year (more) than 60 percent are black or Latino.”^[xii] Carrying on the charade of hypermasculinity, some of the hard boys were conflicted by their own inability to be truly free, to be comfortable in their own skin as bi or gay young men. Most of the residents had not gone through any training or focused discussion on homophobia and gender identity. The faith-based culture of the organization could not address—much less affirm—the multiple layers of queer-of-color lived experience. What also became apparent with our youth interns was that the generally conservative culture of Covenant House could not help them reconcile the deep divide between their elusive dreams of TV, film, and music industry stardom and the reality of crushing poverty that homeless youth face. Although the facility provides some [job search](#) resources, the more important long-term goal of college access is a major stumbling block for permanently transitioning youth of color out of homelessness. Because their lives are marked by constant physical, social, and emotional upheaval, homeless and foster care youth have lower college-going rates and higher attrition rates.^[xiii]

These issues were a perfect storm in the life of “Todd”, one of our most dedicated interns. Bright and well-spoken, Todd had come to Covenant House from a background of sexual abuse and prostitution. He seesawed between wanting to go to nursing school and cosmetology school. Speaking to high school students about his experiences on the streets trading sex for food, pocket change, and shelter, he emphasized the dangerous options queer youth have after being rejected by their families. At home and in the street, trans and queer youth are more likely to experience sexual abuse and sexual assault. Lacking meaningful job skills, resources or education, Todd and many other youth at Covenant House were forced to rely on survival sex to stay afloat.

Racialized stereotypes about normative black and Latino gender roles also place trans youth at high risk, both on the streets and in schools. The brutal 2008 murder of gender non-conforming teen Lawrence King by a male student at an Oxnard middle school shone a national spotlight on transphobia and violence. But the fact that King was a working-class boy of color, possibly grappling with racist cultural misperceptions about what his “rightful” gender identity should be, was not examined in mainstream discussions about the tragedy. The 2009 suicides of Carl Walker Hoover and Jaheem Herrera, eleven-year-old boys of color who had been harassed at school because they were suspected of being gay did not make headlines. At the same time, bullying-related suicides involving white gay youth were more widely publicized and seized on as national calls to action.^[xiv] These cases were highlighted in magazines and on cable TV and network news. Town halls were convened, experts were tapped, and bullying prevention became the mantra in public schools. But the mainstream view that youth of color aren’t deserving victims prevents them from getting the mental health intervention and social reinforcement that they need. Layer on being queer in a homophobic culture that demands hypermasculinity from young men of color and feminine submission from young women of color (vis-à-vis heterosexual relationships, physical contact with males, caregiving, and life aspirations) and gender non-conforming youth of color are doubly and triply victimized.

Although many homeless youth have to resort to prostitution and survival sex, the issue is especially acute for women of color. Racist/sexist notions of black female hypersexuality and pure white womanhood influence the way black women are perceived in the dominant culture. As I argue throughout this book, women of color have never had the luxury of looking down on white women from pedestals or plantation houses. The legacy of the dirty, rapacious, black Jezebel or spicy “bitch in heat” Latina shapes the way young women of color are perceived as naturally sexual and, hence, born prostitutes. Lesbians of

African descent are triply stigmatized by cultural demands for racial, sexual, and gender respectability. For *all* American girls, conventional gender mores emphasize sexual purity and unswerving allegiance to men. Narratives of home, hearth, and romance are supposed to inflame every girl's desire. From an early age, girls of color are socialized with the heterosexist script that being desired by a man and having children should be their authentic destiny in life. Nowhere is this message more fiercely promoted than in the global toy industry. Shoehorning girls into dolls, domestication, and dress-up, the global toy industry rigidly polices gender roles, reinforcing heterosexual conformity. More insidiously, big-box retailers and toy store conglomerates from Middle to urban America explode with princess merchandise. With its emphasis on dressing up, hooking up, melodrama, pink power, and pageantry, the rise of the Disney princess industry has made hyperfemininity (laced with token displays of "girlish" spunk and "independence") the national creed for millions of girls. Consequently, there is little space in American culture for young queer women of color who are not perceived as "femme" or actively seeking male validation.

Talking openly about homophobia during a workshop facilitated by my [Women's Leadership Project](#) and Gay/Straight Alliance (GSA) students at Washington Prep High School in South L.A., some of the male students pushed back when asked whether or not they had an obligation to defend a gay friend who was being harassed. Predictably, the football players in the group were the most vehement. They felt that there was a clear line between the way gay and straight males behaved. With its rigid culture of hypermasculinity and big endorsement deals tied to alpha male and All-American girl superstardom, organized sports have long been a stronghold of anti-gay discrimination. According to the *Los Angeles Times*, there are virtually no *active* professional sports figures that are out[xv]. So if a gay male was acting "gay" (i.e. flamboyant) at school then he was asking for a beat-down. I don't want to seem homophobic, one student said, but that's not "natural." Nature determined what was moral. "Gaydar" (being able to tell who was and was not gay largely based on stereotypes about gay male effeminacy) was a truism that even the most conscious students believed in. The girls in the GSA asked whether the ball players would feel the same if someone tried to jump them because they were black males. Would it be ok for racist police, white supremacists, or other men of color to target them for being black? That's different, some said, but others were silent, letting the analogy sink in. If we had had the space for debate most would've talked about the physical fact of their bodies, arguing that blackness is an indelible biological fact, a magnet for every storeowner, cop, or teacher who views black youth as guilty until proven innocent. Pastors, community leaders, and other adults have drilled it into them that equating gayness and blackness is sacrilegious; a ruse manufactured by elite white gay people to claim oppressed status and mooch off of African Americans' civil rights legacy. As the students thought about their allegiances, a teacher who has been a leader on social justice issues at the school challenged them to speak out. He likened their moral complicity with homophobia to society's indifference to the racism and sexism they experience every day. Several years ago, the school was slapped with an anti-gay bias discrimination suit that led to a settlement.[xvi] Since then district policy around bullying and harassment has become more stringent, mandating that teachers and administrators report bias incidents and attend anti-bullying trainings. Though important, mandates and anti-bullying trainings are ultimately band-aid correctives that don't disrupt heterosexist American gender norms, identities, family structures, and cultures. Similarly, simply including Hughes, Bayard Rustin, Gloria Anzaldua, Audre Lorde, Adrienne Rich or other LGBT literary and historical figures in a textbook without the cultural context of their struggles and vision is a variation on the Charismatic Great Person one-trick pony. And setting untrained teachers adrift in the classroom without culturally responsive professional development makes these policies virtually worthless for affecting long-term change in classroom pedagogy.

Because segregated post-industrial capitalist America allows few authentic cultural spaces in communities of color, churches are dubious sanctuaries at best. Some of the students in our GSA say that their churches accept everyone without judgment. But when we probe more deeply they cannot recall open embrace of LGBT families or relationships from the pulpit. Nationwide, gay African Americans and Latinx are more likely to be raising children in same-sex relationships. [xvii] Thus, for many, "acceptance" means silence. In its article "Black Churches May Be More Friend than Foe to Gay Congregants," the Center for American Progress challenges the dominant culture's belief (amplified during California's landmark 2008 anti-gay marriage initiative Proposition 8) that black communities and churches are more homophobic than their white counterparts.[xviii] The article contends that gay folks' "relationship with black churches in fact provides safe spaces and a steadfast social network that helps them deal with societal oppression at large." [xix] It quotes the Reverend Delman Coates of Maryland, "who...says he has seldom come upon the anti-gay vitriol that black churches are alleged to

promote (and) that, at most, some churches may employ a code of silence around sexuality, but few actually preach division and hate from the pulpit.”^[xx] But Coates’ distinction between explicit anti-gay sentiment and “benign” silence is a disingenuous one. Lesbian activist and writer Reverend Irene Monroe is critical of the view that the black church is a more welcoming space for queer and same-gender loving African Americans. Although a number of black pastors followed President Obama’s lead when he finally declared his support for same sex marriage in early 2012, Monroe points out that:

Church doctrine throughout African-American denominations hasn’t changed on the topic of homosexuality, keeping the church tethered to an outdated notion of human sexuality and a wrongheaded notion of what constitutes civil rights...Many African-American ministers still believe the institution of marriage, at least within the black family, is under assault, and that LGBTQ people further exacerbate the problem. For these ministers, some of whom support LGBTQ civil rights broadly but draw the line at same-sex marriage, espousing their opposition to same-sex marriage is a prophylactic measure to combat the epidemic of fatherlessness in black families. In scapegoating the LGBTQ community, these clerics are ignoring the social ills behind black fatherlessness, such as the systematic disenfranchisement of both African-American men and women, high unemployment, high incarceration, and poor education, to name a few.^[xxi]

Gay-friendly faith organizations dangle the promise that being queer, moral, and “good with God” are compatible. But like the original sin of sexual temptress Eve and other dirty reprobates soiled with the sht of the Fall, this goodness comes with caveats and conditions. Recently, I had a conversation with a local pastor who was struggling to address homophobia among his parishioners. Some of them were vehemently opposed to a lesbian couple who wanted their partnership blessed in a church ceremony. The pastor has expressed his acceptance of LGBT parishioners but was clearly shaken by the congregation’s response. Tolerant pastors always discover that it is one thing to be tolerant in word and another to be moral and just in *deed*, given the inhumanity of the Bible. Ultimately, to be part of the regime of Christian goodness there must be constant vigilance against the fundamentalist barbarians at the gate of Kumbaya who police whether or not “homos” get into heaven.

Believers who support same-sex marriage and LGBT equality insist that this is a bootleg un-Christian version of God. Trust us, they say, to rescue God from the flat-earth fundamentalists. Liberal Christians and spiritualists alike insist that the “real God”—their god—is a loving, kind, benevolent, New Testament-friendly patriarch (or matriarch). Their god is a fount of inspiration, a benign spirit for good that moves and grooves within everyone and embraces all comers regardless of creed or deed. The good believers assure us that this is so. But they are always looking over their shoulders at the corrupt fire breathing believers nipping peskily at their heels like night of the living dead zombies. They are subject to the same gyrations and justifications as fundamentalists for why their version of god is good, just, and right, worthy of the prizefight and fitting of the title. In the 1970s Joyce Carol Oates short story “Shame,” a pastor corrects a young woman who asks him about the certainty of religious authority figures: “‘You don’t have the right idea,’ he says, ‘It isn’t non-believers who doubt, but believers.’”^[xxii]

^[i]Mignon Moore, *Invisible Families* (Berkeley: UC Press, 2011), pp. 182, 206-207.

^[ii]Ibid., p. 207.

^[iii] David M. Barnes and Ilan H. Meyer, “Religious Affiliation, Internalized Homophobia, and Mental Health in Lesbians, Gay Men, and Bisexuals,” *American Journal of Orthopsychiatry* (Volume 82, Issue 4), October 2012, pp. 505-515. The study was conducted exclusively from 2004-2005 to New York city. Though the study was not exhaustive, the “results supported the general hypothesis that non-affirming religion was associated with higher internalized homophobia.”

^[iv] It’s estimated that one in seven foster care youth become homeless. See “Hopes and Hurdles: California Foster Care Youth and College Financial Aid,” Report by *The Institute for College Access and Success*, 2009, p. 5.

^[v] “No Way Home: Understanding the Needs and Experiences of Homeless Youth in Hollywood,” Report from Children’s Hospital Los Angeles, 2010, pp. 18-19. The overrepresentation of African Americans is also reflected in the broader Los

Angeles County homeless population.

[vi] Nicholas Ray, "Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness," National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless, 2006, pp. 4-6. The report questions the granting of service provision funding to religious organizations that have historically viewed homosexuality and gay people as sinful. Under former president George W. Bush, faith based initiative subsidies were indiscriminately doled out to religious organizations with no accountability. Under the faith based initiative policy religious organizations can discriminate in hiring and service provision. Covenant House is a recipient of faith based funding and has only recently begun to adopt culturally responsive policies that allow trans youth to be considered as the gender they identified with, rather than their biological sex, and live in non-segregated quarters.

[vii] Covenant House Texas was accused by LGBT activists of "identifying its transgender clients according to the gender shown on birth certificates and...ignoring complaints of bullying and discrimination." Josef Molnar, "Covenant House Opens up to Transgender Youth," *Out Smart*, June 16, 2011, <http://outsmartmagazine.com/2011/06/covenant-house-opens-up-to-transgender-youth-gender-preference-now-recognized-by-center>.

[viii] Ibid.; See also, Ray, pp. 4-6.

[ix] Rachel Aviv, "Netherland," *The New Yorker*, December 10, 2012, p. 65.

[x] Ibid.

[xi] Tom Gallagher, "Helping Kids, One Bold Kindness at a Time," *National Catholic Reporter*, October 13, 2012, <http://ncronline.org/news/people/helping-kids-one-bold-kindness-time>.

[xii] Jerome Hunt and Aisha Moodie Mills, "The Unfair Criminalization of Gay and Transgender Youth: An Overview of the Experiences of LGBT Youth in the Juvenile Justice System," Center for American Progress, June 29, 2012, p. 1.

[xiii] *The Institute for College Access and Success*, p. 2.

[xiv] The bullying-related suicides of Phoebe Prince and Tyler Clementi elicited national coverage; prompting condemnation from president Obama and the creation of the "It Gets Better" anti-bullying campaign.

[xv] As the Los Angeles Times reports, "Even though public opposition to same-sex marriage and gay rights is rapidly eroding, the locker rooms and clubhouses of the country's four major sports leagues remain among the last bastions of homophobia in the U.S." The article states that there have been no active professional sports players in the NFL, NHL or NBA that have come out during their careers. See Kevin Baxter, "In Pro Sports, Gay Athletes Still Feel Unwelcome," *Los Angeles Times*, December 29, 2012. <http://www.latimes.com/sports/la-sp-sports-homophobia-20121230,0,5283191.story>.

[xvi] Among the charges were that LGBT students were being disciplined more harshly and bigoted religious condemnations were made toward out students and faculty.

[xvii] See for example, Francine Ramsey, Marjorie Hill, et al, "Black Lesbians Matter: An Examination of the Unique Experiences, Perspectives and Priorities of the Black Lesbian Community," *The Zuna Institute*, July 2010, pp. 5-6; Sabrina Tavernise, "Parenting By Gays More Common in the South, Census Shows," *New York Times*, January 18, 2011, <http://www.nytimes.com/2011/01/19/us/19gays.html>. According to this article, childrearing in the South is more prevalent than in any region of the country and the majority of gay Southern parents are people of color. Black and Latino couples are "twice as likely as whites to be raising children."

[xviii] Aisha C. Moodie-Mills and Karen Miller, "Black Churches May Be More Friend than Foe to Gay Congregants," *Center for American Progress*, October 30, 2012, <http://www.americanprogress.org/issues/lgbt/news/2012/10/30/43299/black-churches-may-be-more-friend-than-foe-to-gay-congregants/>.

[xix] Ibid.

[xx] Ibid.

[xxi] Irene Monroe, "Will Obama's Support of Marriage Equality Keep Some Blacks Home on Election Day?" *The Huffington Post*, September 25, 2012, http://www.huffingtonpost.com/irene-monroe/will-obamas-support-of-marriage-equality-keep-some-blacks-home-on-election-day_b_1895246.html.

[xxii] Joyce Carol Oates' "Shame," *The Wheel of Love*, New York: Fawcett, 1970, p. 106.

Tagged with: GLBTQ • hiv • homophobia • race • religion

Homeless People Have Higher Rates of HIV, Hepatitis C, and TB

Details Category: [HIV Policy & Advocacy](#) Published on Friday, 24 August 2012 00:00
Written by Liz Highleyman

Rates of HIV, hepatitis C, and tuberculosis (TB) vary considerably among homeless populations, but are significantly higher overall than those of people with stable housing, according to a study published in the [August 20, 2012, advance online edition of *Lancet Infectious Diseases*](#).

Experts estimate that there are approximately 650,000 homeless people in the U.S. and perhaps 100 million worldwide, though accurate numbers are not available for many countries.

Ulla Beijer from the Karolinska Institute in Stockholm and colleagues performed a meta-analysis to determine the prevalence of 3 infectious diseases of public health significance -- HIV, hepatitis C virus (HCV), and TB -- among global homeless populations.

The researchers searched the PubMed, Embase, and Cumulative Index to Nursing and Allied Health Literature databases for relevant studies published between 1984 and 2012; they also searched bibliographic indices, scanned reference lists, and corresponded with study authors. They explored potential sources of heterogeneity (inconsistency) in the estimates and calculated prevalence ratios to compare estimates for homeless people compared with the general population.

Results

43 eligible studies were identified-- all but 4 from the U.S. or Europe -- with a total population of 63,812 homeless people; this was reduced to 59,736 after accounting for duplication due to overlapping study populations.

Prevalence of HIV infection ranged from 0.3% to 21.1%.

Prevalence of hepatitis C ranged from 3.9% to 36.2%.

Prevalence of TB ranged from 0.2% to 7.7%.

There was substantial heterogeneity in prevalence estimates for all 3 infections.

Prevalence ratios for homeless people compared with the general population ranged from 1 to 77 for HIV, 4 to 70 for hepatitis C, and 34 to 452 for TB.

In the U.S., homeless people had a 20-fold higher HIV prevalence, 4-fold higher HCV prevalence, and 46-fold higher TB prevalence compared with the general population.

Similar patterns were seen in most other countries with available data, including the U.K., France, Sweden, Brazil, and India; adequate information was not available for most low-income countries.

TB prevalence was higher in studies that used chest X-rays compared with other diagnostic methods.

HIV prevalence among the homeless was lower in more recent studies and higher in the U.S. than in other countries included in the analysis.

Higher infection rates were associated with prolonged homelessness and malnutrition.

"Heterogeneity in prevalence estimates for tuberculosis, hepatitis C virus, and HIV suggests the need for local surveys to inform development of health services for homeless people," the study authors concluded.

"The role of targeted and population-based measures in the reduction of risks of infectious diseases, premature mortality, and other adverse outcomes needs further examination," they added, suggesting that focusing on homeless people for detection and treatment could have a major impact on public health.

TB prevalence among the homeless was higher in countries with higher prevalence in the general population, but this was not the case for HIV or HCV, they explained in their discussion. "This result is potentially important from a public health perspective because it suggests that general population measures to reduce rates of hepatitis C virus and HIV infections might not translate into lower prevalences in homeless people," they wrote.

Although they could not identify enough studies to include in the meta-analysis, the authors noted that homeless people have also been found to have high rates hepatitis A and B, diphtheria, influenza, foot problems, and skin infections including scabies and lice.

They recommended that TB screening should involve "active case-finding," and not be restricted to symptomatic individuals accessing health services. Measures including syringe exchange programs and free condom distribution could help prevent HIV and hepatitis C.

In addition to these targeted measures, they added, "reduction of the inequalities faced by homeless people in overall social determinants of health could be part of a wider public health strategy to address infections in some countries."

8/24/12

Reference

U Beijer, A Wolf, and S Fazel. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. *Lancet Infectious Diseases*. August 20, 2012 ([Epub ahead of print](#)).





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Homelessness Proves to Be a Major Block in Treating HIV

By Candace Y.A. Montague

May 8, 2012

Hello there! This Examiner has been on a bit of a hiatus thanks to a writer's block. I am happy to report that it is over. What's new? A study from the researchers at the [University of California in San Francisco](#) about HIV and homelessness. AIDS advocates have been screaming for years that housing is treatment. Who can forget the [stunning piece](#) about a homeless HIV positive woman named Crystal that was published last year for CNN? Now yet *another* study has been published that further proves their point. The study was published in the April 25th issue of [PLoS One](#).

Researchers followed a cohort of 288 HIV positive men in San Francisco who reported being homeless. They were recruited from homeless shelters, free meal programs, and single occupancy hotels for people who live on low incomes. The study lasted for six years. The researchers found that out of all the participants only 58 or one fifth of the men were actually taking their antiretroviral medications. One third of the participants reported currently having symptoms of chronic illness. The three biggest barriers to treatment that the men listed were not having stable housing (including food and hygiene), lack of family and/or social support, and drug use. Dr. Elise Riley, principal investigator and Associate Professor in the UCSF HIV/AIDS Division at San Francisco General Hospital and Trauma Center, stated that the inability to meet subsistence needs has a negative effect on health. "This study shows that a simple focus on providing medications will neither effectively treat nor end HIV in inner cities. **A person's ability to get needed care and take medications becomes less of a priority when they don't have food or a place to sleep.** If we could improve opportunities for people to meet their basic subsistence needs, in tandem with providing antiretroviral therapy, we could improve patients' health and better realize the potential gains to public health." Medication [adherence](#) not only lowers an infected patient's [viral load](#) and prolongs their life but it also makes them less contagious and thus reduces the infection rates.

So what does this mean in terms of ending the epidemic? Simply put, if you want to make a difference in the fight against HIV, you zone in on only giving out condoms and medication. Housing, unemployment, substance abuse, mental health and many other factors must be included in an effective, comprehensive plan. Clearly there is more to this battle than safe sex practices and affordable healthcare (although those things are still very critical). Stigmatized homeless people who are infected with HIV have more pressing issues on their minds than managing medications. They need a stable place to live and regular, commensurate income. What this Examiner wants to see now is how their drug use and their mental health issues are addressed. Would effective substance abuse treatment and counseling for [depression](#) further help with medication adherence? I think it would but I am no expert. I'm just an observer advocating for treating the entire patient over the long haul and not settling for a quick fix.

For more information about this study, [click here](#). If you want to see local AIDS housing advocacy in action, check out [Housing Works](#) and [National AIDS Housing Coalition](#). Both organizations have offices in Northwest D.C.



Is housing and HIV connected?
You bet it is. Photo credit:
[HousingWorks.org](#).