

MAKING CHANGE REAL

The State of AIDS in Black America 2009

Black AIDS Institute
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FROM THE CEO

An Opportune Moment—If We Act

As a 52-year-old Black gay man with HIV, I have many reasons to welcome the inauguration of Barack Obama. A big one is that an Obama administration has enormous potential to reinvigorate a struggle that has been allowed to flag over the last eight years: our national fight against HIV/AIDS.

With our country facing so many challenges—two wars, a financial meltdown and the growing threat of environmental devastation—it may be tempting to relegate the AIDS epidemic to the lower rung of national priorities. That would be a grave mistake. Every year, more than 56,000 people in this country contract HIV. The devastation is worst among Black Americans, who represent nearly half of all new HIV infections, including two-thirds of the new cases among women and 70 percent of the new cases among adolescents.

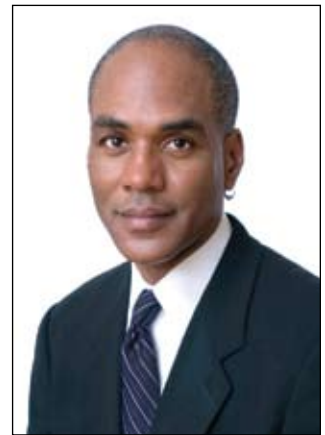
AIDS clearly has affected certain groups more than others. But as then-Sen. Obama said in 2006: “We are all sick because of AIDS—and we are all tested by this crisis. It is a test not only of our willingness to respond, but of our ability to look past the artificial divisions and debates that have often shaped that response.”

AIDS, in short, is a sickness at the very heart of the American family. Like any family, America must respond to the sickness in its midst by displaying both solidarity with those who are living with HIV and a determination to make sure no one else gets infected.

This report—Making Change Real, the 2009 installment of our annual State of AIDS in Black America series—details both the promise and the peril of the era we now enter.

We have elected a new president and a new Congress that have vowed to take aggressive action to end the epidemic, and to focus those efforts on Black America. Our community is more aware of the crisis we face than ever. And as the State of Our Movement section of this report details, Black leaders and organizers are also tuned in, making AIDS a part of their broader work like never before. That’s all the promise.

But 2008 brought shocking news of the danger we face, too. The U.S. Centers for Diseases Control and Prevention reported that the domestic epidemic is 40 percent larger than we have long believed. Even more troubling, the CDC learned, the epidemic is growing at a faster pace



than we have understood. Black Americans are vastly overrepresented among the new infections in every population—men, women, youth, you name it.

The first half of *Making Change Real* spells out these details and explains the trends behind them. But it also discusses the many political and public policy challenges these findings created. The federal government's response to the epidemic has been at best negligent over the past eight years, and our efforts to slow the virus's spread and care for those already infected have suffered mightily as a result. The incoming administration has much work to do in reversing those trends.

We cannot, however, relegate the AIDS fight to the government alone, not even with President Obama at the helm. We must become involved in the political process, holding both Obama and his congressional colleagues accountable for the campaign pledges they made.

We must support efforts to develop a National AIDS Strategy and we must partner with the Obama administration to strengthen HIV prevention. When opposition surfaces to needle exchange or school-based HIV prevention programs, we must speak out and persuade decision-makers that true "family values" don't allow more HIV infections to occur when proven methods exist to prevent them.

The disproportionate vulnerability of Black gay and bisexual men to HIV infection stems in no small part from the prevailing stigma associated with homosexuality. If we are serious about lowering the rate of new HIV infections, we must actively oppose stigma and promote acceptance in our churches, schools and local communities.

We must make knowing your HIV status a universal community norm. The CDC estimates that more than one in five people living with HIV don't know they are infected. Such people are often diagnosed late in the course of disease, which significantly reduces life expectancy. Late HIV testing also contributes to the spread of HIV, because people who are unaware of their infection are at least three times more likely to expose others to the virus than are people who know they are HIV-positive. We need to urge everyone to get tested, and to explain, again and again, the benefits of doing so.

Throughout much of the HIV/AIDS epidemic, mainstream Black organizations stayed on the sidelines. Thankfully, that has changed. Organizations like the Black AIDS Institute, the Balm in Gilead and the National Black Leadership Commission on AIDS have assisted leading Black organizations and historically Black colleges and universities in developing organizational action plans on AIDS. In the *State of Our Movement* section of this report, we update you on the process of turning those plans into actions.

Unfortunately, despite the progress we've made, we're still not where we need to be. That's in no small part due to resources. In 2006, private U.S.-based foundations gave less than a tenth of their HIV-related contributions to activities in this country—less than a tenth! While we continue to help Africa and other hard-hit regions, we need to put out the fire here at home.

The new administration offers enormous promise for a new day in our nation's long struggle against HIV/AIDS. However, President Obama and his team won't be able to reinvigorate the national AIDS response on their own. Let's roll up our sleeves and get to work.

Yes, we can!

Yours in the Struggle,



Phill Wilson
CEO, The Black AIDS Institute

EXECUTIVE SUMMARY

Making Change Real

The 2009 edition of the Black AIDS Institute's annual State of AIDS in Black America report lays out both the promise and the peril of the unique moment at which we've arrived in this epidemic.

On one hand, the historic election of Barack Obama and a congressional majority that has been more supportive of the AIDS fight offers great opportunity. Similarly, Black America is engaged in the struggle to end AIDS like never before. Together, these two realities could create real, lasting change in the course of this epidemic.

At the same time, 2008 witnessed great setbacks, particularly in the effort to prevent the virus's spread. We are seeing the outcome of too many years of neglect, at both the governmental and communal level.

The Challenges We Face

New infections

In 2008, the U.S. Centers for Disease Control and Prevention released its long-awaited study re-examining the size and depth of the U.S. epidemic. Using new technology that allows researchers to learn more detail about individual HIV infections, the CDC discovered, among other things:

- The U.S. epidemic is at least 40 percent larger than previously believed and growing by between 55,000 and 58,000 infections a year;

- The U.S. has never logged fewer than 50,000 new infections a year, contrary to prior belief that we leveled out at 40,000 new infections a year in the mid-1990s;

- Black Americans represented 45 percent of people newly infected in 2006, despite being just 13 percent of the population;

- Men who have sex with men accounted for 53 percent of all new infections in 2006, and young Black men were particularly hard hit;

- In 2006, Black gay and bisexual men between the ages of 13 and 29 accounted for more new HIV infections among gay and bisexual men than any other race or age group. And more than half, or 52 percent, of all Black gay and bi men infected that year were under 30 years old.

Deaths

The racial disparity in AIDS deaths continued in data released last year:

- In 2006, the latest year for which data is available, 7,426 Black Americans died from AIDS. That number represents a meaningful improvement over the previous year—a decline of 1,253 deaths.

■ But Blacks continue to represent a far outsized proportion of deaths each year. In 2006, Blacks accounted for just over half of all AIDS deaths.

The 2009 State of AIDS in Black America report includes a chart pack—"The Black Epidemic: By the Numbers" on page 58—which details key data about the Black epidemic.

Resources

The federal commitment to all areas of AIDS work—prevention, treatment and research—has all but disappeared.

■ The CDC's annual HIV-prevention budget has never topped \$800 million—a fraction of what the U.S. spends on the Iraq war in a week;

■ The prevention budget has been cut by 20 percent in the past five years, in real dollar terms;

■ The CDC spent just under \$369 million on Black-specific prevention and research in fiscal year 2008, or 49 percent of the overall budget.

■ Between 2004 and 2008, the discretionary domestic AIDS budget remained virtually flat, while global spending increased by more than 20 percent annually.

The Promise of a New Era

While the challenges are great, Black America is perhaps better poised to meet them today than ever before.

The new Obama administration has vowed to take action on several fronts, including drafting America's first comprehensive strategy to direct our efforts. (See "Call to Action for a National AIDS Strategy" on page 30, and "What Obama Has Promised" on page 21.) But just as crucial, our community is engaged like never before. From individuals on up to our traditional Black organizations, we've accepted the idea that this is our problem and we must find the solution.

In 2006, 16 traditional Black institutions launched the National Black AIDS Mobilization by signing on to the National Call to Ac-

tion and Declaration of Commitment to End the AIDS Epidemic in Black America (see BlackAIDS.org for text and list of signatories). The 16 institutions are not typical AIDS organizations. These groups, many of which have histories that span generations, were founded to meet a wide range of communal needs and concerns; they have now formally added AIDS to their work.

This report offers an update on the progress each group has made in fulfilling its pledge to act. Many of them have made great strides; others are just beginning their work. In all cases, far more resources and support are required from both public and private funders who seek to impact the AIDS epidemic.

Some highlights from the State of Our Movement section of this report include:

■ In 2008, two crucial groups joined the list of those that have completed strategic plans detailing how they will address HIV/AIDS: the National Association for the Advancement of Colored People and the National Urban League;

■ 100 Black Men of America partnered with Aetna to create a website that members use as a healthcare management tool focusing on HIV/AIDS as well as prostate cancer/colorectal cancer, depression, cardiovascular disease and sickle cell anemia;

■ The National Council of Negro Women hosted a panel discussion at its national convention, a town hall meeting and an online survey that all resulted in a series of recommendations for the next president, including a call for a national strategy to end AIDS;

■ In the fall of 2007 the National Newspaper Publishers Association began a 25-week series of HIV/AIDS opinion pieces that were published in 200 Black newspapers each week;

■ The Potter's House continued its HIV work with Texas ex-offenders and expanded its AIDS work in southern Africa.

These are just a handful of the many initiatives traditional Black organizations undertook in 2008. A full accounting for each group can be found in the State of Our Movement section of this report, and each of their strategic plans are online at BlackAIDS.org.





The State of AIDS in Black America

The State of Prevention From Bad to Worse

Barack Obama stood, jacket off and sleeves rolled, shouting into his mic and straining to be heard over the roaring crowd that turned up to welcome him back to Kenya. It was August 26, 2006, and the world was already watching.

The young senator was just a few months away from launching his improbable bid to become the 44th president of the United States, and he needed to demonstrate his ability to walk on the global stage. So he'd chosen a swing through Africa as his first major diplomatic foray, with a grand return to his father's homeland as the highlight. The trip would be roundly praised. He'd be warm, but also challenging. He'd make a bold statement against corrupt government in African nations. And he'd offer his family as a deeply personal example of leadership in the fight against HIV.

"One of the reasons that we're here today," Obama began, having quieted the crowd gathered around him in front of a tiny mobile clinic, "is because HIV and AIDS have ravaged the community." His visit to Kenya had just begun and he'd decided to use this welcoming moment, in which thousands thronged the streets, to send a pointed message about ending AIDS. He told the

crowds that he and his wife, Michelle, were about to take HIV tests—and if they could do it, so could everyone else present. "I am so happy now because I know the status of my wife and I," Obama declared after the test. "We are both negative, and I can take control of my family and all tasks that lie ahead of me."

Just over two years later, those tasks are greater and graver than anyone ever imagined. President Obama now faces crises ranging from a global economic collapse to a rapidly destabilizing environment. But the challenge he chose to highlight that Saturday afternoon in Kenya has also grown more urgent, including right here in the United States.

Over the past eight years, America has rested on the AIDS treatment successes of the previous decade, turning its focus solely abroad while assuming a domestic victory it has not yet won. The result, as the Black AIDS Institute outlined in our 2008 report, *Left Behind: Black America—A Neglected Priority in the Global Epidemic*, is a Black epidemic that looks more and more similar to those in places like Kenya. From rural Alabama to densely-packed Oakland, California, the Black American epidemic's breadth and complexity mirrors that of poor communi-

ties throughout sub-Saharan Africa. (See “Left Behind” on this page.)

During his presidential campaign, Obama signaled that he understands the tangled-up crises that have produced the epidemic in Black neighborhoods, and he vowed not to shrink from that reality if elected. “When we are impoverished,” he said during a primary debate at Howard University, “when people don’t have jobs, they are more likely to be afflicted not just with AIDS, but with substance abuse problems, with guns in the streets. So it’s important for us to look at the whole body here.”¹

His campaign platform included a plan he argued would do just that. (See “What Obama Has Promised” on page 21.) Complex, big-picture analyses like the one Obama offered at Howard too often become excuses for inaction in the face of tough problems; it’s a trap that many people in all walks of life have fallen into when confronted by HIV. But Obama’s potential is to spring policymakers from this trap and end Washington’s three-decade-old vacillation between ignoring the problem and groping for a quick fix to it.

It will be tempting for policymakers and advocates alike to allow the hard work of realizing the new administration’s potential on AIDS to drop in priority, given the overwhelming economic challenges the nation faces. We cannot afford that delay. Like many of the challenges President Obama now faces, the previous administration’s neglect of Black America’s downward spiral into AIDS makes urgent action a dire necessity now.

From Bad to Worse

The year 2008 was chock-full of bad news, far too much of it as predictable and preventable as it was devastating. AIDS was no different.

For many Americans, the news got lost amid the uproar over soaring gas prices and plummeting 401(k)s. But the summer of 2008 marked a similarly grave turn for the health of Black neighborhoods: The U.S. Centers for Disease Control and Prevention, or CDC, announced that the American AIDS epidemic

is at least 40 percent larger than previously believed.²

Nearly a decade ago, the CDC began developing a new system for monitoring the American AIDS epidemic. For years, HIV tests could determine only whether the virus was in a person’s blood, not how long it had been there. That meant researchers couldn’t differentiate a new infection—say, one that’s six months old—from an old infection—one that’s six years old. And as a result, they couldn’t detect with precision how fast or slow the virus was spreading, only how fast or slow health workers were diagnosing its spread.

A new testing technology, however, now allows the CDC to essentially time-stamp an infection. “It’s like shifting from standard-view to wide-screen HD TV,” quipped CDC’s HIV and STD prevention director Kevin Fenton in explaining the technology to reporters. And using that sharper vision, CDC’s number crunchers went back and de-

Left Behind

In August 2008, the Black AIDS Institute published *Left Behind: Black America—A Neglected Priority in the Global AIDS Epidemic*. The report asked how an independent Black America would compare to the rest of the world. It found that Black America, as its own country, would have an epidemic on par with those that have been targeted for emergency aid in the global epidemic. An independent Black America would have, among other things:

- More people living with HIV than seven of the 15 countries targeted for special assistance by the U.S.;
- More people living with HIV than just 16 countries;
- An HIV prevalence greater than just four countries outside of sub-Saharan Africa;
- A lower life expectancy than Algeria and the Dominican Republic;
- An infant mortality rate twice that of Cuba.

veloped new estimates for the annual growth of America's epidemic. The results, published in the August 6, 2008, issue of the *Journal of the American Medical Association*, were arresting.

Since the early 1990s, the CDC had estimated that 40,000 Americans were newly infected each year. We now know that America has never logged fewer than 50,000 new infections a year. That low mark came in the early 1990s, where it stayed until the late 1990s, when infections began ticking upward. From that point forward, between 55,000 and 58,500 Americans have contracted HIV every year; in 2006, the most recent data available, the CDC found 56,300 new infections.³

The study confirmed what we already knew about where all those new infections are being found: among Black people, from all walks of life, and among gay and bisexual men of all races. In 2006, Black Americans accounted for 45 percent of new infections, though we're just 13 percent of the overall population. Gay and bisexual men were 53 percent of infections that year.⁴

Later, in September 2008, a follow-up study drilled down on those numbers to provide disturbing details: The Black epidemic

is not only larger and faster-growing than the rest of the American epidemic, it's also younger. Among Black gay and bisexual men in particular, an entirely new generation is being captured by HIV.

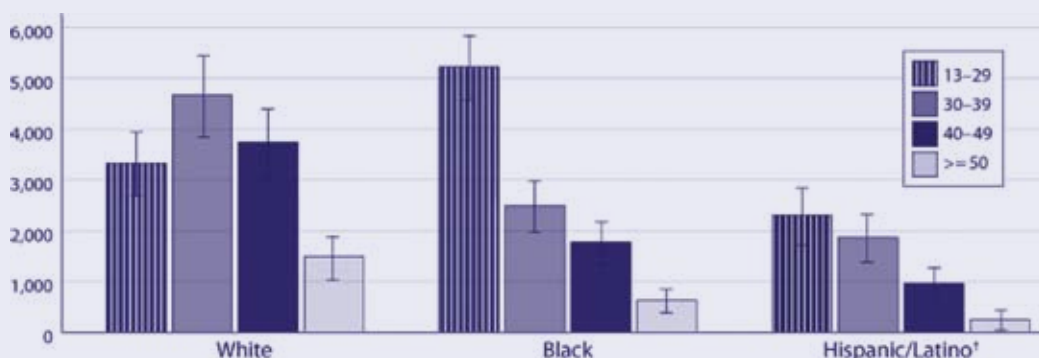
Black Gays in 'Urgent Need'

The most dramatic news from the 2008 CDC studies involved those whom public health workers call "men who have sex with men," a term that encompasses everyone from those who identify as gay to those who have occasional homosexual relationships. Conventional wisdom had held that, while more people were getting infected every year, the pace at which those new infections occurred wasn't quickening. The CDC's new testing technology allowed researchers to prove this assumption deeply wrong among gay and bisexual men. "Infections have in fact been rising among men who have sex with men," said Fenton in August, "since the early '90s."

And they've been rising most sharply among young Black men. In 2006, the CDC has discovered, Black men between the ages

Losing a New Generation

In 2006, Black men between the ages of 13 and 29 accounted for more new HIV infections among gay and bisexual men than any other race or age group. And more than half, or 52 percent, of all Black gay and bisexual men infected that year were under 30 years old.



Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, MMWR, 57(36);985-989.

of 13 and 29 accounted for more new HIV infections among gay and bisexual men than any other race or age group. And more than half, or 52 percent, of all Black gay and bi men infected that year were under 30 years old.⁵ (See “Losing a New Generation” on previous page.)

Overall, 63 percent of all Black male infections were found among men who have sex with men in 2006.⁶ “These data,” Fenton concluded, “point to an urgent need in this population.”

For years, public health watchers have worried about “HIV prevention fatigue” among young gay men. But we now know that the rapid growth of infections among young men is unique to Blacks. Among whites, for instance, new infections were more evenly spread, with men in their 30s and 40s accounting for the largest share, while men under 30 accounted for just 25 percent of new infections.⁷

So why does it appear young white gay men are avoiding the pitfalls of their elders while young Black men are not?

That is yet another unanswered question about the Black AIDS epidemic. CDC officials theorized during the rollout of the agency’s September 2008 report that Black gay youth are more likely to have sex with older men, and thereby put themselves at greater risk. Other researchers have noted that, like Blacks overall, young Black men who have sex with men choose sex partners from within smaller pools of people and, thus, once HIV is introduced it spreads quickly.

One thing that seems clear is that young Black gay and bisexual men do not perceive themselves to be at great risk for HIV, which in turn may make them less likely to learn their HIV status and to take steps to protect themselves or their sex partners. In a dramatic June 2005 study, the CDC found nearly half of the Black gay and bisexual men it tested were HIV positive; roughly two-thirds of them had not been diagnosed.⁸ An older CDC study, conducted in the 1990s, found that 90 percent of the twenty-something Black gay and bisexual men who tested HIV

positive hadn’t considered themselves to be at risk.⁹

But there is also research suggesting that this disconnect between actual and perceived risk isn’t entirely made up. It appears that young Black gay and bisexual men do not think they are at greater risk for HIV because they aren’t doing things they’ve been told would put them at greater risk. CDC researcher Greg Millet, who is both Black and gay, has culled several studies to illustrate this fact.¹⁰ Young Black men who have sex with men are less likely to have unprotected anal sex of any sort than either their white or Latino counterparts, Millet says, and they are no more likely to have unprotected anal sex as the receptive partner (HIV is transmitted far easier as the receptive partner than as the inserting partner in anal and vaginal sex). They are also far less likely to use crystal meth, cocaine, injection drugs—even “poppers.” And they are no more likely to work as prostitutes.

The question remains what factors, then, put them at greater risk—and what can be done to reduce that risk. Those factors are likely manifold, ranging from biology to social networks to individual emotional challenges. But one thing is clear: We won’t stop AIDS until we stop it among young Black gay and bisexual men. Both national and local studies dating back to the 1990s have been finding dramatic racial disparities among young men who have sex with men.¹¹ The 2008 data only reinforces the point by making it clear that the epidemic’s growth over the last 15 years is in no small part due to its growth among Black men who have sex with men.

Black Women and STDs

The CDC’s 2008 reevaluation of the epidemic’s scope in America also reinforced what we know about racial disparities among women. Although the majority of new HIV infections among Blacks in 2006 were found

Penny Wise, Pound Foolish

The U.S. Centers for Disease Control and Prevention's domestic HIV prevention and research budget has never reached \$800 million a year—a fraction of what the U.S. has spent in a week of war in Iraq—and was cut or held flat every year of the Bush administration. Meanwhile, 56,300 new infections were logged in 2006 alone, the last year for which data is available. Here are some facts about America's financial commitment to ending the epidemic's spread.

CDC's FY2008 HIV prevention budget	\$753.6 million
Amount targeted at Black community	\$369 million*
Budget CDC says it needs in FY2009	\$1.6 billion
Potential cost of new infections in 2006	\$56 billion

Sources: CDC, *Professional Judgment Budget*, submitted to U.S. House of Representatives Committee on Oversight and Government Reform, September 16, 2008

* Roberts, G, *HIV/AIDS among African Americans: CDC's Strategies for a Heightened National Response*, presentation at CDC Consultation on HIV/AIDS and African American Women, June 20, 2007, accessed online on January 4, 2008, at <http://www.cdc.gov/hiv/topics/aa/cdc.htm>.

among men who have sex with men, Blacks were again far overrepresented among women who contracted the virus. Just over 60 percent of women infected in 2006 were Black, who had a rate of new infection that was almost 15 times as high as their white counterparts.¹²

CDC offered no new information about the forces driving the racial disparity among women. But a separate study, in the spring of 2008, reaffirmed at least one major cause that has received far too little attention within the Black community: the high prevalence of undiagnosed and untreated STDs, which greatly facilitate HIV transmission.

Since the turn of the millennium, far too many conversations about the racial disparity in HIV infections among women have been dominated by speculation over their relationships with closeted gay men—popularly known as men “on the down low.” And research does suggest that Black men who have sex with men are much less likely to identify as gay or bisexual than their white peers or to disclose their sexual orientation, regardless of the identity or terminology they use for it.¹³ However, there appears to be little link between this fact and their HIV risk.

In fact, men who identify themselves as

“gay” are both more likely to report behavior that puts them at risk for HIV and are more likely to be HIV positive than men who have sex with men but do not identify as gay. The same dynamic is true among men who do not disclose their sexual orientation—they are both less likely to be HIV positive and less likely to take sexual risks with their male partners than men who are “out.”¹⁴

Yet, the conversation about “down low” men has deeply overshadowed the far more crucial one about STD testing and treatment among both Black women and Black men. HIV requires a route of entry to a person's bloodstream—something that is actually relatively difficult for the virus to find. Certain types of sex offer more ready entry points than others—the vaginal and anal canals, for instance, offer HIV far more access than the penis does. But STDs make everything much easier, because they both create breaks in the skin and increase the density of cells that HIV targets.¹⁵

Moreover, a person who has an STD and is also HIV positive is far more infectious than one who only has HIV. An HIV positive man with gonorrhea, for instance, has a concentration of HIV in his semen that is 10 times higher, as a median, than his counter-

part who has only HIV.¹⁶

As a result of these factors, the presence of an STD makes a person as much as five times more likely to contract HIV when she or he encounters it.¹⁷

And in 2006, Black Americans had higher rates of all STDs than their peers. Black women were 16 times more likely to have syphilis than white women, 15 times more likely to have gonorrhea and seven times more likely to have Chlamydia.¹⁸ (See “How STDs Help HIV” on page 68.)

Here again, young people are of particular concern. In March, at the CDC’s annual HIV and STD prevention conference in Atlanta, the agency released a stunning study showing that half of Black teenage girls have had a sexually transmitted infection.¹⁹

For the study, which was the first of its kind, researchers culled through 2003-2004 data in an ongoing, annual health survey of American households. As part of that survey, 838 14- to 19-year-old girls were tested for a handful of common sexually transmitted infections—chlamydia, herpes and human papilloma virus, or HPV. Forty-eight percent of Black girls had at least one of the STIs, compared to 20 percent of white and Mexican American girls (the only Latino group CDC broke down the numbers on). Researchers expect the teen STI and STD rate to be even higher than they actually found, because the study didn’t include a number of serious infections, such as syphilis and gonorrhea.²⁰

Obama and HIV Prevention

In all of this, from syphilis and chlamydia to HIV, public health officials have stressed and re-stressed the need for more people to get tested. That’s part of what made Barack and Michelle Obama’s dramatic, personal example in Kenya so significant. CDC stresses that roughly a quarter of Americans who are HIV positive don’t know it and the agency believes a lopsided share of new infections stem from

that fact.²¹ (See “HIV Testing and Transmission in America” on page 66.)

But in the course of his presidential campaign, Barack Obama also made some pointed policy commitments related to preventing HIV’s further spread. Most significantly, he declared his support for comprehensive sex education in public schools and vowed to “pursu[e] a strategy that relies on sound science and builds on what works.”²²

The Bush administration offered vigorous support for abstinence-only sex education, which bars educators from discussing safer sex tools like condoms. According to the Sexuality Information and Education Council of the United States (SEICUS), a sexual health research and advocacy group, the fiscal year 2007 federal budget included \$176 million for abstinence-only programs, and Washington had spent \$1.5 billion on these programs since 1996. Yet, study after study has proven them to not only fail in keeping students from having sex, but also to disseminate dangerous and inaccurate information. The body of evidence against abstinence-only is so great that, according to SEICUS, 25 states had refused to accept the federal money as of August 2008.²³

The incoming Obama administration and Democratic Congress can take a simple, direct step toward ending HIV’s spread by turning off the federal spigot for abstinence and directing funds to support locally designed, comprehensive sex education.

More broadly, the new administration and Congress can make real change by putting meaningful money into the CDC’s woefully underfunded prevention work.

On March 8, 2007, CDC called dozens of movers and shakers in the African American community together for a meeting in Atlanta to launch what it has dubbed the Heightened National Response to the HIV/AIDS Crisis among African Americans. The attendees were a mish-mash of community leaders, ranging from the National Medical Association’s chief to Ludacris’s mother, and the agency extracted pledges from all of them to get involved in the fight against AIDS. CDC Director Julie Gerberding in turn pledged

to get them some money with which to get involved.

And the CDC has indeed targeted its domestic HIV prevention and research funds at Black Americans. According to CDC, 49 percent of that budget goes to programs working in the Black community—reflecting the fact that 45 percent of new infections are in Black America. That means CDC spent just under \$369 million on Black-specific prevention and research in fiscal year 2008. The agency has vowed to direct still more funds toward Black-focused prevention work as they become available. It says that 63 percent of the prevention dollars newly available in fiscal years 2006 and 2007 went to programs targeting Black Americans.²⁴

The problem is that even targeting the whole of CDC's paltry HIV prevention budget toward Black communities wouldn't do the job. The CDC's annual HIV-prevention budget has never topped \$800 million—a fraction of what the U.S. spends on the Iraq war in a week. Indeed, the prevention budget peaked in fiscal year 2001, at the Bush administration's start, with just \$767 million. It has declined or remained flat every year since then. The only area of the prevention budget that has increased in recent years is that for testing, though even that money has actually come from moving cash out of other piles, according to the Community HIV/AIDS Mobilization Project.

Few genuine stakeholders inside or outside of government would argue that this funding history reflects the need. In September 2008, the House Committee on Government Reform and Oversight reacted to the summer's news about the epidemic's growth by holding the first-ever oversight hearing on HIV prevention in the U.S. CDC Director Gerberding testified that her agency should spend \$1.6 billion this year on HIV prevention—more than double the current budget—and \$4.8 billion over the next five years.²⁵ “Not only do we need to expand what we know can work, we've got to find new things,” Gerberding told Congress, according to press reports. “The research for new tools is a very important part of it.”²⁶

The cost of not investing in prevention is far greater than the funding Gerberding requested. As outlined in a report Gerberding submitted to the House committee, the costs of medical care and early death are estimated to be over \$1 million for every person living with HIV. “Put another way,” the report explains, “56,300 new HIV infections each year may cost the nation over \$56 billion.”²⁷ (See, “Penny Wise, Pound Foolish” on page 14.)

Meanwhile, the number of people getting infected—particularly in Black neighborhoods—has climbed each year that the prevention budget has stagnated and declined. That trend will continue in the first year of the Obama administration, and in every subsequent year, if the new president does not recognize AIDS as a similarly pressing priority as the economy and the environment. If, however, President Obama offers the same sort of political leadership as he displayed in his personal life during his Kenya visit, he can change the course of this epidemic.

Notes

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Q&A

Dr. Anthony Fauci

National Institutes of Health

The largest share of the discretionary AIDS budget is dedicated to scientific research, housed at the National Institutes of Health. In fact, AIDS research accounts for 11 percent of NIH's overall budget. The Black AIDS Institute spoke with Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, about the agency's prevention research.

BAI: We got lots of bad news in 2008 about prevention and the size of the epidemic. From NIAID's perspective, did that tell you anything new?

Fauci: The data maybe was new to the public, but it was something that I had been aware of. As you might expect, I was really quite saddened and disturbed about the extraordinary disparity that we're seeing, with the numbers that you're so familiar with...which tells us that we're really not doing things optimally from the standpoint of prevention in general.

One thing we heard about prevention last year was that we don't know enough about what works among Black gay men. Can you point to anything on NIH's research agenda dealing with that?

The National Institute of Mental Health and NIAID have a number of studies. These are difficult studies to do. I would say that the behavioral modification studies—they are important and are being pursued—are really very difficult, because understanding the behavior and changing the behavior are two very different things. But there are studies that are ongoing and that are being proposed at the NIMH and NIAID about behavior modification that specifically relates to African Americans.

I know that there's a lot of research on microbicides. Can you talk about what kind of progress we have or haven't seen so far?

First of all, is there a need for a topical microbicide? The answer is overwhelmingly yes. Particularly in the circumstances that we see widely in the developing world, and we even see it in some subsets of cultures



in our own country—the lack of ability of a woman to negotiate her own sexual behavior with a sexual partner, the disenfranchisement, the encroachment on what are fundamental human rights of women. We see that throughout the world, but we also see that situation in the United States. So women need to have a method of being able to protect themselves.

The issue with the topical microbicide is there's been disappointing results so far. The products that have been used have irritated the vaginal mucosa and whatever potential HIV-blocking affect has been overridden by the inflammatory response. Or, by the fact that in some studies women are not actually

inserting the topical microbicides into their vaginas.

But, what has been a series of failures, hopefully—and I say this with some cautious optimism—will be replaced by progressive advances as we start to test topical microbicides that have an HIV-specific antiviral in them. Most of the previous studies were of actual physical blockers of HIV and other microbes—almost being spermicides, or materials that would physically block, as opposed to have an antiviral effect. The fundamental scientific basis for the antiviral microbicides is on much firmer ground.

And for vaccines? There has been disappointing news in recent months. Where do we stand?

It's been quite problematic with regard to vaccine development. People ask the question, appropriately, 'Why is it that, although we have vaccines for so many other even deadly diseases, we can't get a vaccine for HIV?' There are a number of reasons.

The one that is easiest to understand is that when we develop vaccines for viruses ranging from smallpox to polio to hepatitis, the body does us a favor. And the favor is that it already developed a proof of concept for us. Because despite the fact that 15 percent of the people who get smallpox die, or many get disfigured, at the end of the day the body ultimately clears the virus, stops

the disease and leaves you with, usually, lifelong protection against subsequent challenge. So it's proven that the body can respond to these viruses. So when you make a vaccine, you try to mimic natural infection; that's what most vaccines do.

Unfortunately, that's not the case with HIV, because the body, for reasons that we still don't understand, does not in most cases mount an effective immune response against HIV. There's a very small percentage, maybe 5 percent, who are able to control the virus. The body almost always gives in to the virus, because the virus evades the body's immune response. So when we develop a vaccine, we don't have the advantage of the body mounting guideposts for us.

With HIV, we have been fundamentally using classic vaccinology approaches—hoping that the body would make an effective immune response. We now know—through learning more about how the virus works over the years, as well as some disappointing results with the vaccines we've tried—that we have to turn the knob of our research a bit away from development and much more towards discovery. We have to ask and answer some of the fundamental questions that natural infection has not answered for us.

That sounds like, 'Back to square one.'

I wouldn't say square one, but it's going back and

filling in some of the blanks that we assumed would not need to be filled in, as was the case with other types of virus and vaccines.

Many advocates have complained about resources dedicated to AIDS in recent years. Do you feel like your research efforts have been held back because of the resources you've had? And what are you saying to the incoming Congress about what resources you'll need?

Well, whenever you talk about science, there's never enough, because science is discovery, and until you've made all of the discoveries that you need to, you always could use more. At the NIH, we've been in a very difficult position for the last five years: Our budget has been flat.

Having said that, we have a very robust budget. I mean, 11 percent of the entire NIH's resources are for AIDS research. So we do spend a lot of money on research in general, and \$2.9 billion a year on AIDS research. That's a lot of money. Could we use more? Absolutely. And as I have in the past, I will continue to make the point to the administration and the Congress that we do need more resources and we can do things better and quicker with more resources.

The State of Treatment Planning for Life

One thing is clear about the new Congress and the Obama administration: They agree on the fact that health care reform, broadly, must be among the first policy challenges tackled in 2009. Indeed, the first nomination hearing the new Congress held upon convening in January was for Tom Daschle, Obama's choice to lead the Department of Health and Human Services, as well as his newly-created White House Office of Health Reform. Daschle has emphasized that he believes the Clinton-era reform effort failed primarily because the administration waited too long to roll it out, and he's vowed not to repeat the mistake.

It's similarly certain that the national debate over what our new health care system looks like will be a grueling one. So much so that, in early January, Obama's transition team began floating CNN personality Sanjay Gupta as a candidate for surgeon general—bringing a celebrity voice and skilled television communicator to the team. The question remains, however, whether whatever system emerges from the fight will be one that is prepared to deal with the increasingly complex

and steadily worsening AIDS epidemic.

Over the past 12 years, America's combined successes and failures in responding to the AIDS epidemic have put the country on track for a major treatment access crisis. On one hand, the phenomenal success of antiretroviral drugs has kept people alive. The AIDS death rate in America plummeted 70 percent in just two years when combination therapy hit the market. Today, people living with HIV and AIDS have 28 meds in five drug classes from which they can build treatment regimens. More options are still on the way.

But the drugs are not a cure, and that means there are also more people in need of ongoing, lifelong care and treatment today than ever before. Many of them, particularly those who are Black, do not have adequate private health insurance to cover the massive costs of that care. The federal program that supports care and treatment costs for low-income people with HIV/AIDS had more than half a million clients in 2006 and paid for meds for just under a third of people with AIDS getting treatment.¹ Medicaid and Medicare cover about half of people in treatment.²

States share the costs of these public care systems with the federal government—and carry a significant portion of the finan-

cial burden. That's bad news in the current economy. As governors and state legislators scramble to deal with exploding budget deficits, AIDS programs are as likely as any other to face serious budget cuts. This, just as more people lose private insurance and turn to the public system. In many states, particularly in the South, AIDS programs are likely to be among the most vulnerable. Yet, the already tattered AIDS safety net—which has been severely neglected over the past eight years—can hardly afford that financial instability.

Obama and Daschle have vowed to avert disaster. Both have pledged to make sure that AIDS funding reflects the demographics of the epidemic—which must mean that more resources get spent in Black communities, among gay and bisexual men and in the South. And most significantly, Obama has vowed to overhaul the AIDS safety net by drafting America's first ever national strategy for addressing the epidemic—and to begin implementing it in his first year in office.

Death in Black America

In 2006, the latest year for which data is available, 7,426 Black Americans died from AIDS. That number represents a meaningful improvement over the previous year—a decline of 1,253 deaths.³ That's in keeping with the trend of steadily declining annual deaths that began more than a decade ago, with the arrival of combination therapy.

But despite the improvement in numbers, Black Americans continue to represent a far outsized proportion of deaths each year. In 2006, Blacks accounted for just over half of all AIDS deaths, though we represent just 12 percent of the population.⁴ The racial disparity in AIDS deaths is the countering trend to the gradually decreasing number of annual deaths: Blacks have accounted for roughly half of annual deaths ever since combination therapy hit the market in the mid-1990s, and have represented a steadily increasing share of deaths since the epidemic's start.⁵

Similarly, southern states—which have larger Black populations and rapidly intensi-

What Obama Has Promised

Barack Obama made many impressive promises about how he'd deal with AIDS during the campaign. Given the host of massive, historic challenges the new administration faces, it will be tempting to allow these pledges to linger on the back burner. But AIDS is one more issue that cannot afford delay, after more than a decade of neglect.

Obama's AIDS Platform

- Draft and implement America's first national strategy for dealing with HIV/AIDS, to be completed in the first year in office.

- The strategy will encompass all federal agencies and include "measurable goals, timelines and accountability mechanisms."

- Target "resources to promote innovative HIV/AIDS testing initiatives in minority communities and partnering with a wide-range of community leaders from churches to community organizations."

- Support HIV prevention based on "sound science," including providing funds for comprehensive sex education and lifting the ban on federal funding of syringe exchange.

- Increased funding for prevention research, particularly for microbicides and other tools that help women take prevention into their own hands.

- Increased funding for both Ryan White CARE Act and the Housing Opportunities for People With AIDS program.

- Expand Medicaid to make low-income, HIV positive people who are not yet disabled eligible.

Source: Obama for America, Barack Obama: Fighting HIV/AIDS Worldwide, accessed online on January 14, 2008 at <http://www.barackobama.com/pdf/AIDSFactSheet.pdf>.

fying epidemics—have hosted a steadily increasing share of deaths since the treatment revolution of the mid-to-late 1990s. In 2005, more than four in 10 AIDS deaths occurred in the South.⁶

Researchers have explored many reasons for the racial disparity in AIDS deaths, and there are many more we don't yet know or understand. But one contributing factor that seems certain is the fact that Blacks are less likely to learn about their HIV infection before they get sick and, thus, before the infection reaches an advanced stage. The HIV therapies that have kept patients alive for the last 12 years depend upon halting the virus' progress before it has dug too deeply into the body to reverse.

HIV testing numbers can be deceptive. Black Americans are significantly more likely to report having been tested recently than other racial and ethnic groups. (See "HIV Testing and Transmission in America" on page 66.) But at the same time, a far larger share of Black Americans is likely to be HIV positive—which means a far larger share of positive Blacks haven't been tested. The CDC estimates more than half of HIV positive Blacks are undiagnosed.⁷ Black gay and bisexual men are particularly likely to discover their infections only after they have reached advanced stages.⁸

CDC and others speculate that this late-stage diagnosis is in part owing to Blacks' limited access to preventive health care. And that limited access to care, broadly, is itself likely an additional factor driving the racial disparity in deaths.

Study after study has shown Black Americans overall to have less access to quality care than their peers. More than one in five Blacks lacked health insurance in 2006, twice the rate among whites.⁹ This unequal health care system produces starkly unequal results, across the board. From diabetes to heart disease to prenatal care, Blacks fare far worse with preventable, treatable diseases than any other racial or ethnic group. And as a result, life expectancy for Black Americans is on par with the Gaza Strip, and lower than that of countries like Algeria and Sri Lanka.¹⁰

AIDS, of course, is no exception to these deadly rules.

Making up Lost Time

HIV-positive Blacks who do find care and treatment are far more likely to get it through a public program, such as Medicaid, Medicare or the AIDS Drug Assistance Program. One study found that two thirds of Blacks in treatment for HIV rely upon public insurance programs.¹¹

Indeed, a close look at the clients who rely upon programs funded by the Ryan White CARE Act is telling.

The CARE Act is the primary vehicle Congress uses to direct AIDS funds to state and local governments, who then augment the resources and disperse them to local-level efforts. The CARE Act funds things ranging from community-based clinics to the AIDS Drug Assistance Program, which purchases medications for people who don't qualify for Medicaid but are nonetheless uninsured or inadequately insured.

In 2006, 59 percent of CARE Act clients were people of color. Nearly a third of people with AIDS getting treatment that year paid for it with ADAP, and 60 percent of those people were of color.¹² (See "Who Needs It?" on next page.)

But these public health care systems face enormous budgetary pressures today. Even before the economic collapse of 2008 gripped state budgets nationwide, both Medicaid and CARE Act programs had been on a multi-year slide to insolvency. ADAP systems—administered at the state level—face budget shortfalls every year, leading to waiting lists and service cuts. As recently as 2007, at least four people died while lingering on the waiting list for service in South Carolina.

Today, ADAP is on more stable ground, after Congress pumped emergency funding into the program. In the current fiscal year, it's one of few AIDS programs to have received additional resources. The Medicare

prescription drug benefit has also helped to offset ADAP expenses. But these piecemeal responses are not likely enough to prevent the crisis from returning. And beyond ADAP, local-level CARE Act programs around the country have been reporting resource shortages for years, forcing them to cut back on services.

The difficult reality is that even as the epidemic has grown larger than ever—and, thus, the demands on the AIDS care and treatment safety net greater than ever—funding has ceased to increase. And, as with HIV prevention funding, in many cases resources for AIDS care and treatment have shrunk during the Bush years—and in real dollar terms have certainly done so.

Medicaid, Medicare and Social Security are mandatory items in the U.S. budget, and federal funding for them must rise and fall according to a set formula. Together, they account for roughly half of the U.S. domestic AIDS budget. The rest is discretionary, decided upon by Congress and the White House each year—and they’ve decided not to spend. Between 2004 and 2008, the discretionary domestic AIDS budget remained virtually flat, while global spending increased by more than 20 percent annually. (See “Surrendering at Home” on next page.)

Meanwhile, the CARE Act awaits—and needs—significant reforms.

The program must be reauthorized every five years, and was due for its regular reevaluation in 2005. But a bitter geographic feud has delayed the process. Southern states and their congressional representatives have argued that the existing formula for dividing up the money is unfair because it gives preference to older, urban epidemics in places like New York City and San Francisco. Lawmakers and advocates in those places have pushed back, arguing that they face problems of their own and should not be penalized for having dealt with them for decades. A compromise bill reauthorized the program for three years and set in motion a process for an orderly, comprehensive review, led by Sen. Ted Kennedy’s office.

In Tom Daschle’s confirmation hearings,

two Republican senators—North Carolina’s Richard Burr and Oklahoma’s Tom Coburn—asked Daschle to commit that federal dollars would “follow the epidemic.” That means directing more money to Black communities, sure, but the geographic jab could not be missed either.

“Do you agree with me,” Burr asked during his questioning, “that the funding should follow those that are infected with HIV?”

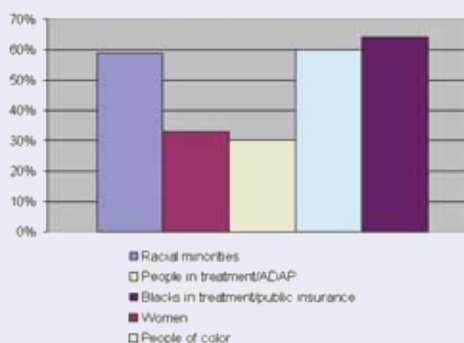
“While I think there are differences with regard to how the overall funding ought to be calculated,” Daschle responded, “I generally believe that that direction in funding is appropriate and ought to be respected.”

But wherever dollars get directed, there must first be enough of them to matter. And

Who Needs It?

When the AIDS care safety net frays, who loses out? You guessed it—African Americans.

■ Number of people the CARE Act serves	530,000
■ Share who are racial minorities	59%
■ Share who are women	33%
■ Share of people in AIDS treatment paying with ADAP	30%
■ Share of those who are people of color	60%
■ Share of Blacks in treatment paying with public insurance	64%



Source: Presentation by Deborah Parham Hopson, HIV/AIDS Bureau of the Health Resources and Services Administration at Black AIDS Institute briefing, October 13, 2006. Washington, D.C.

the reality is that, long before an economic crisis erupted, AIDS care and treatment funding had been so neglected that a crisis has developed. Any effort to reform the system will demand the new Congress and administration, at minimum, close the resource gap that opened up over the past eight years.

Obama's Promises

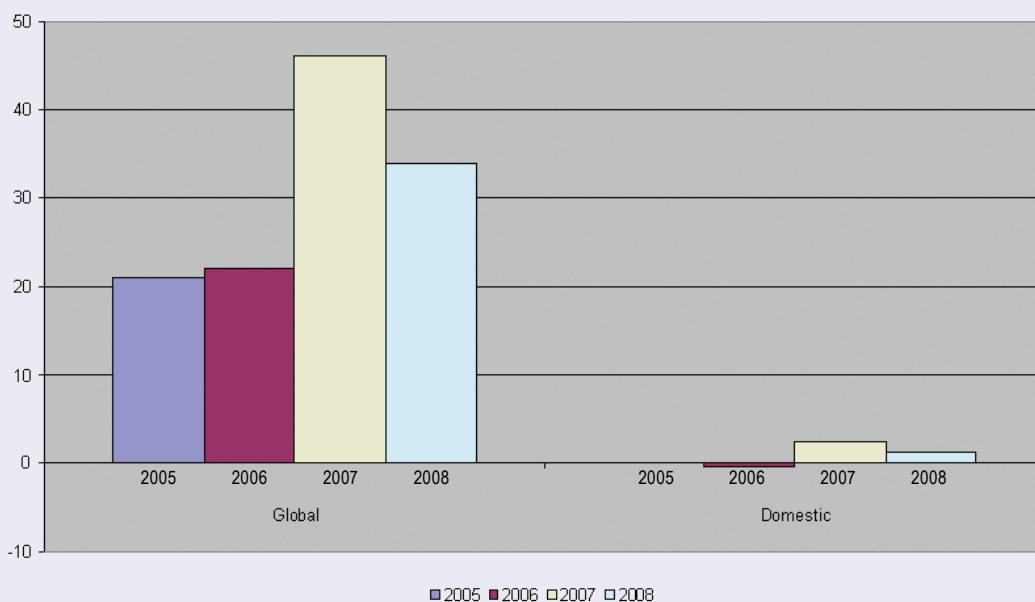
Obama has vowed to deal with all of these AIDS treatment and care challenges through

Surrendering at Home

Over the last five years, the White House and Congress have increased spending on HIV prevention, treatment and support programs for low-income countries dramatically – at the same time that domestic spending has remained all but flat. Domestic spending remains by far the largest share of the U.S. AIDS budget, but primarily in the form of mandatory expenditures on Medicaid, Medicare and Social Security, which account for roughly half of overall U.S. HIV/AIDS spending. Congress must pay a fixed share of the expenses for these programs, regardless of how high the cost grows. The graph below compares global spending with discretionary domestic spending, or the budget Congress and the White House decide upon each year for all prevention programs and treatment and support programs for the uninsured.

Year-to-Year Change in U.S. HIV/AIDS Spending, Fiscal Years 2004 to 2008

Year	Global change*	Domestic discretionary change**
2005	+21%	+ 0%
2006	+22%	−0.4%
2007	+46%	+2.5%
2008	+34%	+1.2%



*Does not include international research

**Does not include mandatory spending such as Medicaid, Medicare and Social Security

Source: Kaiser Family Foundation. U.S. Federal Funding for HIV/AIDS fact sheets for fiscal years 2004-2008.

his broader health system reforms. He argues his plan will achieve universal health coverage in America. The details will be hashed out over the coming months, but the broad idea is to build a public program to compete with existing private insurers.

So what will Obama's new public insurance program look like? During the campaign, he outlined a few broad principles:¹³

- Employers will have to either offer insurance or contribute to the program;

- The public plan will be on par with that offered through the Federal Employees Health Benefits Program, which insures members of Congress;

- The public plan will be portable—or, not tied to any employer;

- He will create a National Health Insurance Exchange, which will act as a clearinghouse for people to buy the public or any private plan. The Exchange will also serve as a quality-control watchdog for those plans.

Two features are most specifically relevant for people living with HIV and AIDS:

- People who can't afford the public plan but don't qualify for Medicaid will receive a subsidy they can use toward buying either public or private coverage—and Obama vows to expand Medicaid, including to allow people who are living with HIV but not yet disabled to qualify;

- No plan, public or private, will be able to deny coverage based on preexisting conditions.

But the most important commitment Obama has made to making sure everyone living with HIV/AIDS has access to care is the same one that matters for his prevention goals, too. He has vowed to draft and begin implementing America's first-ever national strategy on AIDS.

It's hard to believe, but 27 years into this epidemic, the federal government has never sat down and developed an overarching plan for how it will use its AIDS resources—a task that we wisely demand any nation receiving foreign assistance for HIV work first complete. It's no surprise then that, billions of dollars later, we're still watching the epidemic grow and people die despite the break-

throughs we've made in treatment science.

In its October 2007 AIDS platform, the Obama campaign pledged that “in the first year of his presidency, he will develop and begin to implement a comprehensive HIV/AIDS strategy that includes all federal agencies.” The platform further specified that Obama's strategy will include “measurable goals, timelines and accountability mechanisms.”

It will be easy for both the Obama administration and the Black community to allow this pledge to languish on the back burner. The new administration and Congress face massive, historic challenges, to be sure—a global economic collapse, war on multiple fronts, a broader debate over health reform. The unfortunate reality is they must deal with all of these challenges simultaneously, and that includes addressing HIV/AIDS. The problem has grown more urgent, more complex and more expensive as we've allowed it to become a decreasing priority over the past decade. Simply put, it is one more issue that we cannot afford to allow Barack Obama to ignore.

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Q&A

Dr. Kevin Fenton

Centers for Disease Control and Prevention

In March 2007, the CDC launched what it has dubbed the Heightened National Response to the HIV/AIDS Crisis among African Americans. The Black AIDS Institute spoke with Kevin Fenton, director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, about the initiative's progress. The Institute receives funding from the CDC.

BAI: What would you say has been the most significant, identifiable accomplishment of the Heightened National Response to date?

Fenton: There have been several; we are making significant progress in all four areas of the Heightened National Response. Over the past year, we have been working specifically to train providers to use two new interventions for African American women, two new interventions for minority youth, and a newly adapted intervention for Black gay and bisexual men (called "D'UP").

In fact, D'UP is actu-

ally an excellent example of how we are working to meet the urgent needs of African Americans at greatest risk. This intervention for Black gay and bisexual men recruits popular people in social networks to promote healthy sexual behaviors among their peers. It was originally developed for gay men generally. But, with CDC support, the North Carolina Department of Health and local community-based organizations adapted it specifically for young, Black gay men and found that it dramatically reduces sexual risk behavior among young men in the communities where it is implemented. Last year, CDC began to disseminate this intervention widely, and train health departments and community-based organizations nationwide to implement the program for African American gay and bisexual men in their communities.

We're also making real progress at increasing HIV testing. In 2008, CDC doubled its investment in a new initiative we launched in 2007 that is devoted to increasing testing among African Americans. Test-



ing efforts as part of this \$70 million initiative are now underway.

CDC is also working to develop new HIV prevention interventions. We're conducting a number of new research studies. Some of these projects will evaluate new prevention interventions for individuals at greatest risk—including Black women, heterosexual men, gay and bisexual men, and incarcerated individuals. Others will investigate how to address deeper social and structural factors that place many African Americans at risk and hinder access to prevention and care.

We're also working on both a national and local level to mobilize the community. In 2007 and 2008, CDC

hosted leadership meetings bringing together more than 200 African American leaders from multiple sectors to discuss concrete actions that can be taken to reach all African Americans with the tools and knowledge they need to protect themselves and their loved ones from HIV. Participants included prominent entertainers as well as civic, faith and business leaders, who share a commitment to intensifying HIV prevention efforts for African Americans.

Locally, CDC has been working with organizations in Philadelphia and Cleveland to launch a testing campaign called “Take Charge, Take the Test” to increase HIV testing rates among African American women. The initial results have been very impressive. In Cleveland, for example, the number of HIV tests taken by Black women in the city increased by more than two-thirds.

What goals has the initiative made the least progress on? Or, what has been the most difficult to move forward?

Programmatically, I think we are making a great deal of progress in each of the four strategic areas of the Heightened National Response. As with any new program effort, we certainly have faced some challenges with coordination and communication around the program—but are working on doing a better job of targeting specific efforts

with partners and improving communication and coordination. These include launching an online community for our partners that will help partners make connections, access HIV information, share best practices and discuss and solve challenges related to HIV/AIDS prevention among African Americans.

We have also made a toolkit widely available to assist organizations in planning and implementing local HIV outreach activities. This kit includes information about the impact of HIV among African Americans, as well as examples of community mobilization activities led by many of our partners.

In addition, we are distributing a monthly newsletter to keep all of our partners in the loop on how the Heightened National Response effort is progressing. There is much to be done. It will take every one of us working on the front lines to fight this devastating disease. Our collaboration is the key to success.

The initiative has been criticized for not sending enough resources directly to Black community-based organizations, as opposed to state and local health departments. Are there plans to funnel a greater share of the resources directly to organizations?

CDC has long recognized the need to support

HIV prevention infrastructure in hard-hit, underserved communities and invests millions of dollars each year directly to community-based organizations with deep roots in African American communities. This is a vital part of our prevention efforts and, in fact, we have worked to intensify these efforts over time.

Some key examples of these efforts include: a recent initiative that directly funds community-based organizations to implement proven interventions for young gay and bisexual men of color; our collaborations with African American medical groups to increase HIV screening and testing in high-prevalence areas; and our ongoing work funding capacity building organizations [Editor’s note: the Black AIDS Institute receives funding from this initiative] with expertise on furthering the ability to provide high quality HIV services in African American communities.

Despite these efforts, we recognize significant unmet needs remain. That’s why in our professional judgment to Congress we highlighted the need to further expand efforts that provide resources directly to these organizations. It’s also why CDC has been working to strengthen and expand our relationships with major national organizations with a long history in African American communities. In the coming year, we will be working even more

closely with these organizations to help integrate HIV prevention more thoroughly into the myriad activities they already undertake to serve African-American communities across the country.

Many advocates have noted Congress's failure to adequately fund the CDC's HIV prevention work, and the agency has itself told Congress it needs roughly double the HIV prevention budget it currently has. How will it affect your work, and this initiative in particular, if Congress fails to meet that request?

Limited resources are always an issue. There are substantial unmet HIV prevention needs in many populations, and the reality is that CDC's HIV prevention budget has remained flat in recent years.

We fully recognize it will take a larger investment to address the scale of the problem. In fact, last year in our professional judgment to Congress we estimated that, with additional funding, the agency could significantly expand its efforts to reach those at greatest risk for HIV infection—reducing HIV transmission, the proportion of those who don't know their HIV status and racial disparities between Blacks and whites by 50 percent, each in just over a decade.

Nonetheless, CDC remains committed to maximizing our current resources to achieve the greatest

impact in reducing the toll of HIV in our nation. As part of that commitment, reducing the burden of HIV among African Americans remains our number one prevention priority—with the majority of our prevention resources focused on fighting the epidemic in Black communities.

This is precisely why the Heightened National Response is so important. We have to ensure efforts are focused on the most effective strategies and that we leverage our resources with community engagement to extend the reach of prevention in African American communities.

Call to Action for a National AIDS Strategy What Barack Obama Must Do First

More than 27 years into the epidemic, America has never had a comprehensive strategy to direct its response to AIDS. That's a simple, essential step that we require of any country seeking our foreign assistance, and it's long overdue. But as recently as World AIDS Day 2008, then-President-elect Barack Obama reaffirmed his commitment to draft and begin implementing a national strategy. Given the range of grave, pressing challenges, it will be easy to allow that commitment to linger on the back burner of priorities. But as outlined in the pages of this report, America—particularly Black America—cannot afford further delay.

That's why, as of October 2008, approximately 350 organizations and 1,200 individuals had signed a Call to Action for a National AIDS Strategy. The Black AIDS Institute was a founding signatory. The Call to Action calls upon the Obama administration to lead in drafting a strategy that addresses the urgent need to:

- Improve prevention, care and treatment outcomes through reliance on evidence-based programming;
- Set ambitious and credible prevention, care and treatment targets and require annual reporting on progress toward goals;
- Identify clear priorities for action across federal agencies and assign responsibilities, timelines and follow-through;
- Include, as a primary focus, the prevention and treatment needs of African Americans and other communities of color, women of color, gay and bisexual men of all races and ethnicities, and other groups at elevated risk for HIV;
- Address social, economic and structural factors that increase vulnerability to HIV infection;
- Promote a strengthened and more highly coordinated HIV prevention and treatment research effort; and
- Involve many sectors in developing the national strategy, including government, business, community, civil rights organizations, faith-based groups, researchers and people living with HIV/AIDS.

To sign on to the Call to Action, visit NationalAIDSStrategy.org.

The Process for Developing a National AIDS Strategy

The signatories of the Call to Action have urged President Obama to create an open, orderly and accountable process for drafting his national strategy. The following recommendations incorporate both the Black AIDS Institute's own recommendations and those of the overall coalition.

Establish an inclusive, comprehensive panel to guide the process.

The coalition recommends that the president, acting through the Domestic Policy Council, appoint a panel of experts on HIV/AIDS from every department of the United States government with responsibilities for responding to the epidemic. The panel must also include representatives of key non-governmental and civil society organizations, people living with and at risk for HIV, and other stakeholders.

This panel must reflect the diverse communities affected by HIV/AIDS. It should hold at least one meeting at which it receives public input into the development of the strategy, and at least two meetings at which its deliberations are open to the public. The panel should take into account stakeholder input—gathered in multiple ways—and the best available evidence on effective strategies to achieve HIV prevention, care and research goals.

Begin work immediately. In keeping with President Obama's campaign pledge, the strategy should be fully developed no later than January 20, 2010, and be operational until December 31, 2014. Further, President Obama should appoint a national AIDS strategy panel within his first 100 days in office, as well as a White House-level presidential advisor to oversee the strategy's development and implementation.

Appoint an AIDS czar with meaningful power.

President Obama should reinvestigate a White House-level office to direct federal AIDS policy—a longstanding function that waned under the Bush administration. The office should provide staffing to the national strategy panel and be headed by a presidential advisor with authority to oversee and coordinate all government agencies and federally funded non-governmental organizations involved in implementing the strategy.

Budget enough money to make meaningful planning possible.

President Obama must request and Congress must appropriate sufficient funding for Fiscal Year 2009 to allow the White House-level AIDS office to plan and implement a national AIDS strategy. The president must commit to continued funding in his subsequent budget requests to assure the development, implementation, and evaluation of the strategy. This funding must be in addition to the desperately needed investments for ongoing prevention, care, treatment and research efforts.

Have measurable, realistic and specific goals. The national AIDS strategy should not repeat or recreate the exhaustive set of goals that have characterized previous planning efforts to respond to the epidemic, though many of the goals these plans have described are important. Instead, the national AIDS strategy must:

- Describe a limited and focused set of strategic initiatives that will increase to the highest possible levels the number of Americans who know their HIV status and the number of HIV-positive Americans who are engaged in comprehensive, high-quality care and treatment for HIV and related conditions; reduce to the lowest possible levels the disparities in health outcomes that are experienced by gay and other men who have sex with men, communities of color, and women; and reduce to the lowest possible levels the number of new cases of HIV infection that occur annually;

- Prioritize initiatives targeting populations or jurisdictions with the highest

prevalence and incidence of HIV/AIDS in the nation (consistent with current epidemiological data), with emphasis on outcomes related to African Americans and other communities of color, women of color, and gay men of all races and ethnicities;

- Describe the legislation, policies and programs that are necessary to carry out those initiatives;

- Set specific outcomes by which each of the initiatives will be evaluated, along with timelines for implementing them;

- Assign responsibility for implementation of each of the action steps to appropriate government agencies and create mechanisms to facilitate collaboration between these agencies and non-governmental organizations;

- Determine the annual cost and financing mechanisms necessary for implementing each initiative, along with recommended sources of funds. Sources may include the redirection of existing federal resources to the action steps contained in the strategy, as well as additional resources that should be sought by the president from the Congress; and

- Develop a mechanism by which existing sources of federal funding for HIV/AIDS will be made consistent with participation in the initiatives described in the strategy.

The Black AIDS Institute encourages all Black Americans to contact both the Obama administration and the Congressional Black Caucus to let them know you support these principles specifically and the creation of a national AIDS strategy more broadly. The new administration and Congress represent a remarkable opportunity for Black America to finally bring this epidemic under control. But to do so, we must have all hands on deck. Let's speak up and support our elected officials' efforts to end AIDS once and for all.

OF AMERICA, INC.



RAINBOW PUSH
COALITION

NCPS

National Coalition of Pastors' Spouses



NBJC



National Black AIDS Mobilization

The State of Our Movement

Harnessing Resources for Action

There is little doubt that Barack Obama's election presents not only an historic moment for Black America, but one filled with enormous potential for change. As outlined in the State of AIDS in Black America section of this report, the new administration and Congress face grave challenges, but also great opportunities to revive Black America's health. The same can be said of our community's mobilization to end AIDS.

Our community has never been as well positioned to act on this epidemic as it is at the start of 2009. From politics to popular culture, there is no disputing that Black leaders have accepted the reality that AIDS is our problem, and that it cannot be solved without our hard work. That's an intellectual and emotional step that creates great potential.

Realizing our potential, however, will require far greater resources than are currently available. It will require Black organizations to dedicate more of their existing resources—in time, money and priorities—to the epidemic. It will require Black individuals to dedicate more of their personal resources. And it will require both public and

private funders who care about AIDS to offer far greater and far more meaningful support to the work of Black leaders.

The National Black AIDS Mobilization

In 2006, 16 traditional Black institutions, in conjunction with the Black AIDS Institute, launched the National Black AIDS Mobilization, by signing on to the National Call to Action and Declaration of Commitment to End the AIDS Epidemic in Black America (see www.BlackAIDS.org for text and list of signatories). The 16 institutions are not typical AIDS organizations—those that have been working hard to provide services, spread the message and bird-dog policymakers since the epidemic's start. These groups, many of which have histories that span generations, were founded to meet a wide range of communal needs and concerns; they have now added AIDS to their work.

For the first stage of the mobilization, 12 of the 16 participating organizations completed strategic action plans in 2007. As of the beginning of 2008, the members of

Two-Year Effort to Screen 1 Million People

Although HIV testing has been made simpler, faster and more accessible, many people remain in the dark about their HIV status. In



an effort to promote HIV testing in the Black community, the Black AIDS Institute has launched the

Test 1 Million campaign, a two-year effort to screen one million people for HIV by June 27, 2010 (National HIV Testing AIDS Day).

This campaign is supported through partnerships with National Black AIDS Mobilization partners, state departments of health and local AIDS service organizations to offer HIV screenings at health fairs and testing rallies throughout the country. This community-based initiative engages leading Black civil rights, media, academic, faith-based and professional organizations to encourage HIV testing among their own constituents.

The Institute recently launched the campaign during a Test 1 Million rally on National HIV Testing Day 2008. The event was held at the Los Angeles Sentinel newspaper

headquarters in the Crenshaw district of L.A., and drew both people from the community and Black leaders and celebrities such as L.A. City Councilmember Bernard Parks, City of Inglewood Mayor Roosevelt Dorn, singer Jodi Watley, actors Tatiana Ali, Kimberly Elise, Darius McCrary, Jimmy-Jean Louis and Tasha Smith, among others. The Test 1 Million campaign will be making stops in 25 American cities including Washington, D.C.; New Orleans and Shreveport, La.; Columbus and Cleveland, Ohio; Atlanta, Ga.; Durham, S.C.; Oakland, Calif.; Memphis, Tenn. and Houston, Texas.

Organizations and individuals can sign up for the Test 1 Million campaign at www.BlackAIDS.org. Individuals interested in joining the campaign are asked to get tested for HIV/AIDS in order to become an official Test 1 Million member. Organizations interested in joining the campaign as affiliates commit to testing individuals in their community and hosting HIV/AIDS community events. The Black AIDS Institute provides supplemental support to organizational affiliates with materials as well as speaker requests, promotional campaign materials, and technical assistance opportunities.

the Black AIDS Mobilization had committed, through their strategic action plans, to achieve the following benchmarks in the next five years:

- 250,000 Black people brought into HIV counseling, testing and linkages to care;

- 77,450 Black people reached with HIV health-education materials;

- 600 HIV health-education events and forums held, focusing on HIV prevention, education, treatment and care. These events will particularly focus on stigma and discrimination;

- 72 markets targeted with billboard campaigns;

- 30 public service announcements produced and aired; and

- 30 short television series focusing on

HIV/AIDS in Black America.

This chapter provides an update on the commitments each of the mobilization members have made and on the progress and barriers they have encountered over the last year.

Many of the organizations that have committed to the National Black AIDS Mobilization have stepped up despite already overwhelmed budgets and with no additional funding or staff capacity. As a result, the review of their work in 2008 is mixed. Many of the partnering organizations have encountered significant leadership and staff turnover; most have been strapped for resources and staff to dedicate to this initiative. Yet many have still worked to live up to their collective commitment to eradicate HIV/AIDS in the Black community.

People Taking Action

Kenneth Robinson, Atlanta, Ga.

In 1993, before Kenneth Robinson had entered recovery, before he had been diagnosed with HIV, before he had a relationship with the health department, "It hit me in my



spirit [that I had to] to pass out condoms at the clubs, the crack houses, the places where no one wanted to go." A year later, he was sober—and developing a reputation. Medical students

of one of his mentors started buzzing about some guy out in the streets of Atlanta trying to get people to take care of themselves.

Today, Robinson works closely with Georgia's Order of Black Masons to develop and run HIV/AIDS projects in all of the order's houses. The order is made up of Black people from various sectors of the community—sororities and fraternities, civil rights organizers, members of the media and members of faith-based organizations. The 24 male Consistories and 22 female Assemblies are organized around the principle of service to the community, and they're now turning their attention to the AIDS epidemic.

Robinson held six different kinds of events at the end of 2008, as a culmination of his participation in the Black AIDS Institute's African American HIV University. One event educated participants with an overview of the fundamentals of clinical and prevention science, an update on the Black AIDS epidemic and a look at the AIDS policy agenda. Another event included voter registration, HIV information tables, testing and outreach—through which he distributed 2,000 condoms. And he's already getting requests for more programs.

Robinson believes we all must focus on "the holistic healing of the person"—not just on HIV. He knows many aspects of a person's life create risk for HIV—things like poverty, homelessness and incarceration. These realities, he stresses, deserve just as much focus as the modes of transmission for the disease.

Robinson says he's not in this for "the Kodak moment" of praise. He's driven by his fear that "people are not going to hear the message until they get a positive diagnosis." So he's got to go on passing out condoms like he did at the beginning—on his own time, outside of any professional role. He still recalls that moment when his spirit helped him focus in on what his role needed to be. He knows what he is supposed to do.

—Janet Quezada

New Resources from Washington

At this report's writing, a significant development stood on the horizon for 2009 that has the potential to increase the capacity of several mobilization partners: A CDC initiative to support new staff positions for Black organizations that have added AIDS to their work.

In Fall 2008, the CDC solicited proposals for its ACT Against AIDS Leadership Initiative. The initiative, a part of the CDC's Heightened National Response to HIV/AIDS among African Americans, was designed to build mobilization efforts within the Black community by strengthening and extending the reach of community groups. The CDC initiative's goals align with those of the National Black AIDS Mobilization:

- Reduce HIV incidence in the Black community;
- Increase the number of Black Ameri-

cans who know their HIV status;

- Increase the number of HIV-positive people who are in appropriate treatment and care; and

- Reduce stigma in the Black community.

Through the CDC's initiative, several National Black AIDS Mobilization partners may get funding to hire an HIV/AIDS project coordinator and support the projects laid out in each of their strategic plans. The CDC will target funding at projects that increase HIV awareness; drive HIV testing and get people into care; coordinate and facilitate HIV prevention; and develop, maintain, and support partnerships among community groups.

This initiative represents a welcome, much-needed advancement in the federal commitment to fighting AIDS in Black communities.

It's Not Enough

While the new CDC initiative offers much-needed support, it does not nearly meet the full need. The initiative itself is limited in scope and duration: It offers funding only through September 2009, with no guarantee that the support will continue thereafter.

Further, there remain questions about how much of the CDC's overall resources are going directly to support the work of Black organizations. The CDC has said that nearly half of its domestic HIV/AIDS prevention budget is targeted at fighting HIV in the Black community, meaning the agency set aside just under \$370 million for the effort in fiscal year 2008.¹ But only \$30 million went directly to community-based organizations in 2007.²

The vast majority of the money that CDC targets to the Black community goes directly to state and local health departments.³ Further, many critics argue that the health departments and AIDS service organizations that obtain the majority of CDC's prevention funding lack either the will or the competency to effectively mobilize, partner with and gain the trust of the Black community.

It must also been noted, however, that the Heightened National Response was launched at a time of drastic budget cuts for domestic AIDS work of all sorts: Over the last five years, the CDC's HIV prevention budget has been cut by nearly 20 percent (in real dollar terms).⁴ The reality is that the money for the Heightened National Response does not represent new money budgeted for the effort, but rather a realignment of existing, insufficient resources. If the CDC's Heightened National Response is to generate real change, Congress and the new administration must pump significantly more money into the CDC's HIV prevention work, and the agency must in turn direct that money toward traditional Black institutions.

Notes

1. Roberts, G, HIV/AIDS among African Americans: CDC's Strategies for a Heightened National Response, presentation at CDC Consultation on HIV/AIDS and African American Women, June 20, 2007, accessed online on January 4, 2008, at <http://www.cdc.gov/hiv/topics/aa/cdc.htm>; and CDC, Professional Judgment Budget, submitted to U.S. House of Representatives Committee on Oversight and Government Reform, September 16, 2008.

2. CDC, Fighting HIV/AIDS Among African Americans, accessed online on January 4, 2008 at http://www.cdc.gov/hiv/topics/aa/resources/factsheets/pdf/AA_response_media_fact.pdf.

3. Ibid.

4. Holtgrave, D, When "Heightened" Means "Lessened": The Case of HIV Prevention Resources in the United States, *Journal of Urban Health*, 84(5): 648–652.

The Mobilization Partners

Update on the Strategic Plans

In 2008, two crucial organizations joined the list of traditional Black groups that have completed draft strategic plans detailing how they will address HIV/AIDS within their broader work: the National Association for the Advancement of Colored People and the National Urban League.

Both the NAACP and NUL are critical to the broad-based community mobilization envisioned by the National Black AIDS Mobilization. The NAACP is the nation's oldest civil rights organization and a leader in the fight for civil rights for all. It boasts a membership of nearly 500,000, with 2,000 local branches all over the country. The National Urban League, founded in 1910, is another of the community's oldest and most influential organizations. It has a network of over 100 professionally staffed affiliates in over 35 states across the country, as well as the District of Columbia. These affiliates provide direct service to more than 2 million people.

Together, these two organizations play a central role in mobilizing communities, influencing the political agenda of Black America, and increasing awareness in Black communities of critical issues.

National Urban League

HIV/AIDS advocacy is not new to the National Urban League. In 1995, NUL worked with the American Red Cross to develop "Don't Forget Sherrie," an instructor course and video that trains individuals to make nonjudgmental, culturally appropriate HIV/AIDS prevention presentations targeted to the Black community.

Over time, the NUL has used its website, publications and conferences to increase awareness around HIV/AIDS. In 2004, over 40 chapters of the National Urban League Young Professionals (NULYP) held their first "NULYP National Day of Service," lending their voices, time and resources to the fight against HIV/AIDS. Each chapter participated in community service events that included, among other things, volunteering at HIV/AIDS agencies and hospices, sponsoring HIV testing days and health fairs, and holding forums about sex and HIV.

Additionally, many NUL local affiliates have developed HIV/AIDS programming initiatives in their local communities:

■ The Indianapolis Urban League has offered HIV/AIDS and substance abuse services for the local community. Their

Special Populations Support Program (SPSP) provides: on-site substance abuse treatment; one-on-one counseling; free HIV testing (on or off site; either anonymous or confidential); emergency housing assistance and education at various levels.

■ The Milwaukee Urban League hosts an annual Health & Resource Fair where HIV testing is provided at no cost to the community.

■ The Urban League of Greater Dallas has an HIV street outreach program targeting African Americans and other minorities in Dallas County. The outreach teams service approximately 10,000 clients a year with condom distribution and safer sex kits. For those clients identified as high-risk or as HIV-positive through outreach efforts, the group has a prevention case management program that focuses on risk reduction education through individual sessions.

■ The Urban League of Greater Hartford works in partnership with the Department of Community Health to provide services to those infected and/or affected by HIV/AIDS through prevention, education, recovery support, counseling, risk-reduction and referral services.

As a part of the National Black AIDS Mobilization, the National Urban League renews its commitment to the fight against AIDS. Through its newly developed strategic action plan, the National Urban League has committed to address the Mobilization's four goals through the following activities:

Goal One: Reduce HIV incidence in Black America

■ The National Urban League will encourage and enroll 70 percent of its affiliate network to participate in the National Black AIDS Mobilization. Specifically, NUL affiliates will be encouraged to facilitate the distribution of HIV/AIDS prevention information/literature and strategies to the affiliate network, and integrate HIV/AIDS prevention efforts into their existing infrastructure and normal activities.

■ The National Urban League will

provide HIV/AIDS trainings and workshops at its annual Legislative Policy Conference, NULITES Youth Leadership Conference and the Whitney M. Young Urban Leadership Training Conference.

■ The National Urban League will also include HIV/AIDS in its annual publications.

■ Marc Morial, President and CEO of the National Urban League, will participate in a public service announcement regarding HIV/AIDS in the Black community.

Goal Two: Increase the number of Black Americans who know their HIV status

■ Chapters of the National Urban League will collaborate with their local health departments, local HIV counseling and testing services, AIDS services organizations, community clinics, and local chapters of other national Black organizations to offer HIV counseling and testing services to the Black community.

■ To achieve this objective, National Urban League chapters will become organizational affiliates in the Test 1 Million campaign. (See "Test 1 Million" on page 37.) Each chapter will individually pledge to test individuals for HIV/AIDS and host HIV/AIDS awareness events.

■ The National Urban League will incorporate HIV/AIDS testing into their national multi-city Health Screening Bus Tour partnership with Walgreens Pharmacy.

Goal Three: Increase the number Black Americans with HIV/AIDS who engage in and receive care

■ In collaboration with the partners providing HIV testing, counseling and referral services, the National Urban League will collaborate with community-based organizations and/or HIV medical clinics to refer infected patients for medical care and case management services.

Goal Four: Reduce stigma as a barrier to prevention and treatment of HIV/AIDS among Black Americans

■ The National Urban League will use

the aforementioned workshop and plenary sessions to address stigma as a barrier to effective HIV/AIDS education and prevention.

National Association for the Advancement of Colored People

HIV/AIDS has been one of the main focal points for the NAACP Health Department over the last decade. The NAACP advocates a multi-layered approach to eradicate the epidemic that is devastating the African American community and is committed to eliminating the racial disparities that exist in the epidemic.

Since 2005, the NAACP has:

- Provided HIV training at its seven regional conferences;
- Published a co-branded report with Black AIDS Institute—*The Way Forward: The State of AIDS in Black America, 2006*—which it distributed to all units and at regional conferences;
- Has provided HIV/AIDS forums, trainings and testing opportunities in local communities throughout the U.S. via many of the NAACP's 1,200 local units;
- Distributed HIV/AIDS ribbons with information cards at NAACP Images Awards and at NAACP regional conferences;
- Participated in the CDC's consultation to address the HIV/AIDS epidemic in the Black community;
- Co-sponsored a Capitol Hill briefing on HIV/AIDS in the African American community;
- Served as an advisor on a United Nations report on HIV/AIDS;
- Provided HIV testing at each NAACP annual convention since 2006, including having organization leaders publicly tested at the 97th annual convention;
- Hosted a symposium and luncheon on HIV/AIDS at the 2006 annual convention;
- Hosted a youth workshop on HIV/AIDS at the 2007 annual convention;

- Participated in a call to action on HIV/AIDS on the 25th anniversary of the domestic epidemic;

- Participated in the 2008 International AIDS Conference in Toronto, Canada;

- Co-sponsored the 2006 World AIDS Day rally in Washington, D.C.; and

- Trained its State Health Committee chairs in HIV/AIDS.

As a part of the National Black AIDS Mobilization, the NAACP renews its commitment to the fight against AIDS. Through its newly developed strategic action plan, the NAACP has committed to address the Mobilization's four goals through the following activities:

Goal One: Reduce HIV incidence in Black America

- The NAACP will use state, regional, and national conferences to train state and local health committee chairs in HIV/AIDS and other health issues that impact the Black community.

- Executive Director Benjamin Jealous and other NAACP leaders will participate in a public service announcement on HIV/AIDS in the Black community.

- The NAACP will leverage the NAACP Image Awards as an opportunity to raise awareness around HIV/AIDS in Black America.

- As part of carrying out this objective, the NAACP will seek to increase Image Award participants' knowledge about the impact of the disease on Black people; to develop an accurate perception of HIV risk among participants; to encourage and link participants to HIV counseling and testing, and link those who test positive to medical care.

Goal Two: Increase the number of Black Americans who know their HIV status

- Local chapters of the NAACP will be encouraged to collaborate with their local health department, local HIV counseling and testing services, AIDS service organizations, community clinics, and local chapters

People Taking Action

Rev. Janyce Jackson, Newark, N.J.

When Rev. Janyce Jackson joined Liberation in Truth Fellowship Church, she knew that the church not only had a social justice ministry, it also had a mission to “provide a



spiritual space for LGBT people to worship.” And she knew that meant dealing with the virus. “This was at a time when positive people were discriminated against and treated badly,” she recalls.

The church had to get involved in fighting stigma.

At the time, Rev. Jackson didn’t know anything about HIV. But she began educating herself, meeting HIV-positive people and learning more about the impact that the disease was having in her community. The more she heard, the more she felt that this was deeply important work to do.

Rev. Jackson began as a bookkeeper for the church’s women’s prevention program in 1998. Today, she’s a manager of the church’s HIV/AIDS ministry overall. She is proud of their drop-in center, which serves clients in a caring, non-judgmental atmosphere. “We accept all people,” she stresses. “Everyone who comes through that door.” At both the center and the church, staff accept everyone

as a “whole consciousness,” rather than pick and choose what parts of a person’s life are acceptable and worthy of care. It doesn’t matter if someone is homeless or walks in wearing a business suit, everyone is welcomed in this manner.

“The challenge is really getting support from the larger community,” says Rev. Jackson of her ministry. “Getting the community to understand and be aware of and acknowledge the epidemic.” She struggles against apathy—and to find resources for her small agency. So she and her colleagues are creating a media campaign to raise awareness in Newark about how HIV affects everyone in the Black community. Their “It Takes a Big Man” campaign has been shaped through the work of the coalition she formed while a fellow in the Black AIDS Institute’s African American HIV University.

Rev. Jackson says participating in the HIV University gave her “a global view” of what she could do with her mobilization work by exposing her to different approaches. To her, being in the room with so many fellows from different parts of the country was inspiring, especially when she realized that some of them were just starting their HIV/AIDS work. It let her know that the fight is continuing and that no one will have to get burnt out—not that it’s a concern for her. “I can’t let the apathy stop me,” she says, “because people are still contracting the disease every day.”

—Janet Quezada

of other national Black organizations, and offer HIV counseling and testing services.

■ To achieve this objective, individual NAACP chapters will become organizational affiliates in the Test 1 Million campaign. (See “Test 1 Million” on page 37.) This includes executing agreements with local HIV counseling, testing and referral programs to provide counseling and testing services at NAACP chapter-sponsored events, as well as

state and regional conferences.

■ The NAACP will work with local AIDS service organizations to provide HIV testing at the convention health fair.

Goal Three: Increase the number Black Americans with HIV/AIDS who engage in and receive care

■ The NAACP will collaborate with localized community-based service organiza-

tions and/or HIV medical clinics to create linkages for referring infected patients for HIV medical care and case management services.

Goal Four: Reduce stigma as a barrier to prevention and treatment of HIV/AIDS among Black Americans

■ The NAACP will utilize the aforementioned workshops and training sessions held during NAACP events to address stigma as a barrier to effective HIV/AIDS education and prevention.

What Partners Have Achieved

Updates on the work of the 12 organizations that completed strategic action plans for 2008 are below. You can see their full plans on www.BlackAIDS.org in *Saving Ourselves: The State of AIDS in Black America, 2008*.

100 Black Men of America

100 Black Men of America, Inc. (100 Black Men) is a national nonprofit organization founded in 1963. Its mission is to improve the quality of life within Black communities and enhance educational and economic opportunities for all African Americans. 100 Black Men has 74 chapters throughout the world.

Mobilization update: The 100 Black Men of America has made progress on a number of the commitments made in its strategic action plan. As part of each annual conference, the 100 Black Men of America, Inc. aims to create local impact and outreach through its Community Empowerment Project (CEP). During this year's CEP, the 100 Black Men of America hosted a Healthy Living Town Hall Meeting and free health fair in Orlando, Florida. The town hall was moderated by popular VH1, BET and Ameri-

can Urban Radio host Dr. Ian Smith. It focused on access to healthcare, child wellness, violence prevention, and health disparities facing the African American community, including HIV/AIDS. HIV/AIDS screening was offered to the attendees.

The organization has also partnered with Aetna, a leading diversified healthcare benefit company, to create a website that members are able to utilize as a healthcare management tool focusing upon prostate cancer/colorectal cancer, depression, HIV/AIDS, cardiovascular disease and sickle cell anemia. The website is meant to facilitate the exchange of information related to health disparities that disproportionately impact the Black community and encourage members to be proactive around healthcare information and decision making.

100 Black Men of America, Inc., in collaboration with the Healthcare Georgia Foundation, has also embarked on a health and wellness initiative that increases knowledge and awareness of health inequities affecting African-Americans. This initiative uses "Unnatural Causes: Is Inequality Making Us Sick," the four-hour documentary that offers a detailed examination of social and economic conditions to help reframe the discussion on national health trends and the approaches for reducing health disparities. Each 100 Black Men Chapter in Georgia is using the "Unnatural Causes" documentary, coupled with panels composed of elected officials, community leaders and health care professionals to engage in a dialogue on health disparities and explore issue areas such as health and longevity as related to socioeconomic status, additional health burdens faced by people of color, and how health and well-being are tied to policies that promote economic and social justice. The initiative is linked to the HIV/AIDS work of the 100 Black Men of America through the exploration of how social determinants impact HIV/AIDS incidence and prevalence in communities of color.

American Urban Radio Network

American Urban Radio Network (AURN) is a Black-owned radio network company and is the largest radio network reaching urban America.

AURN's purpose is to entertain and inform, as well as to uplift the community. However, most importantly, AURN exists to keep the Black community informed about contemporary social issues. Headquartered in Pittsburgh, Penn., AURN reaches more Blacks than any other medium in America and produces more select urban programming than every one of the other broadcasting companies combined. AURN broadcasts entertainment, information, news and sports programming through more than 700 radio stations nationwide.

Mobilization update: Since joining the National Black AIDS Mobilization, American Urban Radio Networks has consistently utilized many of its talk shows and the voices of its hosts to raise awareness around HIV/AIDS among its listeners. In particular, the network's evening call-in program, *The Bev Smith Show*, again regularly featured HIV/AIDS discussions. The network has been a founding partner with the Black AIDS Institute in the annual Black Media Roundtable on HIV/AIDS.

Congressional Black Caucus Foundation

The Congressional Black Caucus Foundation, Inc. (CBCF) was established in 1976 as a non-partisan, non-profit, public policy, research and educational institute. The mission of CBCF is to serve as the non-partisan policy-oriented catalyst that educates future leaders and promotes collaboration among legislators, business leaders, minority-focused organizational leaders, and organized labor to effect positive and sustainable change in

the African American community.

Mobilization update: The CBCF has moved forward in the implementation of their strategic action plan. Most notably, in September 2008, the CBCF launched a new fellowship program focusing on the disproportionate impact of HIV/AIDS on the African American community. This program, which is part of the CBCF's Center for Policy Analysis and Research, will give professionals the opportunity to inform policymaking in relevant areas, including HIV prevention, testing and access to care. It is being supported by a grant from the Gilead Foundation. Once chosen, the fellow will be responsible for producing research briefs on HIV/AIDS that will be prepared for members of the Congressional Black Caucus.

National Action Network

The National Action Network (NAN) was founded in New York City in 1991 by the Rev. Al Sharpton and a group of activists who were committed to the principles of non-violent direct action and civil disobedience. NAN is a Black civil rights, non-profit organization, grounded in the spirit of the historic civil rights movement.

NAN addresses social and economic injustices that plague communities of Black people throughout the country. NAN has chapters throughout the United States and maintains important regional offices in Washington, D.C.; Atlanta, Ga.; Detroit, Mich.; Chicago, Ill.; Dallas, Texas; Las Vegas, Nev.; and Los Angeles, Calif.

Mobilization update: The National Action Network has made some progress on the implementation of its strategic action plan. In 2008, the organization hosted an HIV/AIDS panel at its tri-state conference held in New York City. The panel, moderated by Myisha Patterson-Gatson (director of mobilization for the Black AIDS Institute and co-author of this report), featured Debra Frasier-Howze (founder of the National Black Leadership Commission on AIDS), C. Virginia Fields (president of Leadership Com-

People Taking Action

Michelle Delores Morgan, Washington, D.C.

Three years ago Michelle Delores Morgan found out that her uncle had transitioned from AIDS. "Because of stigma, I had not been told that he died because of the dis-



ease," Morgan explains. "So when I made the discovery, two years later, I knew I had to do something about this issue that seemingly wasn't discussed."

Morgan started out as a volunteer for the Whitman-Walker Clinic in Washington, D.C., handing out flyers and directing people on National HIV Testing Day. What she learned as a volunteer is what she brings to her mobilization work. "Everyone is unique and everyone's perception is different," she says. "People have to be met where they are, because when I came to the clinic they met me where I was and gave me HIV 101—without judgment."

Michelle organized an event in her apartment building. Twenty people were in and out the whole day. She gave them goodie bags stuffed with "candy, condoms and fact sheets" provided by the health

department, the American Red Cross and Whitman-Walker. She promoted the event as an open house and many of her neighbors confessed that "they may have not come [if it had been called something else], but once they got there they appreciated the information." She was surprised at how shocked the longtime residents of the District were when she shared the statistics about the epidemic in their hometown.

Now she, and a coalition that she has formed, plan to take the information to the surrounding Prince George's County, "because 88 percent of the cases there are Black American ... and they don't have as much exposure as we do here in D.C." They plan to start out with HIV/AIDS awareness events. During the Valentine's Day shopping extravaganza they want to host testing sites at the biggest mall there, she says, adding "We would like to have a physical testing center there; that is our long-term goal."

Taking part in the African American HIV University has given her information about how to speak to traditional Black institutions and faith-based organizations "which may not be open to condom usage or talking about the different modes of transmission." She says the tools that she gained will help her present the information to the people in the county that she needs to get on board in order to get to achieve her goals.

—Janet Quezada

mission), Terri Williams (author of *Black Pain: It Just Looks Like We're Not Hurting*) and Dr. Monica Sweeney (assistant commissioner for the Bureau of HIV/AIDS Prevention and Control of New York City).

Panelists shared personal stories of loss and explored trends relating to HIV/AIDS in the Black community. Terri Williams linked the history of ignoring mental health in the Black community to high-risk behaviors that contribute to the increased incidence of HIV/AIDS in the Black community. The panel was

attended by NAN members from the tri-state area (New York, New Jersey and Connecticut) and local community members.

National Coalition of 100 Black Women

The National Coalition of 100 Black Women (NCBW) traces its history to the community organizing efforts of a group of committed

Black women in New York City in the late 1960s and early 1970s.

NCBW currently has more than 7,500 members in 72 chapters in 26 states and the District of Columbia, with organizing groups in St. Thomas and London. The vision of NCBW is of an organization of progressive women of African descent whose voice and force for gender equity and sociopolitical advancement drive meaningful change to benefit women of color. The mission of NCBW is to develop leaders who will help to rebuild their communities and redirect the energies of younger Black people who live in those communities.

Mobilization update: NCBW has developed curriculum for its two-day “Teach, Learn and Outreach” campaign workshops, and individual chapters have been successful in attracting 600-1,200 women to local events focused on HIV/AIDS among Black women.

Many local chapters are partnering with other community agencies and organizations to mobilize the community into action. The National Coalition of 100 Black Women, Inc., Metropolitan Nashville Chapter is an example of what many local NCBW chapters are doing on the ground. The chapter partnered with Meharry Medical College’s Center for Women’s Health Research to heighten awareness about HIV and AIDS in Nashville’s African-American communities. The chapter held a press conference on National Black HIV/AIDS Awareness Day at Meharry to encourage citizens to get educated, get tested, get treated and get involved with HIV/AIDS as it continues to devastate Black communities.

National Coalition of Pastors’ Spouses

Founded in 2001 by Vivian Berryhill, National Coalition of Pastors’ Spouses (NCPS) is a nonprofit, nonpartisan, male and female, multi-racial network of more than 2,500 clergy spouses from varying denominations

across the country. NCPS’s mission is to raise awareness through health education and health information dissemination, by working through churches and religious institutions to empower women to take action to improve health. NCPS is now leading the charge to educate and train faith leaders to take action regarding HIV/AIDS, as well as heart disease, stroke, diabetes and teen pregnancy in minority communities.

Mobilization update: NCPS had a busy and successful 2008. Over the past year, NCPS has received funding from the Office of AIDS Policy to implement a train-the-trainer program for faith-based communities in New York, Georgia, Oklahoma, New Jersey, Maryland and Michigan. The program model allows NCPS to go into local communities and train faith-based leaders who then train lay people in their communities and congregations.

Since last May, 400 faith-based leaders have been trained. NCPS is utilizing “HIV/AIDS: Manual for Faith Communities,” a publication developed by NCPS in conjunction with the Department of Health and Human Services, as the curriculum for the train-the-trainer program. As of late 2008, NCPS was granted an extension on their contract with the Office of AIDS Policy and will be funded to expand the program into an additional three states (Mississippi, Arkansas and Tennessee) due to the tremendous success of the program.

National Black Justice Coalition

The National Black Justice Coalition (NBJC) is a civil rights organization dedicated to empowering Black same-gender-loving, lesbian, gay, bisexual and transgendered people focusing on social justice, equality, and an end to racism and homophobia. NBJC’s organization and its programs address the problem of gay inequality in America with a goal of increasing African American support for gay and lesbian equality. NBJC actively pursues

fairness for lesbian, gay, bisexual and transgender families and ways to counter anti-gay organizing within African American communities.

Mobilization update: During the National Black Justice Coalition's 2008 Power of Us National Convention, HIV/AIDS was at the top of the agenda. NBJC set aside the first half of the first day of the conference to focus discussions on HIV/AIDS and other health disparities. In an example of partnerships among Mobilization members, American Urban Radio Network's The Bev Smith Show broadcast from the convention.

National Council of Negro Women

Founded in 1935 by educator and political leader Mary McLeod Bethune, the National Council of Negro Women (NCNW) represents the national and international concerns of Black women. The organization was founded on the principle of giving Black women the opportunity to realize their goals for social justice and human rights through united, constructive action.

Today, the NCNW is a council of 39 affiliated African American women's organizations and more than 240 NCNW organizational sections. This network of affiliated organizations and NCNW sections connect with nearly 4 million women worldwide and represents more than 25,000 members and contributors. NCNW's mission is to lead, develop and advocate for women of African descent as they support their families and communities. NCNW fulfills its mission through research and advocacy and by providing national and community-based health, education and economic empowerment services and programs in the United States and Africa.

Mobilization update: NCNW had an especially productive 2008. At the beginning of 2008, the organization hosted a panel on Black women and HIV/AIDS as a part of the NCNW National Convention. The panel

included a representative from the CDC, an HIV positive woman over the age of 50 and a young woman under 35, highlighting the spectrum of HIV/AIDS among Black women in the U.S. The panel was more than just "talking heads." It invited an interactive discussion with local chapter members to strategize ways that participants could make a difference in their local communities. The panel was highlighted on PBS's *To The Contrary*, during an episode that focused on the health of women of color. NCNW then disseminated over 200 DVDs of that coverage during its first annual National Black Women's Town Hall Meeting.

The National Black Women's Town Hall Meeting also provided NCNW with the opportunity to gauge the concerns of Black women and pass them to the next presidential administration. In response to the feedback from the town hall and an online survey commissioned by NCNW, the organization developed and released the "Black Women and Families Agenda for Change: A Framework for Addressing the Needs of Black Women, Families and Communities in the New Presidential Administration." The document calls on the administration to aggressively address the HIV/AIDS crisis within the Black community and among women specifically, and stands with the Black AIDS Institute's call for the development and implementation of a National AIDS Strategy and for more aggressive funding of efforts to fight the disease among African Americans.

NCNW was also able to partner with the D.C. Department of Health to disseminate HIV/AIDS materials during its annual Black Family Reunion event. In addition, NCNW has posted two fact sheets and HIV/AIDS information on its website to increase awareness.

National Newspaper Publishers Association

The National Newspaper Publishers Association (NNPA), also known as the

People Taking Action

Pamela Richard, Denver, Colo.

Pamela Richard was surprised by the amount of resistance she encountered when she told her friends that she was doing outreach on HI/AIDS in her Denver community. "They



didn't want to know anything about HIV," she says her friends told her. "They didn't want to know their status." This was in 2002; by that time she had already lost an uncle to the disease, as well

as a close friend. But what pushed her to get involved was the realization that she "could be really effective if I worked with women who looked like me."

As a fellow at the Black AIDS Institute's African American HIV University, Richard was required to conduct a needs-assessment of her community. She discovered that what was missing were prevention messages targeting women of faith like her and her friends. So she set to work contacting women's ministries, inviting 60 to come to a mobilization event she called Hats for Health, which created a space for women to talk about spirituality and sexuality.

Richard brought in a local Black female gynecologist and a doctor who has written a book about spirituality and sexuality to talk to the women, who ranged in age from 10 to over 50. She planned the event as a high tea featuring women wearing elaborate hats as

an expression of their culture and traditions. In this relaxing atmosphere women were educated about the virus and were also able to express their concerns about many sexual health topics. The women clamored for more time and Richard is already working on next year's event in order to respond to the depth of the interest the event tapped into.

"The women wanted more information about sex after 40. They wanted programs for youth, they wanted to know about how to heal after being sexually abused and about being single and dating in the church," she says, noting that their requests show the need for comprehensive sex education for women of all ages.

In addition to working on next year's mobilization event, Richard is busy working on another project that was an outgrowth of Hats for Health. She was awarded a grant from the Denver health department to "research the dating habits of women of faith and their thoughts about HIV." She will be conducting focus groups with 40 women and one-on-one interviews with 40 women of faith to get information about what they would want in an HIV/AIDS ministry, so that the churches can design interventions that will really work for them.

Richard has learned a lot from the African American HIV University and she knows that there will be some things that she will do differently as she continues her mobilization efforts. "You just have to stick with it and be flexible," she says. The resistance she encountered at the beginning of her journey could have stopped her; instead it led her to do more.

—Janet Quezada

Black Press of America, is a 67-year-old federation of more than 200 Black community newspapers from across the United States. It publishes the NNPA News Service, which produces original, independent and impactful news stories, columns and commentaries that educate,

empower and promote racial and social justice.

The NNPA News Service currently serves more than 200 Black-owned newspapers along with their websites, together called the Black Press USA network. That network, along with NNPA's Blackpressusa.com,

serves approximately 15 million readers. As the only online community of Black newspapers, the network equips publishers with tools and resources to create and maintain a website. Since the network was introduced in June 2001, it has increased the number of NNPA members publishing online by more than 25 percent.

Mobilization update: In the fall of 2007, the National Newspaper Publisher's Association began a 25-week series of HIV/AIDS opinion pieces that were published in 200 Black newspapers each week. At the press conference announcing the op-ed series, Hazel Trice Edney, editor-in-chief of NNPA, said, "We're going to have people with national name recognition so that we will be sure to get our people's attention. People such as Phill Wilson, Bishop T.D. Jakes, the Marc Morials and Jesse Jacksons of our community, the Al Sharptons, the Danny Glovers and some of the esteemed congresswomen who are here today. We are excited about this opportunity to save lives. Our people are dying, not knowing who will be the next one."

Rainbow PUSH Coalition, Inc.

The Rainbow PUSH Coalition, Inc. (RPC) is the outgrowth of the merger of Operation PUSH (People United to Serve Humanity, founded in 1971) and a political organization, the National Rainbow Coalition (founded in 1985). Founded by Rev. Jesse Jackson, the Rainbow PUSH Coalition is a progressive political and advocacy organization fighting for social justice and equality for all people of color. The coalition is made up of diverse, historically disenfranchised constituencies and their allies. RPC's work is centered on grassroots organizing, political education, faith-based outreach, economic empowerment, labor advocacy, and health information and dissemination.

Mobilization update: In June 2008, The Rainbow PUSH Coalition hosted a

workshop session on HIV/AIDS and other health disparities at its annual convention. Phill Wilson, president and CEO of the Black AIDS Institute, participated in the panel. During the same conference, Rev. Jesse Jackson challenged faith-based leaders to take responsibility for ending HIV/AIDS in the Black community. Rainbow PUSH also partnered with local community AIDS groups to provide onsite HIV/AIDS testing, counseling, and referrals.

Southern Christian Leadership Conference

The Southern Christian Leadership Conference (SCLC) was founded in 1957 by Dr. Martin Luther King, Jr. The SCLC was one of the most significant participants in the civil rights movement in the 1950s and 1960s. Its goal was to build on the success of the Montgomery, Ala., bus boycott, which led to Alabama's segregation laws being declared unconstitutional by the Supreme Court. SCLC's commitment to non-violent, civil breaking of the rules provided the moral leadership that exposed the violence and oppression used to enforce an immoral policy of segregation. The organization continues to play an active role in addressing the issues of social injustice. SCLC has been active and influential in mostly southern states, and has always been based in Atlanta, Ga., the home of many of its leaders. The SCLC is a nonprofit, non-sectarian, inter-faith advocacy organization that is committed to non-violent action to achieve social, economic and political justice.

Mobilization update: During its 2008 National Convention, the South Christian Leadership Foundation launched the "Silence Is Sinful Initiative." Its goal is to build partnerships with churches and work to reduce the stigma of AIDS in the Black community, with particular emphasis on the Black church.

The Potter's House and T.D. Jakes Ministries

The Potter's House was founded by Bishop T.D. Jakes in 1996. Based in Dallas, Texas, this multi-cultural non-denominational church, with more than 30,000 members representing more than 17 nationalities, is one of the fastest growing mega-churches in the world. The Potter's House has a national and global reach that touches millions of people each month through more than 50 ministries, television, radio, a website that generates 1.2 million hits a month and broadcasting via Prison Satellite Network to more than 260 prisons.

Mobilization update: Over the last year, the Potter's House has continued its official HIV/AIDS outreach program, It's Time to Step Up! The ministry, which functions under the church's counseling center, targets the faith community, women and minorities by sharing the latest HIV/AIDS statistics and providing free screening and educational seminars to congregants and community members. Since its inception, the ministry has provided food, clothing, prayer, counseling, testing and community agency referrals to those affected by HIV/AIDS.

Additionally, The Potter's House, working in tandem with a federally sponsored government program, currently administers the Texas Offenders Reentry Initiative (TORI), operating in Dallas, Fort Worth, San Antonio, Austin and Houston. These cities were chosen because they are Texas's five primary "reentry points," cities where former offenders reenter society after serving their sentences in Texas prisons. TORI is the ministry's after-care reentry program providing intensive case management services, including HIV/AIDS awareness and substance abuse recovery counseling and education, and other wrap-around services such as family and marriage counseling, and pre-employment counseling.

The Potter's House recently partnered with World Vision to present a virtual

exhibit of African children whose lives have been devastated by HIV/AIDS. In addition, the church is building homes in Africa where many children have been orphaned due to HIV/AIDS.

During this year's MegaFest, T.D. Jakes Ministries launched MegaCARE, a new component of MegaFest, which allows the event to fulfill its commission of meeting the spiritual and physical needs of all people. Sponsored by Terra Cotta International (TCI) and The Potter's House Office of Counseling and Behavioral Health (OCBH), MegaCARE partners with governmental and faith-based organizations in South Africa and Swaziland to provide free onsite health services in those countries. General health screenings, HIV counseling and testing, dental care, ophthalmic care and referral services, and materials and resources on malaria, tuberculosis, domestic violence and HIV/AIDS were offered to participants.

Society for Family Health/New Start, a partner of PEPFAR (United States President's Emergency Plan for AIDS Relief), provided HIV testing and counseling while Pro-Health International provided the physicians, lab techs, pharmacists and others who delivered expert care and counseling on-site. The CDC was another partner in this initiative.

MegaCARE also facilitated an educational exchange between students in South Africa and school-aged children from Clay Academy, the private college-preparatory school in Dallas affiliated with The Potter's House. Through the program, Clay Academy students visited Sparrow Village, a hospice and orphanage that cares for adults and children impacted by HIV/AIDS, and engaged in shared learning experiences. Additionally, OCBH counselors offered self-care seminars for local school and healthcare personnel.

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How You Can Get Involved

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How You Can Get Involved

So now you know—the State of AIDS in Black America is dire and getting worse. Moreover, over the past eight years Washington has done little to nothing about that fact. So what are you going to do about it? We've got some ideas.

Take Responsibility

First and foremost, make sure you're taking personal responsibility for ending AIDS.

■ **Get Tested.** If you're sexually active, get tested on a regular basis—and take everyone you love with you, especially anyone you're having sex with;

■ **Challenge Stigma.** It's killing us. Don't let shame surrounding HIV—or sex, or drugs, or gay and bisexual relationships—cripple you or your community. Challenge it every time you encounter it, because silence still equals death.

■ **Be Active Locally.** Find out where you can volunteer to help organizations that are combating HIV in your community. Contact one of the national organizations discussed in this report to find out if they have a local chapter.

One great way to get involved locally is to join our Test 1 Million campaign. (See “Test 1 Million” on page 37.) Launched on National HIV Testing Day 2008, the campaign aims to get one million Black Americans to learn their HIV status over the next two years—by

National HIV Testing Day 2010, on June 27 of that year.

Organizations and individuals can sign up for the Test 1 Million campaign at www.BlackAIDS.org. Individuals interested in joining the campaign are asked to get tested for HIV/AIDS in order to become an official Test 1 Million member.

Tell Washington to Get a Strategy

Once you've taken responsibility for yourself and your loved ones, you've got to demand federal policy makers take responsibility, too. The Obama administration and Congress present a unique opportunity for our community's fight against AIDS. But we must engage and support them to ensure their promises and potential lead to real changes.

The first thing you can do is join the Call to Action for a National AIDS Strategy. (See page 30 for details.) Below is a letter you can send to the White House urging President Obama to fulfill his pledge to draft a national strategy; it also contains principles for that strategy that the Call to Action signatories and the Black AIDS Institute have developed.

Log on to BlackAIDS.org and we'll help you send the letter as an email. Once you've sent it to the Obama administration, forward a copy to the Congressional Black Caucus, to let them know you've joined the movement!

Dear President Obama,

I write to congratulate you on your new administration. As someone who cares about the devastating impact HIV/AIDS has had on the Black community, I know that your administration offers enormous promise for a new day in our nation's long struggle against this epidemic. I'm especially encouraged by your promise to develop and implement a national AIDS strategy during your first year in office.

More than 27 years into the epidemic, America has never had a comprehensive strategy to direct its response to AIDS. That's a simple, essential step that we require of any country seeking our foreign assistance, and it's long overdue. Thank you for your commitment to making it happen.

More than 350 organizations and thousands of individuals have already signed a Call to Action for a National AIDS Strategy. I join those voices in urging your administration to begin work on drafting the strategy within its first 100 days. We urge that, in developing the strategy, you adhere to the principles articulated below, many of which you have already championed.

Your administration faces many grave challenges. But as articulated in a recent report—*Making Change Real: The State of AIDS in Black America, 2009*, available at www.BlackAIDS.org—HIV/AIDS presents yet another long-neglected problem that we cannot afford to put off addressing. Every year of delay means another 56,000 new infections, half of them among Black Americans.

Thank you for your continued commitment and leadership in the movement to build a healthy Black America. I look forward to joining you as, together, we end this epidemic!

Yours in the struggle,

My email:

My City and State:

Principles for Developing a National AIDS Strategy

The signatories of the Call to Action for a National AIDS Strategy have urged President Obama to create an open, orderly and accountable process for drafting his national strategy. The following recommendations incorporate both the Black AIDS Institute's own recommendations and those of the overall coalition.

Establish an inclusive, comprehensive panel to guide the process. The coalition recommends that the president, acting through the Domestic Policy Council, appoint a panel of experts on HIV/AIDS from every department of the United States government with responsibilities for responding to the epidemic. The panel must also include representatives of key non-governmental and civil society organizations, people living with and at risk for HIV, and other stakeholders.

This panel must reflect the diverse communities affected by HIV/AIDS. It should hold at least one meeting at which it receives public input into the development of the strategy, and at least two meetings at which its deliberations are open to the public. The panel should take into account stakeholder input—gathered in multiple ways—and the best available evidence on effective strategies to achieve HIV prevention, care, and research goals.

Begin work immediately. In keeping with President Obama's campaign pledge, the strategy should be fully developed no later than January 20, 2010, and be operational until December 31, 2014. Further, President Obama should appoint a national AIDS strategy panel within his first 100 days in office, as well as a White House-level presidential advisor to oversee the strategy's development and implementation.

Appoint an AIDS czar with meaningful power. President Obama should reinvigorate a White House-level office to direct federal AIDS policy—a longstanding function that waned under the Bush administration. The office should provide staffing to the national strategy panel and be headed by a presidential advisor with authority to oversee and coordinate all government agencies and federally funded non-governmental organizations involved in implementing the strategy.

Budget enough money to make meaningful planning possible. President Obama must request and Congress must appropriate sufficient funding for Fiscal Year 2009 to allow the White House-level AIDS office to plan and implement a national AIDS strategy. The president must commit to continued funding in his subsequent budget requests to assure the development, implementation, and

evaluation of the strategy. This funding must be in addition to the desperately needed investments for ongoing prevention, care, treatment and research efforts.

Have measurable, realistic and specific goals. The national AIDS strategy should not repeat or recreate the exhaustive set of goals that have characterized previous planning efforts to respond to the epidemic, though many of the goals these plans have described are important. Instead, the national AIDS strategy must:

- Describe a limited and focused set of strategic initiatives that will increase to the highest possible levels the number of Americans who know their HIV status and the number of HIV-positive Americans who are engaged in comprehensive, high-quality care and treatment for HIV and related conditions; reduce to the lowest possible levels the disparities in health outcomes that are experienced by gay and other men who have sex with men, communities of color, and women; and reduce to the lowest possible levels the number of new cases of HIV infection that occur annually;

- Prioritize initiatives targeting populations or jurisdictions with the highest prevalence and incidence of HIV/AIDS in the nation (consistent with current epidemiological data), with emphasis on outcomes related to African Americans and other communities of color, women of color, and gay men of all races and ethnicities;

- Describe the legislation, policies and programs that are necessary to carry out those initiatives;

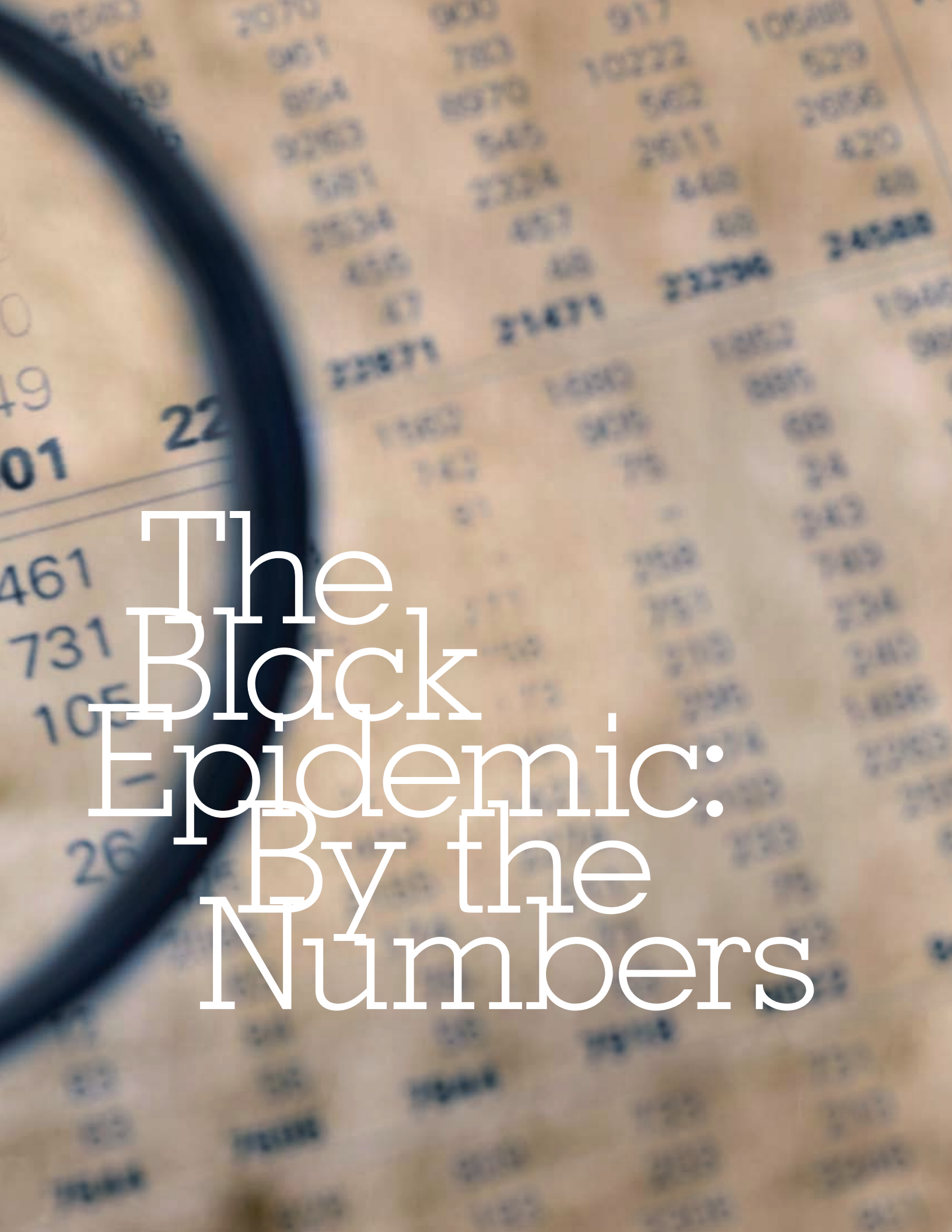
- Set specific outcomes by which each of the initiatives will be evaluated, along with timelines for implementing them;

- Assign responsibility for implementation of each of the action steps to appropriate government agencies and create mechanisms to facilitate collaboration between these agencies and non-governmental organizations;

- Determine the annual cost and financing mechanisms necessary for implementing each initiative, along with recommended sources of funds. Sources may include the redirection of existing federal resources to the action steps contained in the strategy, as well as additional resources that should be sought by the president from the Congress; and

- Develop a mechanism by which existing sources of federal funding for HIV/AIDS will be made consistent with participation in the initiatives described in the strategy.



The background of the image is a close-up, slightly out-of-focus photograph of a document. It appears to be a form or a ledger with various numbers and text. A blue pen is resting diagonally across the middle of the page. The text 'The Black Epidemic: By the Numbers' is overlaid in a large, white, serif font, centered on the page.

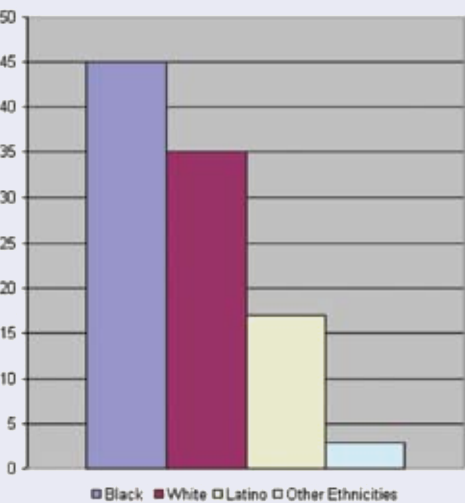
The Black Epidemic: By the Numbers

HIV Infection in America

Race of Newly Infected

An estimate 56,300 people were newly infected in 2006, the most recent year for which data is available. The racial breakdown among them was:

Black	45 percent
White	35 percent
Latino	17 percent
Other Ethnicities	3 percent

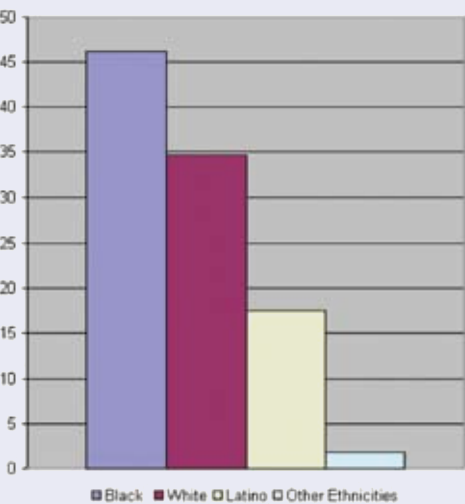


Source: Hall H, Song R, Rhodes P, et al. Estimation of HIV Incidence in the United States. JAMA. 2008;300:520-529.

Race of All HIV-Positive

An estimated 1.1 million people are HIV positive in the United States. The racial breakdown among them is:

Black	46.1 percent
White	34.6 percent
Latino	17.5 percent
Other Ethnicities	1.8 percent

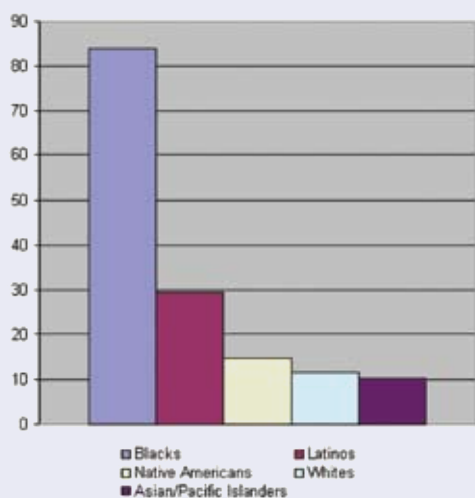


Source: CDC, HIV Prevalence Estimates—United States, 2006, MMWR, 57(39);1073-1076.

Rate of Infection

Black Americans were infected at a rate seven times that of whites in 2006—and Black women were infected at a rate almost 15 times that of whites. The number of people infected per 100,000, by race, was:

Among Blacks	83.7
Among Latinos	29.3
Among Native Americans	14.6
Among Whites	11.5
Among Asian/Pacific Islander	10.3

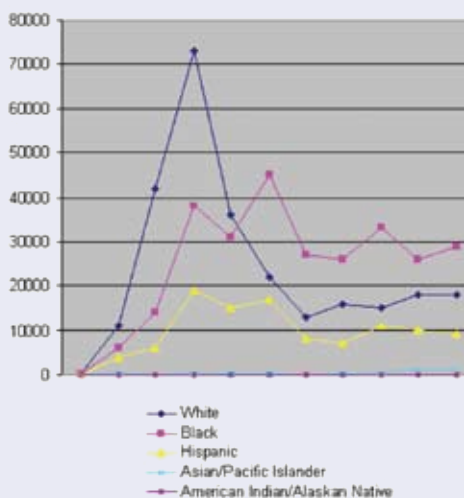


Source: Hall HI, Song R, Rhodes P, et al. Estimation of HIV Incidence in the United States. *JAMA*. 2008;300:520–529.

Infection Over Time

Black Americans' share of new infections has grown steadily over time. By the late 1980s, Blacks began accounting for the largest share of new infections.

Estimated new human immunodeficiency virus (HIV) infections, by race/ethnicity, extended back-calculation model, 50 U.S. states and the District of Columbia, 1977–2006:



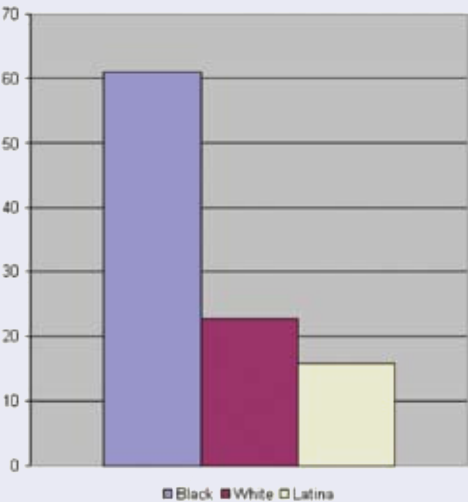
Source: Hall HI, Song R, Rhodes P, et al. Estimation of HIV Incidence in the United States. *JAMA*. 2008;300:520–529.

HIV Infections, Up Close

Among Women

An estimated 14,410 Black, white and Latina women were newly infected in 2006. The racial breakdown among them was:

Black	61 percent
White	23 percent
Latina	16 percent

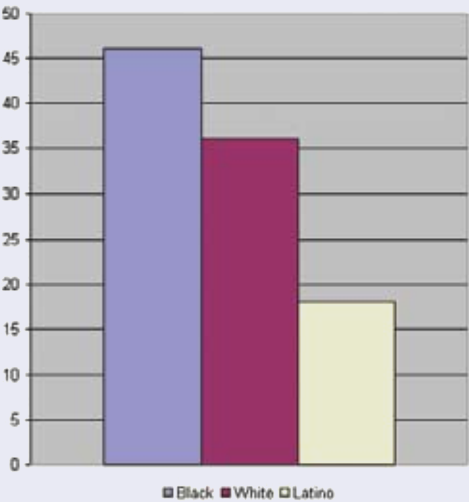


Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, 57(36);985-989. Data not available for any other ethnicity.

Among Men

An estimated 39,820 Black, white and Latina women were newly infected in 2006. The racial breakdown among them was:

Black	46 percent
White	36 percent
Latino	18 percent

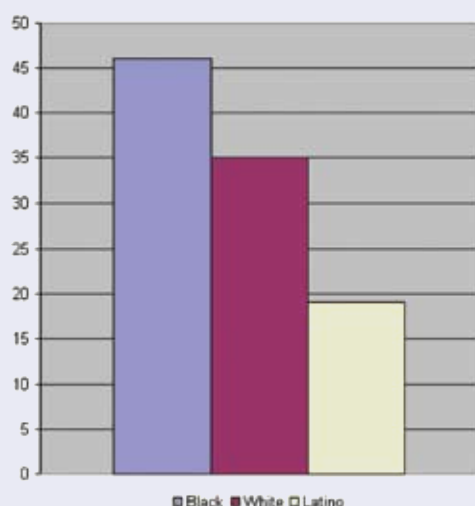


Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, 57(36);985-989. Data not available for any other ethnicity.

Among Gay and Bisexual Men

Gay and bisexual men accounted for more than half of all new infections in 2006. The racial breakdown among them was:

Black	46 percent
White	35 percent
Latino	19 percent

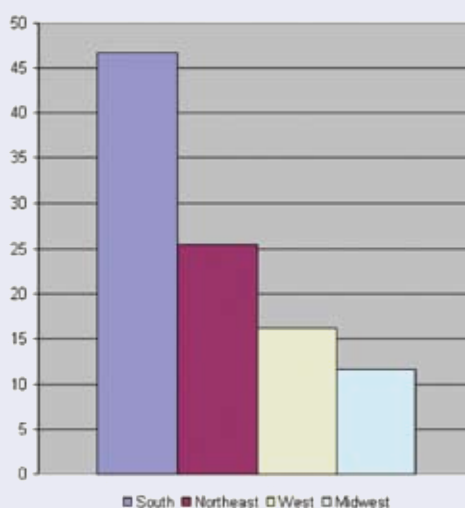


Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, 57(36);985-989. Data not available for any other ethnicity.

Where Newly HIV-Positive Live

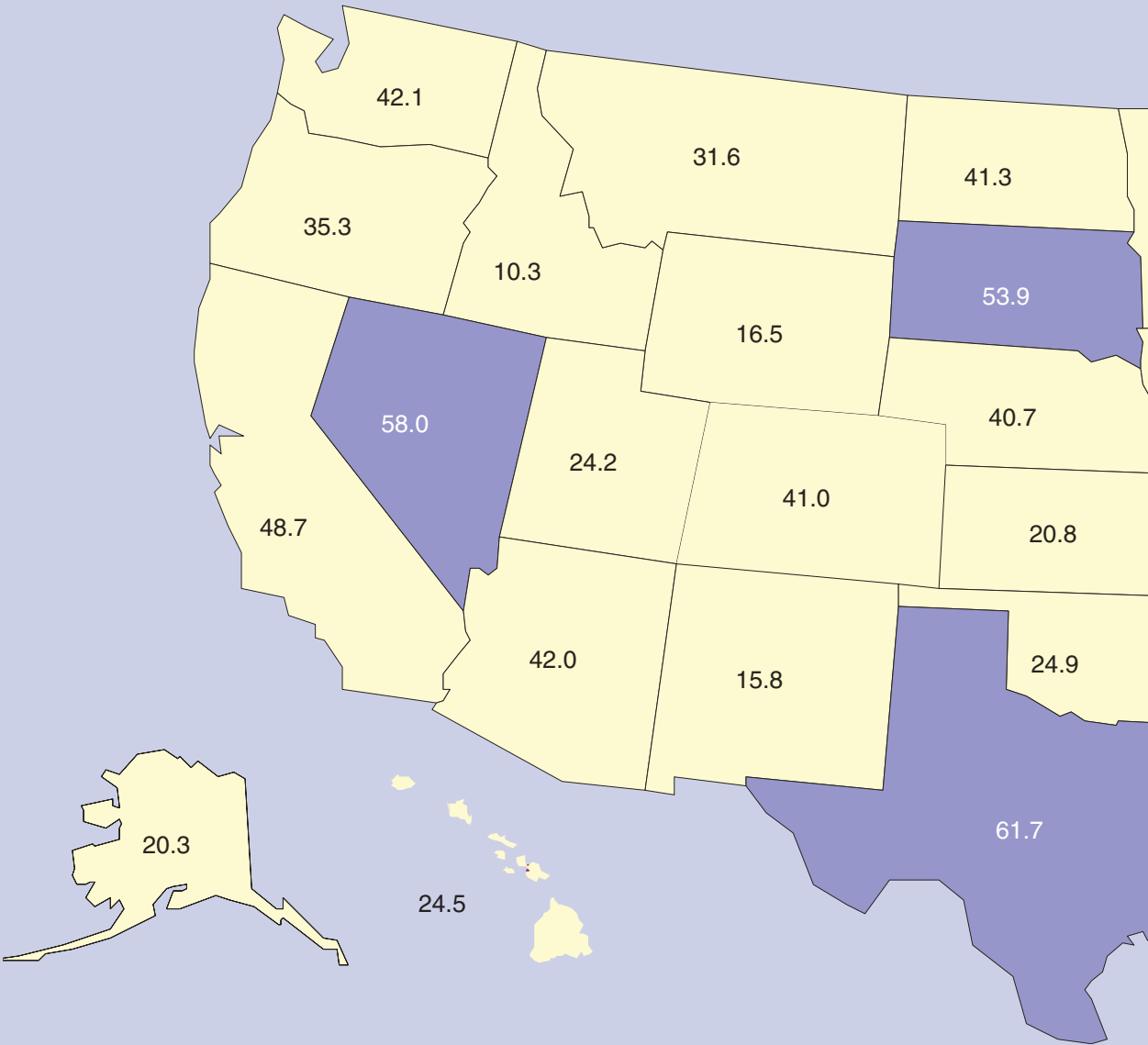
The South is the modern epidemic's geographic frontline, in part because of its sizable Black population. The regional breakdown for new infections in 2006 was:

South	46.7 percent
Northeast	25.4 percent
West	16.1 percent
Midwest	11.6 percent



Source: CDC, HIV/AIDS Surveillance in Urban and Nonurban Areas, slide set, accessed December 16, 2008, at <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/urban-nonurban/index.htm>.

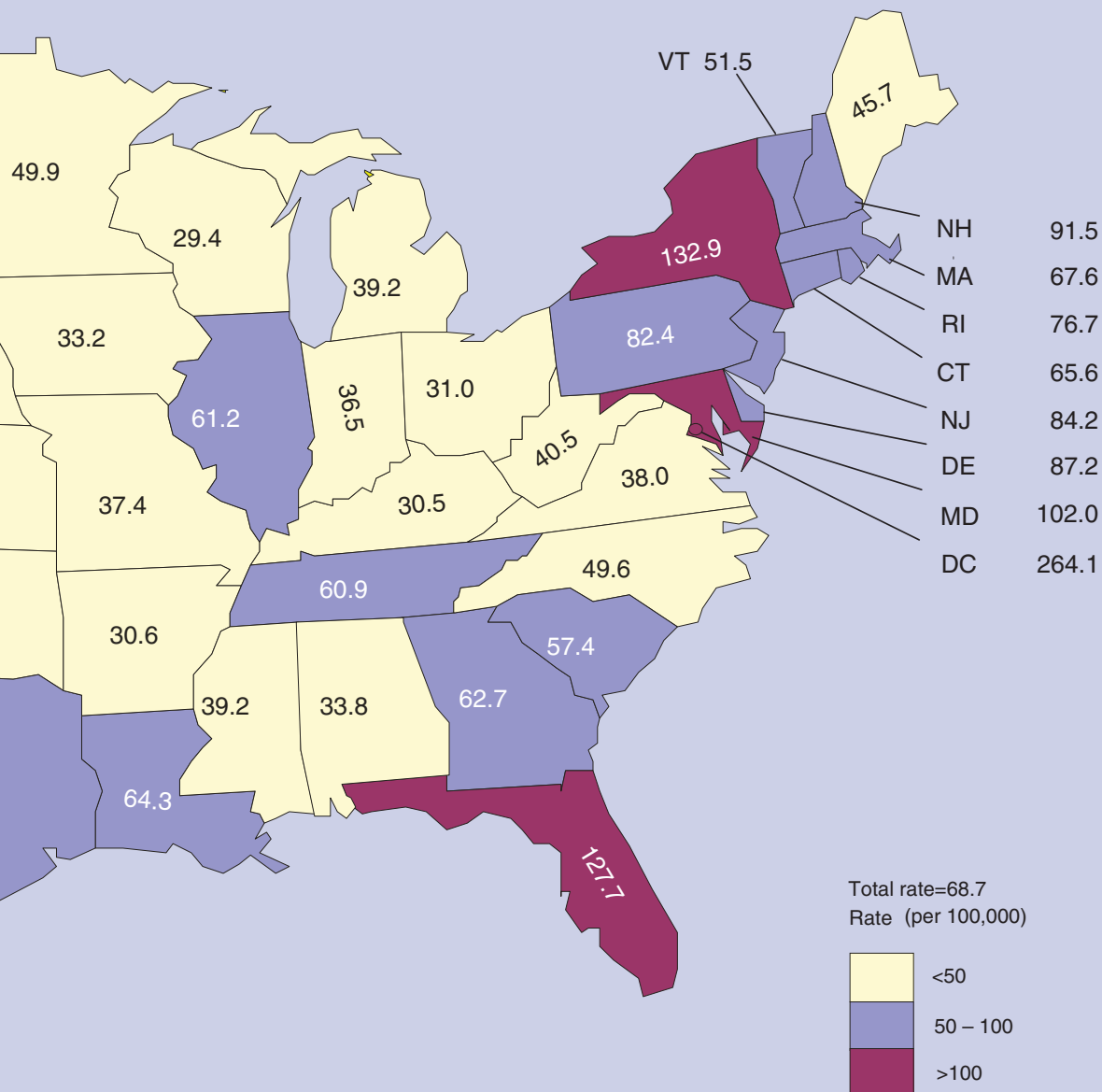
MAP of the Black AIDS Epidemic



Black communities in the Northeast and Southeast—particularly in Florida, Maryland and New York—had the highest rates of HIV infection between 2002 and 2006. Overall, the prevalence of HIV among Blacks is nearly eight times that among whites.*

Sources: CDC, HIV/AIDS Surveillance by Race/Ethnicity, slide set, accessed December 17, 2008, at <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/race-ethnicity/index.htm>.

*CDC, HIV Prevalence Estimates—United States, 2006, MMWR, 57(39);1073-1076.

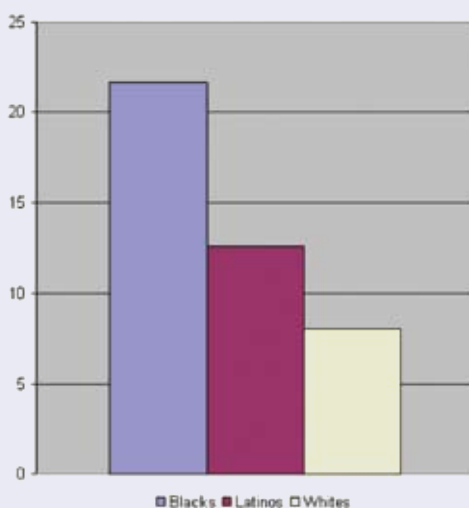


HIV Testing and Transmission in America

Race of Americans Tested

One in ten Americans said in 2006 that they got tested for HIV in the previous year, but Blacks tested at higher rates than any other racial or ethnic group. The share of people who reported getting tested was:

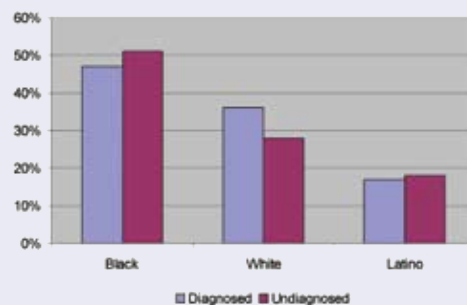
Among Blacks	21.7 percent
Among Latinos	12.6 percent
Among Whites	8 percent



Source: CDC, Persons Tested for HIV—United States, 2006, MMWR, 57(31);845-849. Data not available for any other racial or ethnic group.

Race of Undiagnosed HIV-Positive

An estimated one in five HIV positive Americans don't know they are infected.* But the most recent race-based data shows more than half of positive Blacks are undiagnosed.



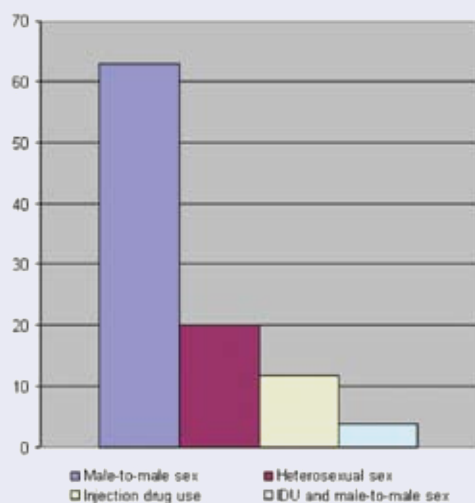
Source: Glynn MK and Rhodes P. Estimated HIV Prevalence in the United States at the end of 2003. Presentation at the 2005 National HIV Prevention Conference, June 14, 2005. Cited in CDC presentation to Black AIDS Institute physicians' forum, October 2006.

*CDC, HIV Prevalence Estimates—United States, 2006, MMWR, 57(39);1073-1076.

How Black Men Get Infected

Male-to-male sexual contact was the primary risk factor for 72 percent of all men infected in 2006. Among Black men who tested positive, risk factors included:

Male-to-male sex	63 percent
Heterosexual sex	20 percent
Injection drug use	12 percent
IDU and male-to-male sex	4 percent

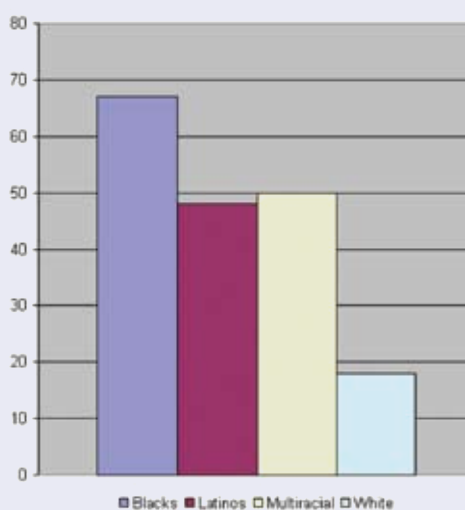


Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, 57(36);985-989.

Undiagnosed Gay and Bisexual Men

A five-city study published in 2005 found 46 percent of Black gay and bisexual men to be HIV positive; well over half of them did not know it. The percentage of undiagnosed infections was:

Among Blacks	67 percent
Among Latinos	48 percent
Among Multiracial	50 percent
Among White	18 percent

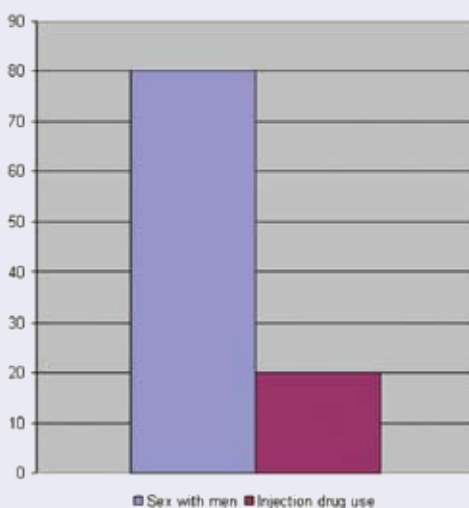


Source: CDC, HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex with Men—Five U.S. Cities, June 2004–April 2005, MMWR, 54(24);597-601.

How Black Women Get Infected

Black women got infected at a rate 18 times that of whites in 2006. Risk factors included:

Sex with men	80 percent
Injection drug use	20 percent



Source: CDC, Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006, 57(36);985-989.

How STDs Help HIV

A person with an STD is two to five times more likely to contract HIV when exposed to it, and HIV positive people who have an STD are more infectious.* In 2006, Blacks had the highest rates of all STDs.

Infection rate among Black women vs. white women for:

Chlamydia	7x higher
Gonorrhea	14x higher
Syphilis	16x higher

Infection rate among Black men vs. white men for:

Chlamydia	11x higher
Gonorrhea	25x higher
Syphilis	5x higher

Sources: CDC, Sexually Transmitted Disease Surveillance, 2006. November 2007.

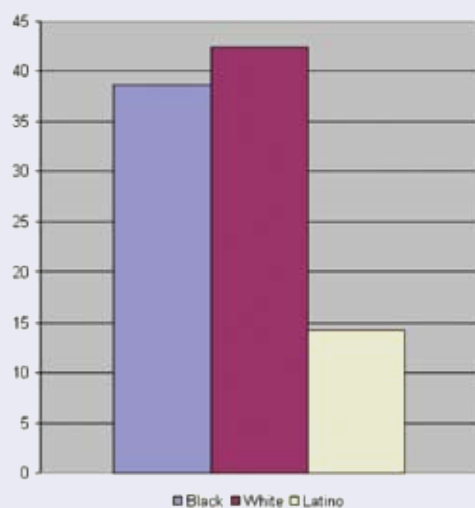
*CDC, The Role of STD Detection and Treatment in HIV Prevention—CDC Fact Sheet, accessed on December 17, 2008, at [http://www.cdc.gov/std/hiv/STDFact-STD&HIV.htm#MoreInfo.54\(24\);597-601](http://www.cdc.gov/std/hiv/STDFact-STD&HIV.htm#MoreInfo.54(24);597-601).

HIV Treatment and Death in America

Who's Dying

In 2006, 7,426 Black Americans died from AIDS—more than twice that of any other group, but 1,253 fewer than the previous year. The racial breakdown for all Americans killed by AIDS as of 2006 is:

Black	38.5 percent
White	42.3 percent
Latino	14.2 percent

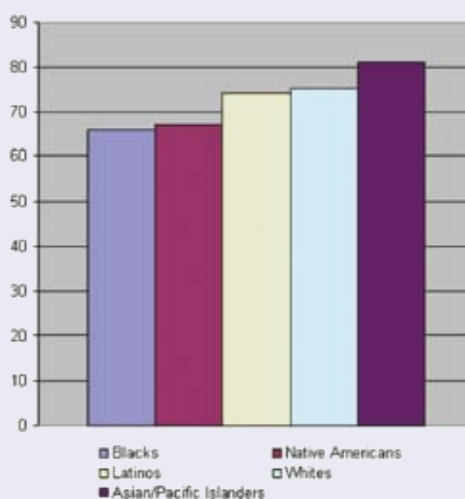


Source: CDC, HIV/AIDS Surveillance Report, 2006. Vol. 18; 2008.

Who's Living

Black Americans are less likely to live 10 years with HIV infection. The share of people diagnosed between 1997 and 2004 who were still alive after nine years is:

Among Blacks	66 percent
Among Native Americans	67 percent
Among Latinos	74 percent
Among Whites	75 percent
Among Asian/Pacific Islanders	81 percent

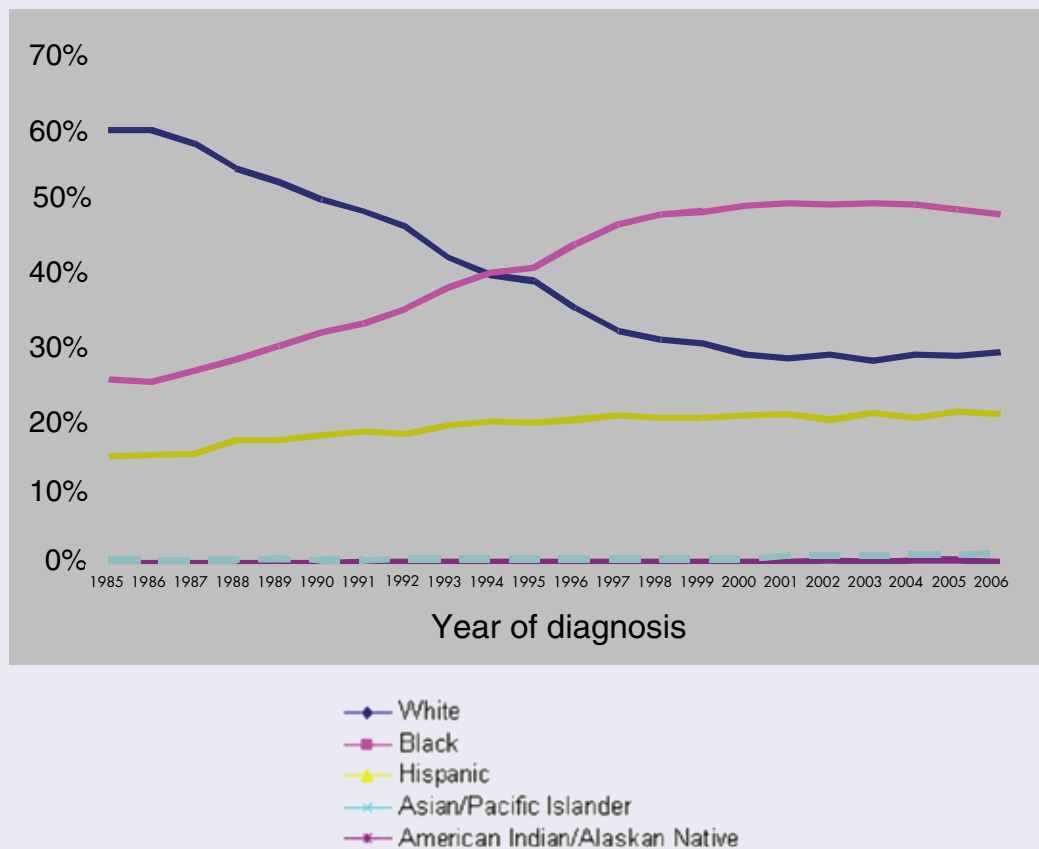


Source: CDC. HIV/AIDS Surveillance Report, 2005. Vol. 17, Figure 4; CDC. HIV/AIDS Among African Americans. HIV/AIDS Fact Sheet. June 2007.

Advanced Disease

Since combination therapy became available in the mid-1990s, Blacks have represented the largest share of people with HIV infections that have advanced to AIDS.

Proportion of AIDS cases among adults and adolescents by race/ethnicity and year of diagnosis, United States and dependent areas, 1985-2006:



Source: CDC, AIDS Surveillance—General Epidemiology through 2006, slide set accessed on December 20, 2008 at <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/epidemiology/index.htm>.

Note: Data have been adjusted for reporting delays.

About the Black AIDS Institute

The Black AIDS Institute, founded in 1999, is the only national HIV/AIDS think tank in the United States focused exclusively on Black people. The Institute's mission is to stop the AIDS pandemic in Black communities by engaging and mobilizing Black leaders, institutions and individuals in efforts to confront HIV. The Institute conducts HIV policy research, interprets public and private sector HIV policies, conducts trainings, builds capacity, disseminates information, and provides advocacy and mobilization from a uniquely and unapologetically Black point of view.

What We Do

The Institute develops and disseminates information on HIV/AIDS policy. Our first major publication was the NIA Plan, which launched a national campaign to stop HIV/AIDS in African American communities by formulating and disseminating policy proposals developed through collaboration with

federal, state and local government agencies, universities, community-based organizations, healthcare providers, opinion shapers and “gatekeepers.”

■ The African American HIV Uni-



versity, the Institute's flagship training program, is a fellowship program designed to increase the quantity and quality of HIV education in

Black communities by training and supporting grassroots educators of African descent. AAHU's Science and Treatment College trains Black people in the science of HIV/AIDS. We believe when people and communities understand the science of AIDS, they are better equipped to protect themselves, less likely to stigmatize those living with the disease or at risk of infection, better able to adhere to treatment and advocate for care, and better positioned to influence public and private HIV/AIDS policies. The Community Mobilization College is designed to enhance the capacity of Black communities to address

the HIV/AIDS epidemic. Through building the knowledge and networks of community leaders around the country and providing a skills-building internship practicum focused on community mobilization, individuals become capable of engaging traditional Black institutions and other stakeholders in local level community activities that will increase access to and utilization of HIV prevention services in their communities

■ **The International Community Treatment and Science Workshop** is a training and mentoring program to help people who are living with HIV/AIDS or who are working with community-based and non-governmental AIDS organizations to meaningfully access information presented at scientific meetings. Program updates will be available for the next International AIDS Conference which will be held in Vienna in 2010.

■ **The Drum Beat** project is the Institute's Black media mobilization designed to train Black journalists on how to cover HIV/AIDS and tell the stories of those infected and affected. The Black Media Task Force on AIDS, a component of the Drum Beat Project, currently has over 1500 Black media members.

■ The Institute publishes **original editorial materials** on the Black AIDS epidemic. Our flagship publication is our *State of AIDS in Black America* series which chronicles statistics, policy and movement activities from year to year. In the past few years, the institute has published reports on Black women, Black youth, Black gay and bisexual men and treatment in Black America. Our website www.BlackAIDS.org attracts nearly 100,000 hits a month. And our weekly AIDS updates currently have over 35,000 subscribers.

■ **Heroes in the Struggle** is a photographic tribute to the work of Black warriors in the fight against AIDS. Featuring elected officials and other policy makers, leading Black clergy, celebrities and entertainers, journalists, caregivers, advocates and people living with HIV/AIDS, the exhibit travels to Black universities, museums and

community-based organizations throughout the United States, providing information on HIV/AIDS, raising awareness, and generating community dialogues about what Black people are doing and what we need to be doing to end the AIDS epidemic in our communities.

■ The Institute provides **technical assistance** to traditional African American institutions, elected officials and churches who are interested in developing effective HIV/AIDS programs, and to AIDS organizations that would like to work more effectively with traditional Black institutions.

Finally, nearly 30,000 people participated in AIDS updates, town hall meetings or community organizing forums sponsored by the Institute annually.

■ **Leaders in the Fight to Eradicate AIDS (LifeAIDS)** is a national Black student



membership organization created to mobilize Black college students around HIV/AIDS. LifeAIDS

sponsors a national Black Student Teach-In and publishes Ledge, the only national AIDS magazine written, edited and published by Black students. Founded in 2004, LifeAIDS is the nation's only AIDS organization created by Black college students to mobilize Black college students to end the AIDS epidemic in Black communities. LifeAIDS has a presence on more than 70 college campuses nationwide.

■ **The National Black AIDS Mobilization** is an



unprecedented five-year multi-sector collaboration between all three national Black AIDS organizations in the United States (The Balm

in Gilead, the National Black Leadership Commission on AIDS and the Black AIDS

Institute) with a goal of ending the AIDS epidemic in Black America by 2012.

BAM seeks to build a new sense of urgency in Black America, so that no one accepts the idea that the presence of HIV and AIDS is inevitable. The campaign calls on traditional Black institutions, leaders and individuals to actions toward ending the AIDS epidemic in Black America.

The project has four key objectives: cut HIV rates in Black America, increase the percentage of Black Americans who know their HIV status, increase Black utilization of HIV treatment and care, and decrease HIV/AIDS stigma in Black communities.

BAM does this in two ways: identifying and recruiting traditional Black institutions and leaders, and providing Black leaders and institutions with the skills and capacity to develop strategic action plans for themselves and/or their organizations. The organizations that have signed on to NBAM are: 100 Black Men of America, American Urban Radio Networks, Congressional Black Caucus Foundation, National Action Network, National Coalition of 100 Black Women, National Coalition of Pastors' Spouses, National Black Justice Coalition, National Council of Negro Women, National Newspaper Publishers Association News Service, RainbowPUSH Coalition, Inc., Southern Christian Leadership Conference, The Potter's House and T.D. Jakes Ministries.



■ The
Test 1 Million
campaign is a
two-year effort
to screen one
million people
for HIV by June

27, 2010. The campaign began with a celebrity-studded press conference in collaboration with SAG and AFTRA at the Screen Actors Guild. Other events include an Oakland-to-Los Angeles run where people will be tested along the California coast run route and a national “get free concert tickets in return for taking an HIV test” program in partnership with leading R&B and hip-hop artists.

About the Authors



KAI WRIGHT is publications editor for the Black AIDS Institute and a columnist for The Root.com. As a writer and editor in Brooklyn, N.Y., his work explores the politics of sex, race and health. Wright has reported from all over the world for leading independent and community-based publications, ranging from *Mother Jones* to *Essence* magazines, and has received several awards and fellowships for his AIDS writing. Wright is author of *Drifting Toward Love: Black, Brown, Gay and Coming of Age on the Streets of New York*, as well as two books of African-American history. He is a native of Indianapolis, Indiana. To check out more of Wright's work, visit Kaiwright.com.



MYISHA M. PATTERSON-GATSON, Director of Mobilization for the Black AIDS Institute, previously served as National Health Coordinator for the NAACP. There she developed and implemented campaigns on Medicare Part D, HIV/AIDS, obesity and smoking cessation. Recently, she developed a mentoring program for high school girls at Greater Mount Calvary Holy Church in Washington, D.C. A life member of the NAACP and a member of Alpha Kappa Alpha Sorority, Inc., Patterson-Gatson is currently working to obtain her Master's of Public Administration in Health Policy and Management at NYU's Robert F. Wagner School of Public Service.

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HOMELAND SECURITY | HOUSING |
AUTOMOBILE INDUSTRY | SUB PRIME | AIDS
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