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Black America Gets Tested

Proposal for a high-impact national television ad campaign

Written by Mustapha Khan

Overall concept

Black America Gets Tested will be a national television commercial campaign consisting of eight 30-second PSA's specifically designed to encourage all African-Americans to be tested for HIV.

More specifically the spots will be upbeat and inspiring--featuring dozens of African American celebrities and real people from every walk of life, proudly exclaiming to camera how they have been tested for HIV and why they think it is important.

Each spot will feature10-15 different celebrities and real people giving us life-affirming sound bytes of their own creation. For example, one teenager might say "I got tested because I care about my life and I care about my future" while Maya Angelou might say because "Our bodies are our temples."

On the other hand, a Reverend might say "because I wanted to be an example to my flock," while Chris Rock might mimic a joke in his stand-up routine and say "cuz ya never know!"

In each case, each person will be seen in a real-life setting and will always give us a sense that they are simply being themselves and being 100% real.

These testimonial soundbytes will then be combined editorially with various images of positive scenes of life in our communities and set to a popular song, which will be used as a soundtrack. Finally a brief closing voice-over will underscore each spot's central message, and an end title card will give specific information about locating testing sites.

Overall, these spots have the potential to be stunningly powerful, as it can truly give Black America the sense that EVERY KIND OF PERSON in the community is getting tested. Moreover, hearing all of these diverse folks speak so proudly and openly about getting tested will do wonders for "normalizing" the act of getting testing, i.e., making it literally no big deal.

Finally seeing so many of our beautiful and talented brothers and sisters in these spots together will empower and inspire the viewing audience with pride, and will underscore the positive message that we are all part a beautiful, powerful vibrant community, which we all want to keep healthy.

The Different Spots

The eight different spots will be similar in general style but will vary in accordance with their respective target audience. The different (and sometimes overlapping) audiences will be:

1) Teenagers (male and female)
2) Women (straight and gay)
3) Men (mostly straight)
4) Expecting Mothers (also featuring small children)
5) Gay Brothers (mostly young)
6) The Church Community (all ages)
7) Seniors (male, female, straight and gay)
8) Black America as a Whole

Each of these spots will feature a different popular, uplifting song as its soundtrack. For example, the Women's spot might feature Desiree's anthem "You Gotta Be" while in the Expecting Mother's spot we might have Stevie Wonder's "Isn't She Lovely."

Similarly the Church spot (which might play on Sunday mornings) would feature a gospel tune; the Teenager spot (which would play on music video channels) would have a hip-hop song.

In addition, the voice-over message at the end of each spot would be specific to each PSA. For example, the voice-over for the Teen spot might start out, "If you think teenagers can't catch HIV, think again..." while the voice-over in the Senior spot might begin, "Just because you're over 50, doesn't mean you can't get HIV..."

Finally, eight spots with 10-15 people in each of them obviously will not mean needing to film 80-120 people. Some people might appear in several different spots.

For example, Kobe Bryant might appear in the Men's spot, the Teen spot and the Black America as a Whole spot. Similarly, Maya Angelou might be in the Women's spot, the Senior's spot and the Black America as a Whole spot.

Celebrities and just Plain Folk

Along with the famous, the spots will feature regular African-Americans from every walk of life, including: urban, rural, rich, poor, professional, blue collar, Southern, Midwestern, East Coasters, West Coasters, religious, secular, gay, straight, very young and very old.

Examples of Famous Folks might include:

Denzel Washington
Chris Rock
Will Smith
Queen Latifah
Oprah Winfrey
Colin Powell
Stevie Wonder
Spike Lee
Eddie Murphy
Gladys Knight
Ruby Dee
Bobby Short
Magic Johnson
Usher
Master P
Brandi
Damon Wayans
Kobe Bryant
Maya Angelou
Wynton Marsalis
Kwaasi Mfume
Jessye Norman
Waler Mosley
Jesse Jackson Jr.
Evander Holyfield
Smokey Robinson
Richard Roundtree
Marian Wright Edelman
Tom Joyner
Lynn Whitfield
Tyra Banks
Eric LaSalle
Geoffrey Holder
Bobby McFerrin

Angela Bassett
TLC
Jada Pinkett
Bill Cosby
Michael Jordan
Cornel West
Dionne Warwick
Jesse Jackson
Samuel L. Jackson
Ossie Davis
Eartha Kitt
Ed Bradley
Mya
Quincy Jones
Busta Rhymes
Shaq
Barry White
Tiger Woods
Julian Bond
Chuck D
Maxine Waters
Skip Gates
Toni Morrison
Ken Griffey Jr.
Vernon Jordan
Gordon Parks
Wesley Snipes
Tony Brown
Heavy D
Halle Berry
John Singleton
Venus Williams
Serena Williams
Alice Walker

Mustapha Khan

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African Americans and HIV

- An analysis of trends in the AIDS epidemic from 1981-98 shows an estimated cumulative total of 1.2 million persons with HIV infection, of whom about 900,000 have been diagnosed with HIV.

- More than 688,000 AIDS cases have been reported, and about 410,800 persons have died from HIV/AIDS. The number of annual HIV infections appears to have peaked in the late 1980's and early 1990's at about 100,000 to 150,000 new infections per year and to have stabilized at about 40,000 new HIV infections annually since 1991.

- As of the end of 1998, approximately 60 percent of the persons reported to have AIDS had died. However, since the new antiretroviral therapies became available, there have been significant declines in mortality and in AIDS diagnoses **-- a drop of nearly 68% between 1995 and 1997.**

- Since 1992, African American populations have continued to represent a disproportionate number of AIDS cases.

- In 1998, White Americans, who comprise 73 percent of the total U.S. population, represented 34 percent of the new reported AIDS cases.

- African Americans represented 12 percent of the population and 45 percent of the new AIDS cases.

- African Americans represent a significantly higher proportion of drug use-related AIDS cases than whites. Through 1998, 35% of the 285,549 AIDS cases reported among African American and Hispanic males were IDU-associated, compared to 9% of the 278,151 AIDS cases reported among whites. More than half the IDU-associated AIDS cases are among African Americans.

- From 1992 to 1996, the number of white pediatric AIDS cases declined by 50 percent, compared to 42 percent decrease in African American populations.

- Women of all racial/ethnic groups are most likely to be infected with HIV through heterosexual contact. The number of women infected through heterosexual contact continues to rise, increasing 243% from 1993 to 1998. In 1998, 7% of the 36,886 AIDS cases reported among adult and adolescent men were attributed to heterosexual contact, compared to 38

percent of the 10,998 reported AIDS cases among females over 13. Of the new AIDS cases reported in 1982, 5 percent were women, increasing to 11 percent in 1990 and to 23 percent in 1998. Among African Americans, 31 percent of reported cases in 1998 were women.

Increases in HIV/AIDS Spending

- Over the last six years, discretionary spending for AIDS research, prevention, and treatment has increased dramatically.

- Altogether, discretionary AIDS-related spending by HHS in the President's FY 2000 budget will total $4.3 billion, up from $2.1 billion in FY 1993.

- In addition, at least $3.9 billion is expected to be expended in FY 2000 for AIDS care under Medicare and Medicaid, up from $1.6 billion in FY 1993. It is estimated that more than 50 percent of Americans living with AIDS rely on Medicaid for their health care coverage.

- In 1998, the President declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities and announced a comprehensive new initiative that invests an additional $156 million in highly targeted funds to improve the nation's effectiveness in preventing and treating HIV/AIDS in the African-American, Hispanic, and other minority communities. $249 million has been approved in the FY 2000 budget.

CDC UPDATE

CENTERS FOR DISEASE CONTROL AND PREVENTION

NCHSTP National Center for HIV, STD & TB PREVENTION

May 4, 2000

CDC ANNOUNCES $9 MILLION PROGRAM TO ENHANCE HIV PREVENTION IN COMMUNITIES OF COLOR

The Centers for Disease Control and Prevention (CDC) today announced a $9 million program that will fund 12 national, regional, and local organizations to enhance HIV prevention activities in communities of color, including African-American, Latino, Native American, and Asian and Pacific Islander communities. The awards are part of the more than $400 million CDC provides each year to help local communities implement effective HIV prevention programs.

The organizations funded under this grant program – officially called "Capacity-Building Assistance Targeting Racial/Ethnic Minority Populations" – will use their grants to help smaller local groups build the skills and infrastructure they need to implement HIV prevention programs. The grants range in size from $200,000 to nearly $2 million.

Activities will include training in the use of HIV prevention science to inform and strengthen local prevention programs, community mobilization strategies, policy development, grant-writing, fiscal management, and human resources support.

These awards reflect CDC's ongoing commitment to enhancing HIV prevention in communities of color, primarily by building capacity within the communities themselves.

The organizations receiving funds have extensive experience in coordinating major health-related initiatives, and in effectively addressing the cultural challenges and unique needs of communities of color. Funded groups include organizations serving African Americans, Latinos, Native Americans, and Asian and Pacific Islanders. *(A full list of organizations and descriptions is attached.)*

Applications were objectively judged for quality by a diverse, highly-qualified group of reviewers from federal agencies and community organizations. The review committee was comprised of representatives from African-American, Latino, Native American, and Asian and Pacific Islander communities. Members of gay, lesbian and bisexual communities, as well as individuals living with HIV infection, also served as reviewers.

The grants announced today complete a $14.5 million, nationwide HIV capacity-building program. The CDC program is comprised of a wide range of local,

regional, and national minority organizations poised to offer training, technical assistance and support to the hundreds of CDC-funded community-based organizations working to prevent HIV among African-American, Latino, Asian and Pacific Islander, and Native American communities at risk.

The nationwide program is designed to build capacity in communities currently hardest hit by the epidemic and to prevent HIV from emerging in other communities at risk. Resources are strategically focused where the HIV and AIDS epidemic is most severe:

- African Americans will receive 52% of funding under this grant, and will also benefit from additional capacity-building assistance secured by the Congressional Black Caucus. This includes efforts to expand faith-based HIV prevention programs and prevention services for gay and bisexual men. When all of these funds are taken into account, African Americans' share of total capacity-building funding is 63%, nearly the same as their share of minority AIDS cases (66%).

- Latinos will benefit from 32% of funds awarded under this grant, and currently represent 32% of minority AIDS cases. Latinos will also benefit from capacity-building grants designed specifically to reach gay men of color.

- Asian and Pacific Islanders and Native Americans will each receive approximately 8% of funding. While these groups each represent only 1% of the AIDS epidemic, there is an urgent need to prevent the emergence of a more severe epidemic, given evidence of risky sex- and drug-related behaviors in many communities and tribes.

CDC has dramatically increased its overall support to communities of color over the last decade. Targeted HIV prevention funding to African Americans has increased more than 12-fold since 1988 – from $11 million to $137 million in 1999. Likewise, CDC support for HIV prevention programs targeting Latinos has jumped by more than 500% since 1988 – from approximately $9 million to more than $58 million today.

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CDC UPDATE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NCHSTP National Center for HIV, STD & TB PREVENTION
May 2000

Capacity-Building Assistance Targeting Racial/Ethnic Minority Populations AWARD RECIPIENTS

The 17 awards described below have been granted to 12 experienced organizations to help improve the ability of smaller, community-based organizations to effectively deliver HIV prevention programs to communities of color.

Awards are granted in four key areas:

Organizational Development

These organizations will be funded to help local organizations improve their management systems and ability to deliver HIV prevention services over the long term. The grantees listed below will provide assistance in streamlining internal systems for efficiency, including staffing, fundraising, information management, training, and quality control.

- *National Minority AIDS Council* (NMAC) builds the leadership ability of communities of color to effectively address HIV/AIDS. NMAC promotes public health and HIV/AIDS policies, organizes the annual U.S. Conference on AIDS, and provides extensive training and education to AIDS organizations serving communities of color. Under this grant, NMAC will establish *Project Excel*, a national initiative to enhance the skills of leaders within minority-led community organizations.

- *Puerto Rican Organization for Community Education and Economic Development* (PROCEED) provides health and social services to disadvantaged Puerto Ricans and members of other minority populations. PROCEED will provide assistance to help improve, develop and sustain organizations that provide HIV prevention services.

NMAC and PROCEED will work collaboratively to strengthen community-based organizations across the country.

HIV Prevention Program Development

These organizations will use CDC funds to help community-based groups use the most recent scientific research and cultural data to tailor HIV prevention interventions to specific populations:

- *Asian & Pacific Islander American Health Forum*, a national advocacy organization that promotes health policy and research for Asian American and Pacific Islander communities through a network of organizations around the country, will work with five partner agencies to provide ongoing assistance in program development for local organizations across the country.

- *Jackson State University,* located in Mississippi, is one of the nation's Historically Black Colleges and Universities (HBCU). Jackson State currently reaches African-American communities through its National Alumni AIDS Prevention Project and will partner with four other organizations with extensive expertise in capacity building to create a Prevention Intervention Center in each region of the country.

- *National Native American AIDS Prevention Center* (NNAAPC) addresses HIV prevention and AIDS care among Native Americans. NNAAPC sponsors the annual Native American Institute at the U.S. Conference on AIDS, which assists Native communities in developing, running, and evaluating HIV prevention programs. NNAAPC will work with regional organizations to develop and improve HIV prevention programs in local communities.

- *National Latino/a Lesbian, Gay, Bisexual and Transgender Organization (LLEGO)*, a national network that mobilizes local Latino communities, will develop a four-region project to address the cultural, gender, orientation, environmental, social and multi-lingual intervention needs of local organizations serving Latinos.

Building Community Support

The following organizations will receive funds to assist local organizations in strengthening community support for HIV prevention programs through outreach to community leaders and partnerships between community organizations.

- *Asian & Pacific Islander American Health Forum* will, under this initiative, train groups targeting Asian and Pacific Islander women and youth to better network and promote leadership on HIV/AIDS issues in their community.

- *Center for Community Health Education and Research,* a social and health organization for Haitians, will work with Haitian agencies to mobilize leaders in their communities, including church leaders, community members, and professionals to address HIV/AIDS and the accompanying social, political, and cultural barriers.

- *Center for Health Policy Development* will work with local organizations and criminal justice systems to build support for HIV prevention targeted to Latino women at risk of contracting HIV from male partners with a history of incarceration.

- *Inter Tribal Council of Arizona, Inc.*, educates American Indian tribes to foster community development and to promote public policies that strengthen Indian self-reliance. The Council will create a task force in three states -- Arizona, Utah, and Nevada -- to develop an agenda for HIV prevention among American Indians in those states.

- *Metropolitan Interdenominational Church*, a Nashville ministry that addresses HIV/AIDS issues in the African-American community, will establish a clergy-led capacity-building and technical assistance model that can be duplicated across the country. Their Technical Assistance and Training Network will target more than 40 African-American churches that represent more than 100 congregations.

- *Smart Thinkers for Effective Action (Shisa, Inc.)* will identify prominent African-American opinion leaders in communities throughout the South, to strengthen HIV prevention in their own communities.

- *U.S.-Mexico Border Health Association* will help local community-based organizations mobilize their communities to expand HIV prevention efforts for Latinos born outside the U.S. and less acculturated Latinos living in the U.S.

Participation in Local HIV Prevention Planning

These organizations will use CDC funds to train local minority organizations to more actively participate and influence the "community planning" process, which has been the most significant mechanism for directing CDC HIV prevention resources to communities of color. All organizations are described in the sections above.

- *Asian & Pacific Islander American Health Forum*

- *National Minority AIDS Council*

- *U.S.-Mexico Border Health Association*

- *National Native American AIDS Prevention Center*

###

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

January 14, 2000

Dear Colleague:

I would like to call your attention to an article, "HIV/AIDS Among Men of Color who have Sex with Men–United States, January 1989-December 1998," published today in the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* (*MMWR*). This article analyzes recent trends in AIDS incidence among men of color who have sex with men (MSM). Although white men continue to make up 48% of AIDS cases among MSM, the data indicate that men of color now account for a greater proportion than ever before (from 31% to 52%). Researchers believe possible factors contributing to these increases may include homophobia, high rates of poverty, unemployment, and lack of access to prevention and health care.

CDC is implementing a series of activities designed to get more in-depth media coverage of this important article and to stimulate constructive dialogue in communities of color. We encourage you to address this important HIV prevention priority with your own colleagues and constituents. I've attached a fact sheet and press release that should give you adequate background. In addition, I've attached a draft op-ed by Dr. Gayle that we hope to place in a national publication. Feel free to use it in community or organization newsletters, as appropriate.

As always, if you have any questions or comments, please feel free to call our Office of Communications at (404) 639-8890.

Sincerely,

Ronaldi serri

Ronald O. Valdiserri, M.D., M.P.H
Deputy Director
National Center for HIV, STD, and TB Prevention

Attachments

CDC

January 14, 2000 / Vol. 49 / No. 1

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

HIV/AIDS Among Racial/Ethnic Minority Men Who Have Sex with Men — United States, 1989–1998

In the United States, racial/ethnic minority populations account for an increasing proportion of acquired immunodeficiency syndrome (AIDS) cases, including cases among men who have sex with men (MSM) (*1*). This report presents recent trends in AIDS incidence and deaths among MSM who belong to racial/ethnic minority populations*, and compares data on human immunodeficiency virus (HIV) diagnoses with AIDS diagnoses during 1996–1998 among racial/ethnic minority MSM in the 25 states† that have conducted confidential HIV surveillance and AIDS case surveillance since 1994. The findings indicate that among MSM, non-Hispanic black and Hispanic men accounted for an increasing proportion of AIDS cases and had smaller proportionate declines in AIDS incidence and deaths from 1996 to 1998. Of HIV and AIDS diagnoses

*Non-Hispanic black, Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander men aged ≥13 years who have sex with men.

†Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

HIV/AIDS — Continued

among racial/ethnic minority MSM, the proportion who are young (aged 13–24 years) is higher than among white MSM.

Trends in AIDS incidence during 1989–1998 among MSM aged ≥13 years from the 50 states, the District of Columbia, and U.S. territories were analyzed by race/ethnicity, age, and geographic area of residence. During 1996–1998, AIDS incidence per 100,000 population was calculated using race/ethnicity-specific Bureau of the Census estimates of males aged ≥13 years for the corresponding years. The number of HIV infection and AIDS diagnoses and deaths among persons with AIDS was adjusted for reporting delays on the basis of cases reported to CDC through June 30, 1999, and for the anticipated reclassification of cases initially reported without HIV-infection risk-exposure data (*1*). Trends examined were from 1989 through 1998 and from 1996 through 1998, the period of highly active antiretroviral therapy (HAART). During 1996–1998, for the 25 states with confidential HIV surveillance, age and race/ethnicity of MSM whose disease status was HIV infection (not AIDS) when initially diagnosed were compared with MSM who had AIDS-defining conditions when first diagnosed.

Characteristics of MSM with AIDS

During 1996–1998, 64,685 MSM were diagnosed with AIDS (Table 1); 31,866 (49%) were racial/ethnic minority MSM. Among this group, 1492 (5%) were aged 13–24 years and 4498 (14%) were aged 25–29 years, compared with 2% and 9%, respectively, of white MSM in those age categories. Metropolitan statistical areas (MSAs) of ≥500,000 population accounted for 27,097 (85%) AIDS cases in racial/ethnic minority MSM. The AIDS incidence in MSM per 100,000 adult male population decreased 32% from 1996 to 1998 (Table 1); rates were highest for black MSM in all years.

The five MSAs that accounted for the largest number of racial/ethnic minority MSM with AIDS during 1996–1998 were New York, 3673 (12%); Los Angeles, 2811 (9%); Miami, 1554 (5%); Washington, DC, 1251 (4%); and Chicago, 1075 (3%). New York and Los Angeles had the largest number of AIDS cases among non-Hispanic black and Hispanic MSM, respectively. Los Angeles and Phoenix were the MSAs with the largest number of AIDS cases among Asian/Pacific Islander (A/PI) and American Indian/Alaska Native (AI/AN) MSM, respectively, compared with New York for white MSM (Table 2).

Trends in AIDS Incidence and Deaths Among MSM with AIDS

During 1989–1998, AIDS was diagnosed in 290,582 MSM. In 1989, racial/ethnic minority MSM accounted for 24,444 (31%) AIDS cases among MSM, and by 1998, racial/ethnic minority MSM accounted for 18,153 (52%) AIDS cases among MSM (Figure 1). The proportion of MSM with AIDS who were non-Hispanic black and Hispanic increased from 19% and 12%, respectively, in 1989, to 33% and 18%, respectively, in 1998. A/PI and AI/AN each accounted for <2% of AIDS cases among MSM throughout this period.

AIDS incidence among all MSM declined 22% from 1996 to 1997 (Table 1). The rate of decline slowed to 12% in 1998 compared with 1997. During 1996–1998, AIDS incidence declined among MSM in all racial/ethnic groups: A/PI (43%), non-Hispanic white (39%), AI/AN (35%), Hispanic (26%), and non-Hispanic black (23%). Overall, the proportionate declines in AIDS incidence from 1997 to 1998 were smaller than those from 1996 to 1997. From 1997 to 1998, AIDS incidence declined 29% among AI/AN, 17% among A/PI, 15% among non-Hispanic white, 10% among non-Hispanic black, and 9% among Hispanic MSM.

TABLE 1. Number and rate of AIDS cases and deaths from AIDS among men aged ≥13 years who have sex with men, and estimated number and percentage in whom AIDS was diagnosed, by race/ethnicity, age at diagnosis, geographic region, and size of metropolitan statistical area (MSA) — United States, 1996–1998

Characteristic	White, non-Hispanic		Black, non-Hispanic		Hispanic		Asian/ Pacific Islander		American Indian/ Alaska Native		Total*
No. cases†											
1996	13,903		7,534		4,197		311		81		**26,088**
1997	10,098		6,491		3,523		225		75		**20,464**
1998	8,678		5,958		3,224		192		55		**18,153**
AIDS rate§											
1996	17.9		66.2		39.3		9.1		11.3		**25.0**
1997	12.9		56.2		31.8		6.3		10.4		**19.5**
1998	11.0		50.7		29.0		5.2		7.4		**17.1**
No. deaths¶											
1996	9,423		4,495		2,271		181		56		**16,436**
1997	4,381		2,718		1,171		91		34		**8,401**
1998	3,332		2,135		917		57		21		**6,467**
	No.	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	
Age (yrs) at AIDS diagnosis											
13–24	526	(2)	933	(5)	521	(5)	31	(4)	7	(4)	**2,019**
25–29	2,994	(9)	2,710	(13)	1,674	(15)	86	(12)	28	(13)	**7,510**
30–39	15,323	(47)	9,417	(47)	5,180	(47)	314	(43)	113	(53)	**30,411**
40–49	9,460	(29)	4,769	(24)	2,446	(23)	215	(30)	46	(22)	**16,975**
≥50	4,376	(13)	2,154	(11)	1,123	(10)	82	(11)	17	(8)	**7,770**
Region†† and MSA size§§											
Northeast											
≥500,000	4,875	(15)	3,815	(19)	2,191	(20)	104	(14)	5	(2)	**11,084**
<500,000	657	(2)	228	(1)	110	(1)	3	(<1)	0	(0)	**1,006**
North Central											
≥500,000	3,136	(9)	2,485	(12)	323	(3)	31	(4)	15	(7)	**5,992**
<500,000	1,347	(4)	268	(1)	83	(<1)	2	(<1)	10	(5)	**1,710**

South											
≥500,000	9,142	(28)	8,016	(40)	2,826	(26)	73	(10)	33	(16)	**20,097**
<500,000	3,253	(11)	2,561	(13)	392	(4)	12	(2)	20	(9)	**6,242**
West											
≥500,000	8,844	(27)	2,269	(11)	3,807	(35)	453	(62)	83	(39)	**15,471**
<500,000	1,282	(4)	146	(1)	311	(3)	42	(6)	45	(21)	**1,830**
Territories											
≥500,000	2	(<1)	0	(0)	568	(5)	0	(0)	0	(0)	**570**
<500,000	6	(<1)	16	(<1)	291	(2)	4	(1)	0	(0)	**317**

*Estimates are adjusted for delays in reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk; data reported to CDC through June 1999.

†Row totals include men for whom race/ethnicity was unknown or missing; column totals may include men for whom information was missing for some categories.

§Per 100,000 males aged ≥13 years.

¶Estimates are adjusted for delays in reporting of deaths and anticipated redistribution of cases initially reported with no identified risk; data reported to CDC through June 1999.

** *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *North Central*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

†† Areas with <500,000 population include areas not in MSAs.

HIV/AIDS — Continued

TABLE 2. Metropolitan statistical areas (MSAs)* with the highest number of AIDS cases† among men aged ≥13 years who have sex with men (MSM) — United States, 1996–1998

Race/Ethnicity (No. cases)	MSA	No. cases	% of racial/ethnic total
Black, non-Hispanic (19,983)	New York, N.Y.	2,034	10.2
	Washington, D.C.	1,135	5.7
	Atlanta, Ga.	951	4.8
	Los Angeles-Long Beach, Calif.	947	4.7
	Chicago, Ill.	848	4.2
	Total	**5,915**	**29.6§**
Hispanic (10,944)	Los Angeles-Long Beach, Calif.	1,728	15.8
	New York, N.Y.	1,570	14.3
	Miami, Fla.	879	8.0
	San Juan-Bayamon, Puerto Rico	568	5.2
	San Diego, Calif.	365	3.3
	Total	**5,110**	**46.6**
Asian/Pacific Islander (728)	Los Angeles-Long Beach, Calif.	126	17.3
	San Francisco, Calif.	84	11.5
	Honolulu, Hawaii	71	9.8
	New York, N.Y.	67	9.2
	San Diego, Calif.	36	5.0
	Total	**384**	**52.8**
American Indian/Alaska Native (211)	Phoenix-Mesa, Ariz.	18	8.5
	Seattle-Bellevue-Everett, Wash.	11	5.2
	Tulsa, Okla.	10	4.7
	Los Angeles-Long Beach, Calif.	5	4.2
	San Diego, Calif.	7	3.3
	Total	**55**	**25.9**
White, non-Hispanic (32,679)	New York, N.Y.	2,138	6.5
	Los Angeles-Long Beach, Calif.	1,931	5.9
	San Francisco, Calif.	1,456	4.5
	Houston, Texas	1,003	3.1
	Dallas, Texas	902	2.8
	Total	**7,430**	**22.8**

*Includes only metropolitan areas with a population ≥500,000. Metropolitan areas are named for a central city or county, may include several cities and counties, and may cross state boundaries.

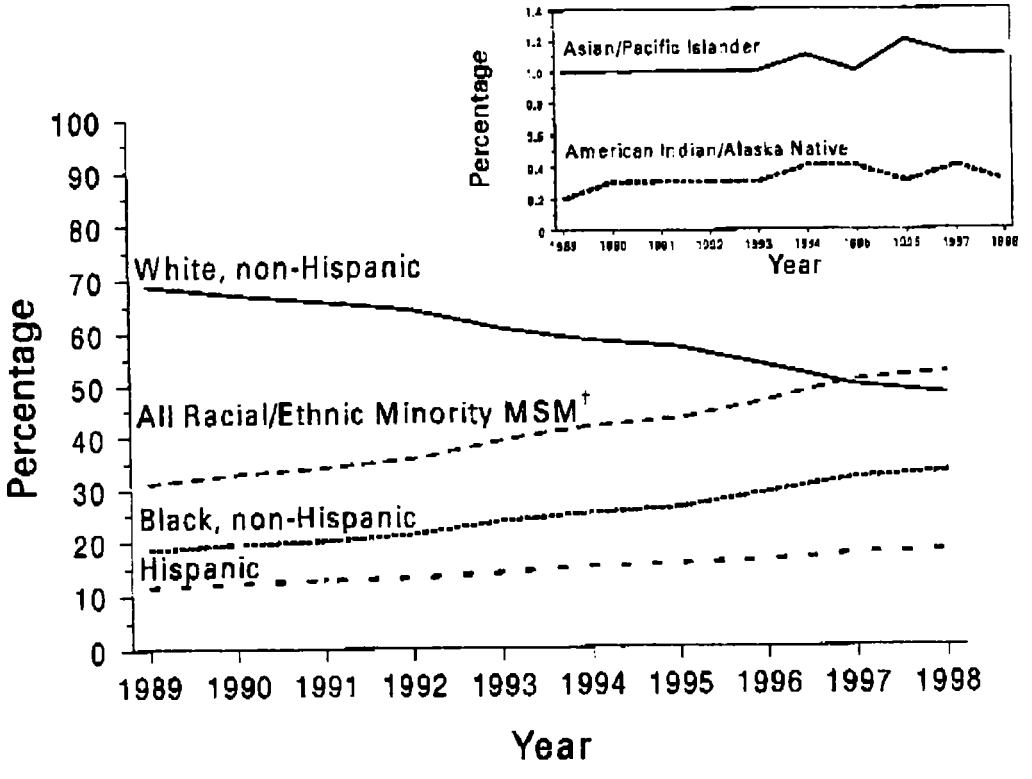
†Estimates are adjusted for delays in reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk; data reported to CDC through June 1999.

§29.6% of 19,983 AIDS cases among non-Hispanic black MSM resided in these five MSAs.

Deaths among all MSM with AIDS declined 49% from 1996 to 1997 (Table 1). The rate of decline slowed to 23% in 1998 compared with 1997. From 1996 to 1998, AIDS deaths declined among all racial/ethnic MSM: A/PI (69%), non-Hispanic white (65%), AI/AN (63%), Hispanic (60%), and non-Hispanic black (53%). From 1997 to 1998, AIDS deaths declined 38% among AI/AN, 37% among A/PI, 24% among non-Hispanic white, 22% among Hispanic, and 21% among non-Hispanic black MSM.

HIV/AIDS — Continued

FIGURE 1. Proportion of AIDS cases* among men aged ≥13 years who have sex with men (MSM), by race/ethnicity and year of diagnosis — United States, 1989–1998



*Estimated number of AIDS diagnoses adjusted for delays in reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk; data reported to CDC through June 1999.

†Defined as non-Hispanic black, Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander MSM.

HIV and AIDS Diagnoses Among MSM in 25 Areas with HIV/AIDS Surveillance

During 1996–1998, HIV infection or AIDS was diagnosed in 23,680 MSM in 25 states with HIV reporting; 11,313 (48%) were racial/ethnic minority MSM: 9497 (40%) non-Hispanic black, 1551 (7%) Hispanic, 113 (<1%) A/PI, and 152 (<1%) AI/AN. Among MSM whose initial diagnosis was HIV infection, the proportion aged 13–24 years varied by race/ethnicity: 16% non-Hispanic black, 15% A/PI, 15% AI/AN, 13% Hispanic, and 9% non-Hispanic white. Among MSM whose initial diagnosis was AIDS, the proportion aged 13–24 years also varied by race/ethnicity: 6% Hispanic, 6% A/PI, 5% non-Hispanic black, 1% non-Hispanic white, and <1% AI/AN.

Reported by: State and territorial health departments; Div of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention; and an EIS Officer, CDC.

Editorial Note: These HIV/AIDS surveillance data highlight the importance of increased efforts to promote HIV prevention and treatment services in racial/ethnic minority communities, particularly among non-Hispanic black and Hispanic MSM.

HIV/AIDS — Continued

These groups had higher AIDS rates and the smallest proportionate decreases in AIDS incidence. The annual number of AIDS cases remains high, although AIDS incidence and deaths have declined among racial/ethnic minority MSM. Threse declines reflect the beneficial impact of HIV prevention programs, HAART, and opportunistic infection prophylaxis. Young non-Hispanic black and Hispanic MSM remain at high risk for HIV infection as indicated by higher proportions of AIDS and HIV cases among non-Hispanic black and Hispanic MSM aged 13–24 years compared with white MSM.

The disproportionate impact of HIV/AIDS on racial/ethnic minority MSM indicated in this report is probably a minimum estimate. The use of all men aged ≥13 years as a denominator (instead of MSM) results in an underestimate of the rate among MSM. Small numbers of cases among A/PI and AI/AN MSM limit the ability to assess trends, although in some locations A/PI and AI/AN MSM might be at substantial risk. HIV/AIDS surveillance data also may underestimate cases among racial/ethnic minorities because of misclassified race/ethnicity in medical records (*2*), which is greatest among AI/AN, A/PI, and Hispanic groups. States that conduct HIV reporting are not representative of the geographic regions with large Hispanic populations. Race/ethnicity itself is not a risk factor for HIV infection; however, among racial/ethnic minority MSM, social and economic factors, such as homophobia (*3*), high rates of poverty and unemployment, and lack of access to health care, are associated with high rates of HIV risk behavior (*4*). These factors also may be barriers to receiving HIV prevention information or accessing HIV testing, diagnosis, and treatment.

Characteristics of persons in whom HIV infection (without AIDS) is diagnosed reflect more recent trends in the epidemic than do characteristics of persons with AIDS. In states with confidential HIV surveillance, a larger proportion of racial/ethnic minority MSM were young (aged 13–24 years) when first diagnosed with HIV infection (without AIDS) compared with white MSM, suggesting that racial/ethnic minority MSM may become infected at younger ages compared with white MSM. Trends in AIDS incidence and deaths are affected now by HIV incidence and by HAART; pre-HAART diagnoses of AIDS were not as substantially affected by treatment. HIV case reports may reflect targeted testing patterns in at-risk populations or differences in test-seeking behavior. However, the increased proportion of racial/ethnic minority MSM among MSM with AIDS and the trends in HIV infection diagnoses, particularly among non-Hispanic black men, are consistent with data from seroprevalence and incidence studies among MSM (*5,6*), which document the high risk for HIV infection among young racial/ethnic minority MSM. Together with AIDS data, HIV data highlight the extent of the need for prevention and treatment to reduce HIV-related morbidity and mortality in this population.

To reduce infection rates and improve the likelihood of survival, prevention programs for racial/ethnic minority MSM need to focus on both HIV-infected and uninfected populations. Challenges to the design and implementation of HIV prevention programs among racial/ethnic minority MSM include reaching MSM who may not identify themselves as homosexual or bisexual, recognizing the importance of representing racial/ethnic minority MSM in HIV prevention planning, addressing language barriers, and improving access to HIV testing and health care. Within racial/ethnic minority communities, the stigma attached to acknowledging homosexual and bisexual activity may inhibit racial/ethnic minority MSM from identifying themselves as homosexual or bisexual (*7*), and they may be more likely to identify with their

HIV/AIDS — Continued

racial/ethnic minority community than with the MSM community (*8*). In a CDC-sponsored study of 8780 MSM with HIV infection or AIDS, 24% of non-Hispanic black MSM, 15% of Hispanic MSM, and 11% of A/PI MSM identified themselves as heterosexual compared with 7% of AI/AN and 6% of non-Hispanic white MSM (CDC, unpublished data, 1999). Racial/ethnic minority community leaders should promote dialogue about issues of sexual orientation to overcome social barriers to HIV prevention for racial/ethnic minority MSM (*3*), especially among young men.

MSM remain a population at high risk for HIV infection, and continued efforts to promote behavioral risk reduction among at-risk youth are needed. Serologic surveys, HIV/AIDS case surveillance, and supplemental research and evaluation studies of racial/ethnic minority MSM and other HIV-infected and at-risk populations are needed to target intervention programs (*9*). In 1999, CDC funded a special program to enhance HIV prevention services for racial/ethnic minority MSM (*10*). CDC and other federal agencies are collaborating to facilitate links between prevention and treatment services for infected and at-risk populations.

References

1. CDC. HIV/AIDS surveillance report. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1999;11(1).
2. Kelly JJ, Chu SY, Diaz T, et al. Race/ethnicity misclassification of persons reported with AIDS. Ethnicity and Health 1996;1:87–94.
3. Stokes JP, Peterson JL. Homophobia, self-esteem, and risk for HIV among African-American men who have sex with men. AIDS Educ Prev 1998;10:278–92.
4. National Commission on AIDS. The challenge of HIV/AIDS in communities of color. Washington, DC: National Commission on AIDS, December 1992.
5. CDC. National HIV prevalence surveys, 1997 summary. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1998.
6. Valleroy L, MacKellar DA, Rosen D, Secura G. HIV and predictors of unprotected receptive anal intercourse for 15-to-22-year old African American men who have sex with men in seven cities, USA. Presented at the 12th World AIDS Conference, Geneva, Switzerland, June 30, 1998.
7. Doll LS, Beeker C. Male bisexual behavior and HIV risk in the United States: synthesis of research with implications for behavioral interventions. AIDS Educ Prev 1996;8:205–25.
8. Health Resources and Services Administration. HIV/AIDS Work Group on Health Care Access Issues for Gay and Bisexual Men of Color. Washington, DC: US Department of Health and Human Services, 1995:33.
9. CDC. Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. MMWR 1999;48(no. RR-13).
10. CDC. Community-based HIV prevention services and capacity-building assistance to organizations serving gay men of color at risk for HIV infection; notice of availability of funds. Federal Register 1999;64:33293–305.

CDC UPDATE

January 2000

Need for Sustained HIV Prevention for Gay and Bisexual Men:
HIV Infections Continue at High Levels Among Men of All Races with Dramatic Impact Among Men of Color

Although gay men have made significant strides in reducing high-risk behavior and HIV infection rates in some communities, researchers estimate that men who have sex with men (MSM) still account for 40% of the overall 40,000 new HIV infections in the U.S. each year, and for 60% of all new HIV infections among men. Additionally, an increasingly diverse population of gay and bisexual men is impacted. The epidemic, which began primarily among white gay men, is now dramatically affecting gay and bisexual men of all races.

There are currently an estimated 325,000-475,000 gay and bisexual men living with HIV in the U.S. As of December 1998, 135,000 of these were living with AIDS. An estimated 356,000 AIDS cases have been diagnosed among MSM since the beginning of the epidemic through June 1999, and nearly 221,000 have died. [1]

Due to the introduction of highly active antiretroviral therapies (HAART), AIDS incidence and deaths have been declining among all risk groups, including gay and bisexual men, since 1996. Declines in disease and death are encouraging for those already living with HIV and AIDS, but have not been accompanied by recent declines in HIV infection of the same magnitude. As new infections continue to occur, and more infected people are living longer, healthier, and sexually active lives, the total number of HIV-infected individuals (HIV prevalence) continues to grow. The result: a greater need for HIV prevention and treatment services than ever before.

Latest Data on Disease and Death

AIDS incidence reported among MSM declined 22% from 1996 to 1997 (from 26,068 cases to 20,464 cases). This decline slowed to an 12% decline from 1997 to 1998 (from 20,464 cases to 18,153 cases). HIV-related deaths among MSM declined 49% from 1996 to 1997 (from 16,436 deaths to 8,401 deaths), and also slowed with a 23% decline from 1997 to 1998 (from 8,401 deaths to 6,467 deaths). The slowing in the

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[1] These figures include gay and bisexual men who were most likely infected with HIV through sex with another man. The figures do not include gay and bisexual men who also inject drugs, because it is not possible to determine the specific route of HIV transmission for these individuals.

decline of AIDS incidence and deaths can most likely be attributed to a combination of factors, including: having already reached most individuals who know they are infected with HIV and are susceptible to treatment, in addition to treatment failure caused by difficulty with adherence to drug regimens.

MSM of Color Surpass White MSM in AIDS Incidence: May be Infected at Earlier Ages

In the January 14, 2000, issue of the *Morbidity and Mortality Weekly Report*, CDC reported that the number of annual AIDS cases among MSM of color[2] has surpassed the number among white MSM. Of MSM reported with AIDS in 1989 (24,444), men of color represented only 31%. By 1998, men of color accounted for 52% of the 18,153 cases of AIDS reported among MSM. While declining from 69% of cases in 1989, white men continued to represent 48% of AIDS cases among MSM in 1998.

Percentages of Annual AIDS Cases Among MSM by Race/Ethnicity, 1989 and 1998

Race/Ethnicity	1989	1998
White	69%	48%
Black	19%	33%
Hispanic	12%	18%
Asian Pacific Islander	1%	1%
American Indian/Alaska Native	<1%	<1%

Because AIDS cases alone are no longer indicative of new HIV infections, CDC also examined data collected from 1996-1998 in the 25 states that reported HIV diagnoses in addition to diagnoses of full blown AIDS during that period. Data on HIV diagnoses among men in the youngest age group (13-24) provide the best indication of recent trends in infection in these states. Among MSM initially diagnosed with HIV during this period, 16% of African Americans and 13% of Latinos were age 13-24, compared with 9% of white men. While the total number of cases was much smaller in other racial/ethnic groups, a similar trend was identified among Asian Pacific Islanders and American Indians/Alaska Natives, with 15% of HIV diagnoses among MSM in both groups occurring among 13- to 24-year-olds. These data suggest that in these states,

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[2] MSM of color is defined as non-Hispanic black, Hispanic, American Indian/Alaska Native, and Asian Pacific Islander men ≥13 years of age who have sex with men.

MSM of color are becoming infected with HIV at younger ages and must be reached early with prevention efforts. Although data are not national, they can point to possible trends elsewhere.

Other Studies Confirm Dramatic and Continued Impact Among Gay Men

Abundant evidence points to the need for sustained prevention efforts for gay men of all races, especially young men of color. Several recent studies have pointed to high levels of risk behavior, HIV infection, and other STDs. STDs are markers of high-risk sexual behavior and may be early warning signs of a possible increase in new HIV infections among MSM. Additionally, an individual is five times more likely to acquire HIV from an infected partner if an STD infection is present in either one of them.

- In a six-city study of HIV incidence among over 96,000 clients of STD clinics between 1991 and 1997, researchers found that approximately 8% of gay and bisexual men were infected per year – a level 17 times higher than that found among heterosexuals seen in the same clinics. The study found the highest level of new infections among African Americans (11% per year), when compared to Hispanics (7.7%) and whites (6.5%).

- A seven-city survey of 15- to 22-year-old MSM sampled at public venues showed alarming levels of HIV infection among young gay men. The Young Men's Survey found that an average of 7% of young men in the study were infected with HIV (HIV prevalence), with 3% becoming newly infected each year (HIV incidence). Both HIV prevalence and incidence were highest among young African-American men (14% prevalence, 4% incidence), young men of mixed race (13% prevalence, 5% incidence), and young Hispanic men (7% prevalence, 3% incidence). HIV incidence increased with age, rising from 2% among adolescent men becoming infected annually, to 4% among young men in their twenties. Additionally, 41% of young gay men in the study had engaged in unprotected anal intercourse in the past six months.

- One 28-city study, the Gonococcal Isolate Surveillance Project, reported that from 1994 to 1998, the proportion of gonorrhea cases among MSM doubled from 6% to 12%.

- Researchers from Seattle-King County reported marked increases in both gonorrhea and syphilis cases among MSM. Most notably, while the county had no cases of early syphilis in 1996, 88 cases were reported between 1998 and the first half of 1999, 85% of which were in gay men. These men reported having multiple partners and frequently engaging in unprotected anal intercourse.

- In Portland, Ore., gonorrhea among MSM increased 45% between 1994 and 1996. Fifty-four percent of MSM diagnosed with gonorrhea were also infected with HIV.

- An STD clinic in the District of Columbia serving a large number of gay and bisexual men reported that gonorrhea cases increased 93% from 1993 to 1996, with 82% of these cases among MSM.

- In San Francisco, the incidence of rectal gonorrhea in males increased from 21 cases per 100,000 adult men in 1994 to 38 cases per 100,000 in 1997. San Francisco also experienced an outbreak of syphilis among MSM in the summer of 1999. This outbreak, which was subsequently linked to contacts made in an Internet chat room, has involved seven people to date, five of whom are HIV-positive. Together, these seven people reported having a total of 99 sex partners in the three-month period prior to the interview.

Optimism Contributing to Complacency About HIV Prevention

These data suggest there may be a resurgence of unsafe sex among gay and bisexual men in the U.S. The impact of treatment advances on the attitudes and sexual practices of gay and bisexual men is one factor that may be contributing to this increase. A 1999 study of 416 gay men from West Hollywood, Ca., found that the more optimistic men were about the new treatments, the less likely they were to use condoms during anal sex, abstain from anal sex, or limit their number of sex partners.

In this study, HIV-positive men who were optimistic about the ability of AIDS treatments to prevent the transmission of HIV and improve the quality of life only used condoms 66% of the time, compared to 80% of the time for HIV-positive respondents who were not optimistic about new treatments. Among HIV-negative respondents, the optimists used condoms 74% of the time, versus 85% of the time for those who were less optimistic.

This and other studies indicate that high-risk populations may be becoming complacent about the need for HIV prevention and lulled into a false sense of security by the availability of powerful new AIDS treatments. HIV prevention programs must be designed to reach both HIV-infected and uninfected individuals with the information, skills, and support needed to overcome complacency and maintain safer sex behaviors.

Need to Expand Access to Effective Prevention Programs

Throughout the past two decades, a great deal has been learned about how to effectively change sexual- and drug-related behaviors and reduce the risk of HIV infection among gay and bisexual men. However, not all groups of gay men have been

effectively reached, and a great deal remains to be done. It is critical that HIV prevention efforts are sustained among white gay and bisexual men so that progress to date is not lost. Additionally, it is also imperative that we work to expand these efforts to gay and bisexual men of color and to young men at risk, reaching them with prevention programs proven to work.

Many lessons have been learned about how to effectively reach gay men. A few examples are provided below. CDC will continue to work with communities to help apply this knowledge more widely and to develop other effective approaches to prevention for all populations at risk, as well as for HIV-infected individuals.

- ***Peer opinion leaders play a critical role:*** One program known as "Popular Opinion Leader" enlisted bartenders from popular gay clubs in three cities to identify peer leaders who would then be trained to promote reduction in risky behavior in the community. These "opinion leaders" then engaged in discussions with peers in the bars about HIV risk reduction. Surveys of nearly 1,300 gay men in cities with and without the "Popular Opinion Leader" program found that men in the intervention communities were 34% less likely to have unprotected sex compared to men from other control communities, three to six months after the intervention.

- ***Innovative approaches required to reach men who don't identify as gay or bisexual:*** Another program, called the B-Boy Blues Festival, recognizes that a significant portion of African-American men who have sex with men may not self-identify as gay or bisexual, thus HIV prevention information is provided in a more acceptable setting. The festival, held in St. Louis, Mo., does not advertise or identify as an HIV/AIDS event and includes entertainment and cultural programs that accompany HIV workshops, HIV counseling and testing, and distribution of condoms and HIV prevention literature. Surveys disseminated at the festival in 1996, 1997, and 1998 have shown significant improvements in attitudes about and knowledge of HIV and AIDS by attendants, illustrating that outreach activities not promoted as HIV/AIDS programs are useful in serving these usually hard-to-reach men.

- ***Programs must address unique needs of HIV-infected:*** As the population of HIV-infected gay and bisexual men continues to grow, prevention services must be designed to assist these men in establishing and maintaining safer behaviors over a lifetime. Previous research indicates that the majority of people diagnosed with HIV do take steps to modify behavior. However, sustained efforts are required, and complex factors must be addressed. For example, HIV-infected men may require assistance in determining how to communicate their infection status to partners. Additionally, research has shown that some men make false assumptions about the HIV status of their partners, assuming that

partners who do not insist on a condom must not be infected, or believing that they have communicated their status by leaving their HIV medications in visible locations. Programs must be designed to address these and other factors influencing behavior and must ensure that messages are reinforced and adapted as needed over time.

CDC has researched community-based initiatives nationwide that have proven to successfully reduce high-risk sexual behaviors and drug use among people who are at greatest risk of infection and has released a new report summarizing the results. For examples of effective prevention interventions for MSM, go to www.cdc.gov/nchstp/hiv_aids/dhap.htm, or call the CDC National Prevention Information Network at 1-800-458-5231.

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CDC

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Contact: NCHSTP Office of Communications
(404) 639-8895

HIV/AIDS CASES AMONG GAY AND BISEXUAL MEN OF COLOR NOW EXCEED CASES AMONG WHITE GAY AND BISEXUAL MEN

Men of color now account for a greater proportion of AIDS cases among men who have sex with men than do white men, according to a new report in the January 14th issue of CDC's *Morbidity and Mortality Weekly Report.*

Based on an examination of U.S. AIDS cases over the past decade, the CDC study found that men of color represent an increasing proportion of AIDS cases among gay and bisexual men, rising from 31% in 1989 to 52% in 1998. African-American men comprised one-third of AIDS cases among gay and bisexual men, while Latino men represented 18% of cases. While declining from 69% in 1989, white men continued to represent 48% of AIDS cases among gay and bisexual men in 1998.

"The face of AIDS among gay and bisexual men is changing," said Helene D. Gayle, MD, MPH, director of CDC's National Center for HIV, STD, and TB Prevention. "African-American and Hispanic men must recognize that this is not a disease that only affects white gay men – gay and bisexual men of all races are affected."

The report examines the areas hardest hit by AIDS and finds that in recent years (from January 1996 to December 1998), 85% of AIDS cases among gay and bisexual men of color were concentrated in cities with populations over 500,000. The five cities with the highest proportion of cases were New York (12%), Los Angeles (9%), Miami (5%), Washington, D.C. (4%), and Chicago (3%). Trends varied by race *(see attached table)*.

New York City had the highest number of cases among African-American gay and bisexual men, followed by Washington D.C. and Atlanta. Los Angeles had the highest number of cases among Latino gay and bisexual men, followed by New York and Miami. While Asian/Pacific Islanders and American Indian/Alaska Natives represent less than 2% of overall cases among gay and bisexual men, the cities

with the highest number of cases among men of these races were Los Angeles and Phoenix, respectively.

Burden of Stigma in Communities of Color

Researchers outline possible factors contributing to the disproportionate toll of HIV and AIDS among gay and bisexual men of color. In addition to economic factors, such as high rates of poverty, unemployment, and lack of access to health care, cultural factors, such as the stigma of homosexuality, may be playing a role.

The study reports the results of a multi-site CDC survey of 8,780 HIV-positive men who have sex with men. Of those surveyed, 24% of African-American and 15% of Latino men who have sex with men identified themselves as being heterosexual. By contrast, only 6% of white men who have sex with men identified themselves as being heterosexual.

Researchers believe the stigma of homosexuality in communities of color may inhibit men of color from identifying themselves as gay or bisexual, despite having sex with other men. According to Gayle, this may prevent men of color from seeking or receiving the HIV prevention and treatment services they need.

Additionally, by not identifying as gay or bisexual, these men may not accept their own risk for HIV, and therefore, may unintentionally put their female partners and children at risk. HIV infection has increased significantly in women of color over the last decade.

"This is a very real and sensitive issue requiring increased dialogue and attention from leaders in communities of color," Gayle said. "The stigma associated with homosexuality in African-American and Latino communities only compounds the traditional factors associated with high rates of disease in our communities. To truly win the battle against HIV, we must be willing to acknowledge and wrestle with the difficult issues."

Gay Men of Color May be More Likely to Contract HIV at Young Age

The CDC study also points to the need to reach African-American and Latino men with HIV prevention programs and messages at an early age.

Because AIDS cases alone are no longer indicative of new HIV infections, CDC also examined data collected from 1996-1998 in 25 states that report HIV diagnoses in addition to cases of full-blown AIDS. Data on HIV diagnoses among men in the youngest age group (13-24) provide the best indication of recent trends in infection in these states.

Among gay and bisexual men diagnosed with HIV during this period, 16% of African Americans and 13% of Latinos were age 13-24, compared with 9% of white men. Although data are not national, they can point to possible trends.

"These data suggest that African American and Hispanic gay and bisexual men are being infected at younger ages than white men," said CDC study author, Janet Blair, Ph.D., M.P.H., "Men of color must be reached early with comprehensive HIV prevention programs, especially in high risk communities."

According to Blair, in addition to expanding prevention programs for men of color, locally based community efforts must also address the need for early HIV testing, diagnosis, and treatment to reduce new infections and improve survival. Since powerful new drug treatments became available in 1996, annual AIDS cases (AIDS incidence) and deaths have declined among all gay men. However, declines have not been as steep among gay and bisexual men of color, as among white gay and bisexual men. Between 1996 and 1998, AIDS incidence among gay and bisexual men dropped 23% among African Americans, 26% among Latinos, and 39% among whites. AIDS deaths among gay and bisexual men dropped 53% among African Americans, 60% among Latinos, and 65% among whites.

Expanded Prevention Urgently Needed

CDC's prevention initiatives to address the growing epidemic among gay men of color include, expanded surveillance to better track the path of local epidemics, increased efforts to reach individuals with HIV counseling and testing linked to prevention and treatment services, and continued expansion of community-based prevention programs. One important element of prevention efforts for gay and bisexual men is the provision of anonymous HIV testing sites. Access to anonymous testing may help ensure that stigma and fear do not prevent individuals from seeking HIV testing. CDC has been working with organizations throughout the country to implement locally designed, targeted prevention programs specifically for men of color who have sex with men, including several designed to reach men who don't identify as gay. To expand these efforts in 1999, CDC awarded an additional $7 million in grants for HIV prevention services specifically targeted to gay and bisexual men of color.

"We must continue to combat complacency about HIV infection, " said Gayle, "HIV remains a serious, lifelong and incurable disease—a disease that can and must be prevented."

The above mentioned $7million is part of a larger initiative. Since October 1998, HHS has been working in a partnership with the Congressional Black Caucus to address the severe and ongoing crisis of HIV/AIDS in communities of color, given the disproportionate impact of the disease in racial and ethnic communities. As part of this effort, HHS spent an additional $156 million in fiscal year 1999 to attack HIV/AIDS in racial and ethnic minority communities. The partnership also includes the deployment of special Crisis Response Teams of HHS experts to work alongside local officials, public health personnel and minority community-based organizations in highly affected communities to help them address their communities of color HIV/AIDS crisis.

Metropolitan statistical areas (MSA's)* with the highest number of AIDS cases among 64,685 men who have sex with men - United States, 1996-1998**

Race/Ethnicity	MSA	# of Cases	% of Racial/Ethnic Total
Black, non-Hispanic (N=19,983)	New York, NY	2,034	10.2
	Washington, D.C.	1,135	5.7
	Atlanta, GA	951	4.8
	Los Angeles-Long Beach, CA	947	4.7
	Chicago, IL	848	4.2
	Total	5,915	29.6
Hispanic (N=10,944)	Los Angeles-Long Beach, CA	1,728	15.8
	New York, NY	1,570	14.3
	Miami, FL	879	8.0
	San Juan-Bayamon, PR	568	5.2
	San Diego, CA	365	3.3
	Total	5,110	46.6
White, non-Hispanic (N=32,679)	New York, NY	2,138	6.5
	Los Angeles-Long Beach, CA	1,931	5.9
	San Francisco, CA	1,456	4.5
	Houston, TX	1,003	3.1
	Dallas, TX	902	2.8
	Total	7,430	22.8

*Includes only those metropolitan areas with a population ≥500,000. Metropolitan areas are named for a central city or county, may include several cities and counties, and may cross state boundaries.

**Less than two percent of cases were represented by the following two groups: Asian/Pacific Islanders (384 cases) and American Indian/Alaska Native (55 cases). Additionally, 140 men were reported without race identified.

DRAFT 1/3/00

THEY ARE STILL OUR BROTHERS

By Helene D. Gayle, M.D., M.P.H.

As an African American woman, working on HIV and AIDS prevention for over a decade, it is heartening to see the accelerated response to the spread of HIV in minority communities--notably African American and Latino communities. However, recently released CDC data find that there is one group that is often forgotten that needs urgent attention. Black and Hispanic gay and bisexual men who have AIDS now outnumber their white counterparts. The CDC data indicate that in 1989, 31% of gay men with AIDS were men of color; in 1998, that proportion increased to 52%.

These data remind us, once again, of how AIDS tends to affect those most out of reach of social safety nets, beyond the network of voices openly talking about HIV. But talk about it, we must, if we are to truly commit to slowing the spread of HIV in minority communities.

This will come as uncomfortable news to some, who historically have had difficulty accepting homosexuality in our communities. Intolerance leads to denial and stigma---both of which contribute to the spread of HIV. Fear has a powerful way of keeping individuals from seeking information and services. In addition, many believe that fear of stigmatization is what causes some men who have sex with men not to think of themselves----nor identify themselves--- as

gay or bisexual. In fact, the recent CDC study found that of men who have sex with men, 24% of blacks, and 15% of Hispanics, but only 6% of whites, identify themselves as *heterosexual*, not gay or bisexual.

By not identifying as gay or bisexual, these men may not even perceive themselves at risk for HIV and, therefore, may be less likely to protect themselves and their partners. And by having sex with both men and women, they may be unintentionally helping to fuel the spread of the disease to women. Overall, women now comprise 26% of reported AIDS cases, while accounting for only 10% a decade ago. Estimates suggest that women also account for 30% of new HIV infections. The vast majority of these women are black and Hispanic.

Stopping the spread of HIV in any community isn't easy. AIDS has always raised uncomfortable issues. But to succeed in HIV prevention, we must be willing to address sexuality in an open and honest manner-- including homosexuality. Gay and bisexual men of all races must recognize that they are at risk for HIV infection, and communities of color must create an environment where all men can access the HIV testing, treatment, and prevention services they need without the fear of estrangement.

And even as AIDS continues to ravage communities across the nation, the disease threatens to drop off the radar screen for many Americans. With the advent of powerful new drugs to treat HIV infection, obituaries are less frequent, the protests have died down, and a dangerous sense of complacency has set in.

We cannot afford to let this complacency continue. As long as HIV continues to spread in any community, it is a problem for all communities.

We are making progress preventing the spread of HIV, but there are more prevention needs today than ever before. Limited resources are being stretched; while AIDS is still with us, and the virus is still a formidible opponent.

HIV Prevention efforts are only effective when they are sustained; and when we recognize and address the full force of societal conditions and norms that foster the epidemic. Fear remains a powerful force-- a force that drives many young black and brown men with AIDS to die alone rather than face the risk of being shunned by loved ones; A force that drives families to silently hope their son is a drug addict when they find out he has AIDS; A force that drives young men away from the people or HIV prevention services that might help protect them.

A substantial reduction in HIV transmission is possible, but it will only happen when we look honestly into the face of AIDS, wake ourselves from denial, and deal directly with very real issues that might be uncomfortable. We must recognize that our gay and bisexual brothers are, after all, still our brothers.

WORD COUNT: 750

HIV/AIDS
Information Packet

for the briefing of the

National Council of Negro Women

Office of National AIDS Policy
December 1, 1999

HIV/AIDS
Information Packet

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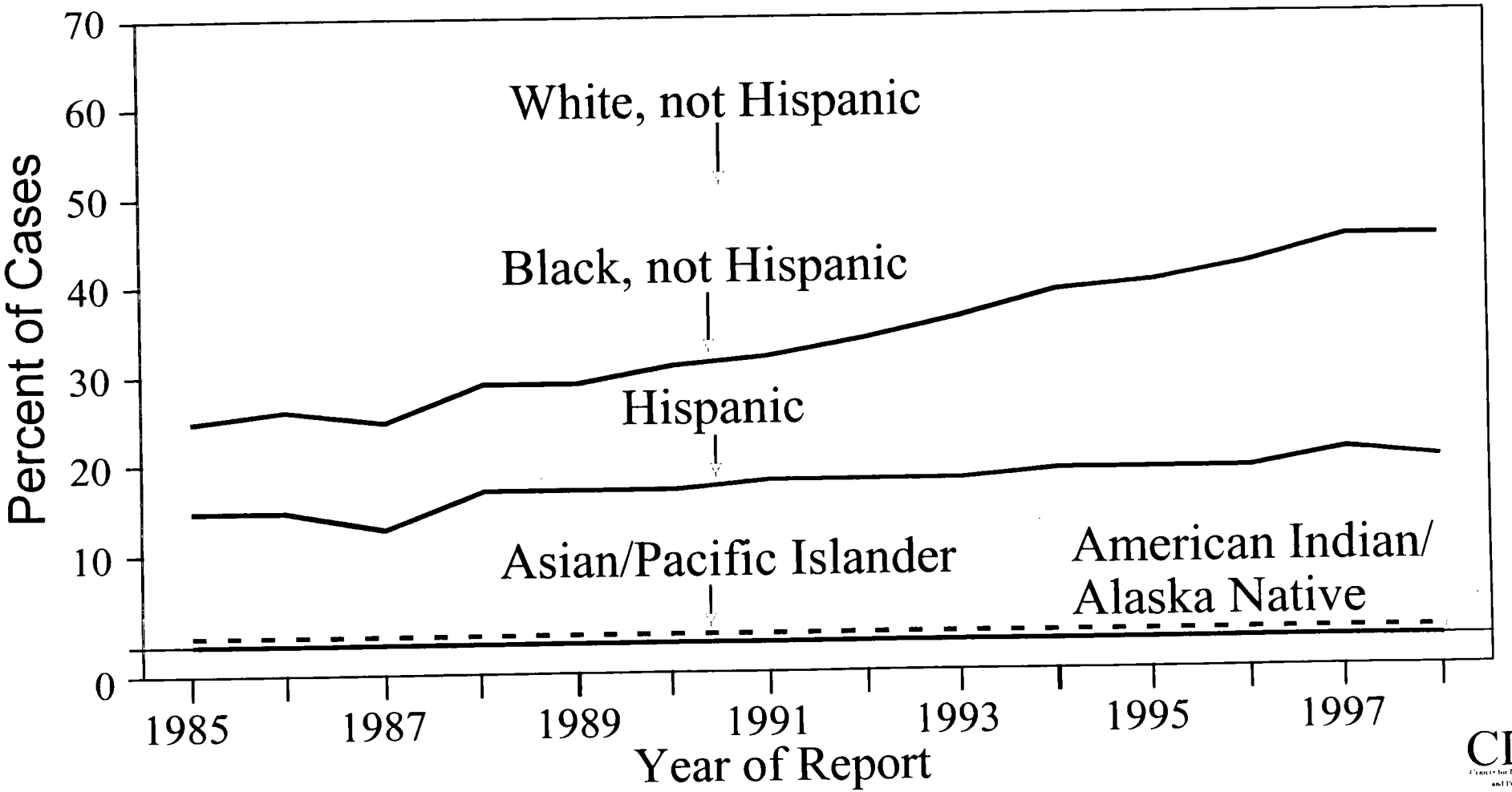
Office of National AIDS Policy
(www.whitehouse.gov/ONAP)

Proportion of AIDS Cases, by Race/Ethnicity and Year of Report,1985-1998, United States



CDC

AIDS Cases in Adult/Adolescent Men by Race/Ethnicity per 100,000 Population, Reported in 1998, United States

Race/Ethnicity	Cases	Rate
White, not Hispanic	14,027	18
Black, not Hispanic	14,740	125
Hispanic	7,511	58
Asian/Pacific Islander	329	9
American Indian/ Alaska Native	117	16
Total*	36,886	34

* Includes 162 men whose race/ethnicity is unknown.

CDC

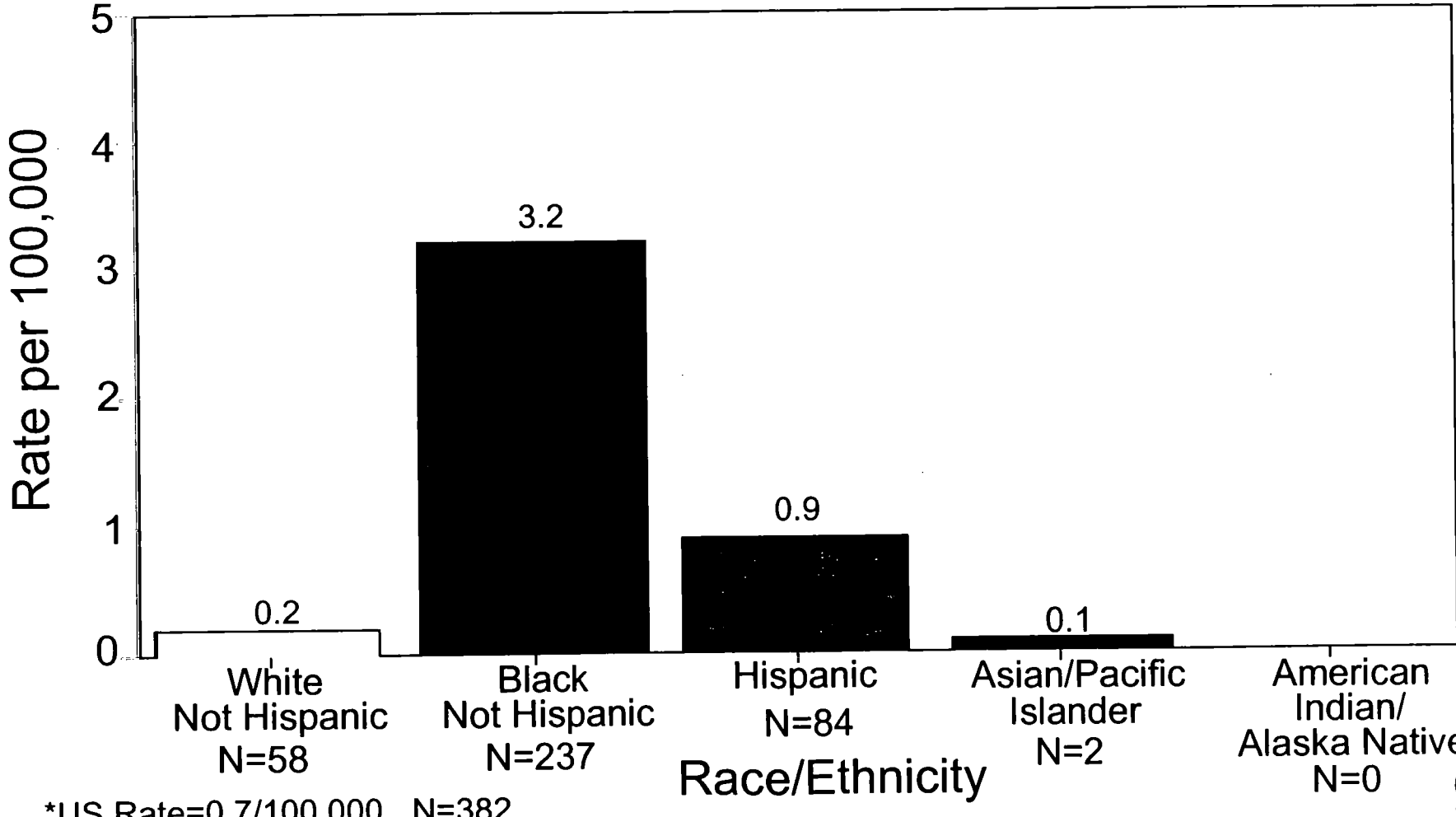
AIDS Cases in Adult/Adolescent Women by Race/Ethnicity per 100,000 Population, Reported in 1998, United States

Race/Ethnicity	Cases	Rate
White, not Hispanic	2,031	2
Black, not Hispanic	6,775	50
Hispanic	2,055	17
Asian/Pacific Islander	59	1
American Indian/ Alaska Native	30	4
Total*	10,998	10

*Includes 48 women whose race/ethnicity is unknown.

CDC

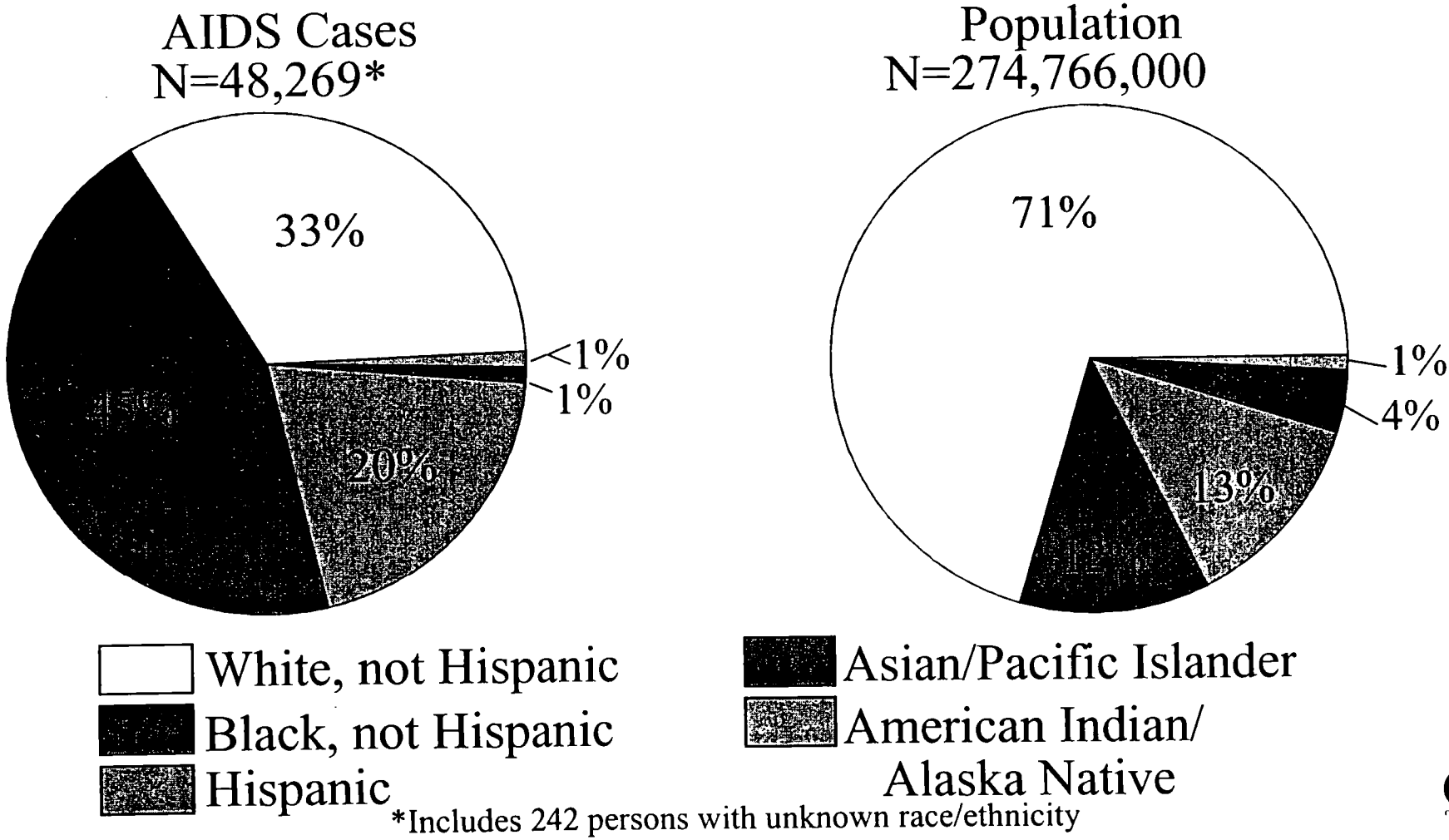
AIDS Rates per 100,000 Children <13 Years of Age by Race/Ethnicity, Reported in 1998*, United States



*US Rate=0.7/100,000 N=382

CDC

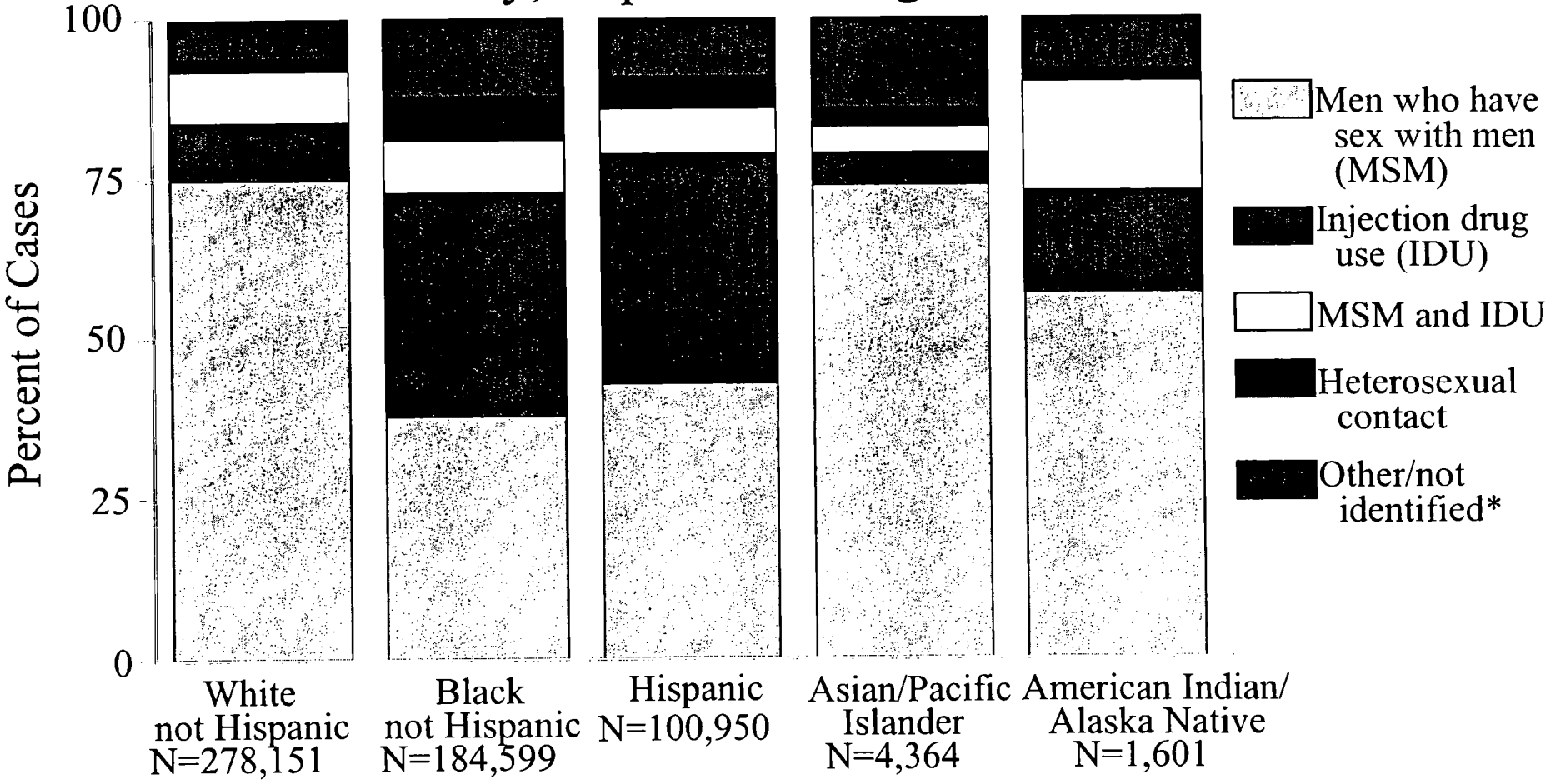
AIDS Cases Reported in 1998 and Estimated 1998 Population, by Race/Ethnicity, United States



*Includes 242 persons with unknown race/ethnicity

CDC

AIDS Cases in Adult/Adolescent Men, by Exposure Category and Race/Ethnicity, Reported through 1998, United States



*Includes patients with hemophilia or transfusion-related exposures and those whose medical record review is pending; patients who died, were lost to follow-up, or declined interview; and those with other or undetermined modes of exposure

CDC

HIV Prevention

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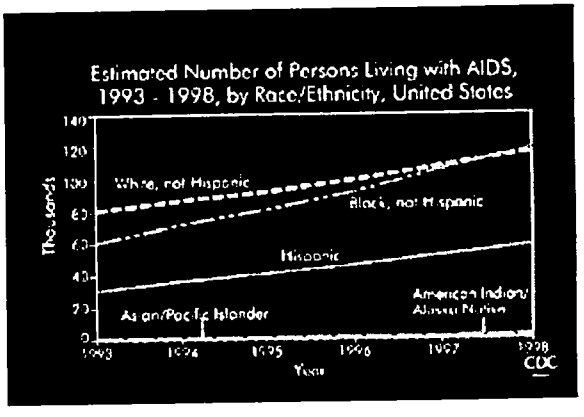
HIV/AIDS Among African Americans

In the United States, the impact of HIV and AIDS in the African American community has been devastating. Through December 1998, CDC had received reports of 688,200 AIDS cases–of those, 251,408 cases occurred among African Americans. Representing only an estimated 12% of the total U.S. population, African Americans make up almost 37% of all AIDS cases reported in this country.



Researchers estimate that 240,000-325,000 African Americans–about 1 in 50 African American men and 1 in 160 African American women–are infected with HIV. Of those infected with HIV, it is estimated that more than 106,000 African Americans are living with AIDS.

In 1998, more African Americans were reported with AIDS than any other racial/ethnic group.

- 21,752 cases were reported among African Americans, representing nearly half (45%) of the 48,269 AIDS cases reported that year.
- Almost two-thirds (62%) of all women reported with AIDS were African American.
- African American children also represented almost two-thirds (62%) of all reported pediatric AIDS cases.
- The 1998 rate of reported AIDS cases among African Americans was 66.4 per 100,000 population, more than 2 times greater than the rate for Hispanics and 8 times greater than the rate for whites.

HIV data from a CDC study* comparing HIV and AIDS diagnoses in 25 states with integrated reporting systems show these trends are continuing. In these states, during the period from January 1994 through June 1997, African Americans represented a high proportion (45%) of all AIDS diagnoses, but an even greater proportion (57%) of all HIV diagnoses. And among young people (ages 13 to 24), 63% of the HIV diagnoses were among African Americans.

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* See *Diagnosis and Reporting of HIV and AIDS in States with Integrated HIV and AIDS Surveillance–United States, January 1994-June 1997*, MMWR 1998, Vol. 47, No. 15 (April 24, 1998).

Prevention Efforts Must Focus on High Risk Behaviors

Adult/Adolescent Men. Among African American men with AIDS, men who have sex with men (MSM) represent the largest proportion (38%) of reported cases since the epidemic began. The second most common exposure category for African American men is injection drug use (35%), and heterosexual exposure accounts for 7% of cumulative cases.

Adult/Adolescent Women. Among African American women, injection drug use has accounted for 44% of all AIDS case reports since the epidemic began, with 37% due to heterosexual contact.

Interrelated Prevention Challenges in African American Communities

Looking at select seroprevalence studies among high-risk populations gives an even clearer picture of why the epidemic continues to spread in communities of color. The data suggest that three interrelated issues play a role – the continued health disparities between economic classes, the challenges related to controlling substance abuse, and the intersection of substance abuse with the epidemic of HIV and other sexually transmitted diseases (STDs).

- ***Substance abuse is fueling the sexual spread of HIV in the United States, especially in minority communities with high rates of STDs.*** Studies of HIV prevalence among patients in drug treatment centers and STD clinics find the rates of HIV infection among African Americans to be significantly higher than those among whites. Sharing needles and trading sex for drugs are two ways that substance abuse can lead to HIV and other STD transmission, putting sex partners and children of drug users at risk as well. Comprehensive programs for drug users must provide the information, skills, and support necessary to reduce both injection-related and sexual risks. At the same time, HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention.

- ***Prevention efforts must be improved and sustained for young gay men.*** In a sample of young men who have sex with men (ages 15-22) in six urban counties, researchers found that between 5% and 9% were infected with HIV. A significantly higher percentage of African American MSM (8-13%) than white MSM (4-6%) were infected.

It is clear that the public sector alone cannot successfully combat HIV and AIDS in the African American community. Overcoming the current barriers to HIV prevention and treatment requires that local leaders acknowledge the severity of the continuing epidemic among African Americans and play an even greater role in combating HIV/AIDS in their own communities. Additionally, HIV prevention strategies known to be effective (both behavioral and biomedical) must be available and accessible for all populations at risk.

For information about national HIV prevention activities, see the following CDC fact sheets:

* *CDC's Role in HIV and AIDS Prevention*
* *Linking Science and Prevention Programs – The Need for Comprehensive Strategies*

For more information...

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Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

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NPIN: http://www.cdcnpin.org

HIV Prevention

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HIV/AIDS Among Hispanics in the United States

The United States has a large and growing Hispanic population that is heavily affected by the HIV/AIDS epidemics. In 1998, Hispanics represented 13% of the U.S. population (including residents of Puerto Rico), but accounted for 20% of the total number of new U.S. AIDS cases reported that year (9,650 of 48,269 cases). The AIDS incidence rate (the number of new cases of a disease that occur during a specific time period) among Hispanics in 1998 was 28.1 per 100,000 population, almost 4 times the rate for whites (8.2 per 100,000) but lower than the rate for African Americans (66.4 per 100,000).

Proportion of U.S. AIDS Cases Reported in 1998 Among Selected Hispanics by Exposure Category and Place of Birth

	U.S.	Mexico	Puerto Rico
MSM	37%	48%	14%
IDU	28%	8%	46%
Hetero-sexual	12%	11%	25%

Hispanics in the United States include a diverse mixture of ethnic groups and cultures. As shown in the chart at left, HIV exposure risks for U.S.-born Hispanics and Hispanics born in other countries vary greatly[1], indicating a need for specifically targeted prevention efforts.

A recent CDC study[2] examining data from the 25 states that had integrated HIV and AIDS surveillance from January 1994 through June 1997 found that HIV diagnoses increased 10% among Hispanics between 1995 and 1996. However, the number of cases reported among Hispanics was relatively small, since many states with large Hispanic populations have not implemented HIV reporting and were not included in the study.

Historical Trends in AIDS Cases Among U.S. Hispanics

Between 1992 and 1997, the number of persons *living* with AIDS increased in all groups, as a result of the 1993 expanded AIDS case definition and, more recently, improved survival among those who have benefited from the new combination drug therapies. During that 5-year period, the characteristics of persons living with AIDS were changing, reflecting shifts in the populations affected by the epidemic. In 1992, 17% of those estimated to be living with AIDS were Hispanic, while in 1997, 19% were Hispanic. In comparison, non-Hispanic whites represented 49% of people estimated to be living with AIDS in 1992, but only 40% in 1997.

Cumulatively, males account for the largest proportion (82%) of AIDS cases reported among Hispanics in the United States, although the proportion of cases among women is rising. Women represent 18% of cumulative AIDS cases among Hispanics, but account for 21% of cases reported in 1998 alone. U.S.-born Hispanics account for the largest number of AIDS cases reported among

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[1] See Table 20, *HIV/AIDS Surveillance Report*, 1998 Year-end Edition, Vol. 10, No. 2.

[2] See *Diagnosis and Reporting of HIV and AIDS in States with Integrated HIV and AIDS Surveillance–United States, January 1994-June 1997*, MMWR 1998, Vol. 47, No. 15 (April 24, 1998).

Hispanics in this country. Among U.S. Hispanics whose place of birth was outside of the United States, individuals born in Puerto Rico account for the majority (58%) of AIDS cases.

From the beginning of the epidemic through December 1998, 100,950 Hispanic men have been reported with AIDS in the United States. Of these cases, men who have sex with men (MSM) represent 43%, injection drug users (IDUs) account for 36%, and 5% of cases were due to heterosexual contact. About 7% of cases were among Hispanic men who both had sex with men and injected drugs. Among men born in Puerto Rico, however, injection drug use accounts for a significantly higher proportion of cases than male-male sex.

For adult and adolescent Hispanic women, heterosexual contact accounts for the largest proportion (47%) of cumulative AIDS cases, most of which are linked to sex with an injection drug user. Female IDUs account for an additional 41% of AIDS cases among U.S. Hispanic women.

Building Better Prevention Programs for Hispanics

While race and ethnicity alone are not risk factors for HIV infection, underlying social and economic conditions (such as language or cultural diversity, higher rates of poverty and substance abuse, or limited access to health care) may increase the risk for infection in some Hispanic American communities.

- ***Transmission related to substance abuse continues to be a significant problem among Hispanics living in the United States,*** especially among those of Puerto Rican origin. Studies of HIV prevalence among patients in drug treatment center find the rates of HIV infection among Hispanics to be significantly higher in some regions of the country, particularly the Northeast and Midwest. Comprehensive programs for drug users must provide the information, skills, and support necessary to reduce both injection-related and sexual risks. In addition, HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention.

- ***Prevention messages must be tailored to the affected communities.*** Hispanic populations need interventions that (1) are consistent with their values and beliefs and (2) include skills-building activities to facilitate changes in sexual behavior. Further, because the HIV/AIDS epidemic among U.S. Hispanics reflects to a large extent the exposure modes and cultural modes of the individuals'birthplaces, an understanding of these behaviors and differences is important in targeting prevention efforts. For example, some high-risk behaviors associated with drug abuse (such as use of shooting galleries) may be more predominant among Puerto Rico-born Hispanics than among other Hispanics. Therefore, for these populations, prevention strategies should emphasize (1) preventing and treating substance abuse and (2) decreasing needle-sharing and the use of shooting galleries. For Hispanics born in Mexico, Cuba, and Central and South America, CDC data indicate that male-male sex is the primary mode of HIV transmission. Messages targeted to these populations must be based on an understanding of their cultural attitudes toward homosexuality and bisexuality, which may be different from those of other populations at high risk for infection.

To improve prevention programs in Hispanic communities across the United States, in addition to addressing underlying social and economic conditions, we must apply the lessons we have already learned about the design of culturally appropriate HIV prevention efforts for each Hispanic population.

For more information...

CDC National Prevention Information Network:
P.O. Box 6003
Rockville, Maryland 20849-6003
1-800-458-5231

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HIV Prevention

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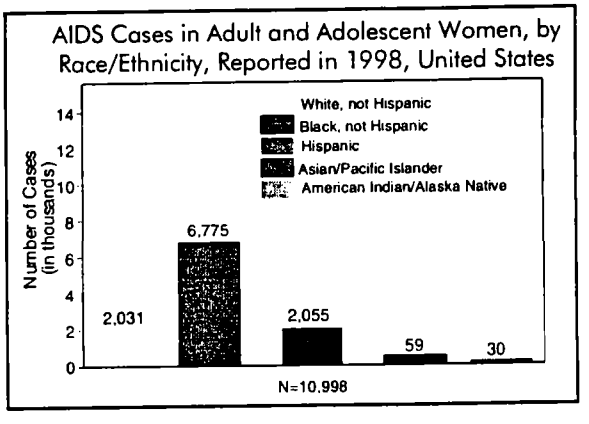
HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk

HIV infection among U.S. women has increased significantly over the last decade, especially in communities of color. CDC estimates that, in the United States, between 120,000 and 160,000 adult and adolescent females are living with HIV infection, including those with AIDS.

Between 1992 and 1997, the number of persons living with AIDS increased in all groups, as a result of the 1993 expanded AIDS case definition and, more recently, improved survival among those who have benefited from the new combination drug therapies. During that 5-year period, a growing proportion of women were living with AIDS, reflecting the ongoing shift in populations affected by the epidemic. In 1992, women accounted for 13.8% of persons living with AIDS – by 1997, the proportion had grown to 19.1%.



In just over a decade, the proportion of all AIDS cases reported among adult and adolescent women more than tripled, from 7% in 1985 to 23% in 1998. The epidemic has increased most dramatically among women of color. African American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (77%) of AIDS cases reported to date among women in our country. In 1998 alone *(see chart above)*, women of color represented an even higher proportion of cases.

While AIDS-related deaths among women are now decreasing, largely as a result of recent advances in HIV treatment, HIV/AIDS remains among the leading causes of death for U.S. women aged 25-44. And among African American women in this same age group, AIDS still results in more deaths than from any other cause.

Heterosexual Contact Now Is Greatest Risk for Women

Sex with drug users plays large role

In 1998 most women reported with AIDS were infected through heterosexual exposure to HIV, followed by injection drug use. In addition to the direct risks associated with drug injection (sharing needles), drug use also is fueling the heterosexual spread of the epidemic. A large proportion of women infected heterosexually were infected through sex with an injection drug user. Reducing the toll of the epidemic among women will require efforts to combat substance abuse, in addition to reducing HIV risk behaviors.

Many HIV/AIDS cases among women in the United States are initially reported without risk information, suggesting that women may be unaware of their partners'

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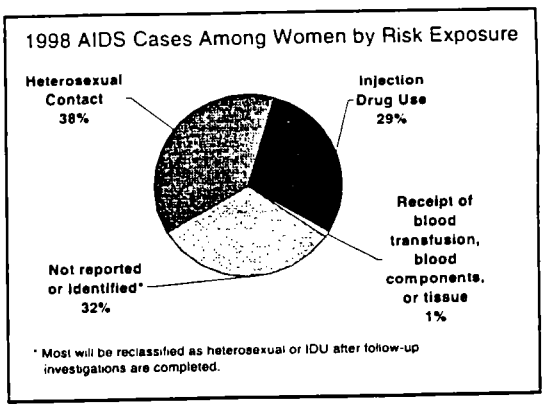
risk factors or that health care providers are not documenting their risk. Historically, more than two-thirds of AIDS cases among women initially reported without identified risk were later reclassified as heterosexual transmission, and just over one-fourth were attributed to injection drug use.



Prevention Needs of Women

- ***Pay attention to prevention for women.*** The AIDS epidemic is far from over. Scientists believe that cases of HIV infection reported among 13- to 24-year-olds are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because this age group has more recently initiated high-risk behaviors–and females made up nearly half (48%) of HIV cases in this age group reported from the 30 areas with confidential HIV reporting for adults and adolescents in 1998. Further, for all years combined, young African American and Hispanic women account for more than three-fourths of HIV infections reported among females between the ages of 13 and 24 in these areas.
- ***Implement programs that have been proven effective*** in changing risky behaviors among women and sustaining those changes over time, maintaining a focus on both the uninfected and infected populations of women.
- ***Increase emphasis on prevention and treatment services for young women and women of color.*** Knowledge about preventive behaviors and awareness of the need to practice them is critical for each and every generation of young women – prevention programs should be comprehensive and should include participation by parents as well as the educational system. Community-based programs must reach out-of-school youth in such settings as youth detention centers and shelters for runaways.
- ***Address the intersection of drug use and sexual HIV transmission.*** Women are at risk of acquiring HIV sexually from a partner who injects drugs and from sharing needles themselves. Additionally, women who use noninjection drugs (e.g., "crack" cocaine, methamphetamines) are at greater risk of acquiring HIV sexually, especially if they trade sex for drugs or money.
- ***Develop and widely disseminate effective female-controlled prevention methods.*** More options are urgently needed for women who are unwilling or unable to negotiate condom use with a male partner. CDC is collaborating with scientists around the world to evaluate the prevention effectiveness of the female condom and to research and develop topical microbicides that can kill HIV and the pathogens that cause STDs.
- ***Better integrate prevention and treatment services for women*** across the board, including the prevention and treatment of other STDs and substance abuse and access to antiretroviral therapy.

For information about national HIV prevention activities, see the following CDC fact sheets:

CDC's Role in HIV and AIDS Prevention
Linking Science and Prevention Programs – The Need for Comprehensive Strategies

For more information...

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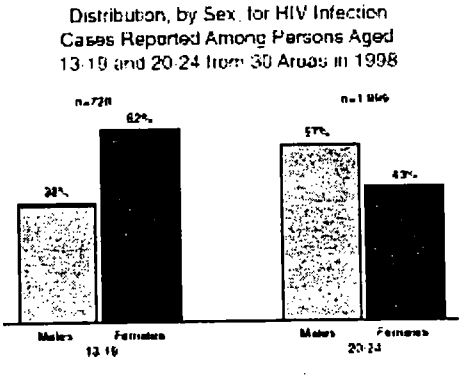
HIV Prevention SAVES LIVES

Young People at Risk: HIV/AIDS Among America's Youth

In the United States, HIV-related death has the greatest impact on young and middle-aged adults, particularly racial and ethnic minorities. HIV is the fifth leading cause of death for Americans between the ages of 25 and 44. Among African American men and women in this age group, however, it is the leading cause of death. Many of these young adults likely were infected as teenagers. It is estimated that at least half of all new HIV infections in the United States are among people under 25, and the majority of young people are infected sexually.

In 1998, 1,798 young people (ages 13 to 24) were reported with AIDS, bringing the cumulative total to 27,860 cases of AIDS in this age group. Among 13- to 24-year- olds, 51% of all AIDS cases reported among males in 1998 were among young men who have sex with men (MSM); 10% were among injection drug users (IDUs); and 9% were among young men infected heterosexually. In 1998, among young women the same age, 47% were infected heterosexually and 14% were IDUs. Among both males and females in this age group, the proportion of cases with exposure risk not reported or identified (22% for males and 39% for females) will decrease as follow-up investigations are completed and cases are reclassified into other categories.

A CDC study that analyzed data from 25 states with integrated HIV and AIDS reporting systems for the period between January 1994 and June 1997* found that young people (aged 13 to 24) accounted for a much greater proportion of HIV than AIDS cases. The study also showed that even though AIDS incidence (the number of new cases diagnosed during a given time period, usually a year) is declining, **there has not been a comparable decline in the number of newly diagnosed HIV cases among youth.**



Scientists believe that cases of HIV infection reported among 13-to 24-year-olds are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because this age group has more recently initiated high-risk behaviors. Females made up nearly half (48%) of HIV cases in this age group reported from the 30 areas with confidential HIV reporting for adults and adolescents in 1998--and in young people between the ages of 13 and 19, a much greater proportion of HIV infections was reported among females (62%) than among males (38%). Cumulatively, young African Americans are most heavily affected, accounting for 56% of all HIV cases ever reported in this age group in these 30 areas.

Improving HIV Prevention for Young People

CDC research has shown that early, clear communications between parents and young people about sex is an important step in helping adolescents adopt and maintain protective sexual behaviors. In addition, a wide range of activities must be implemented in communities to reduce the toll AIDS takes on young Americans.

- **School-based programs are critical for reaching youth before behaviors are established.** Because risk behaviors do not exist independently, topics such as HIV, STDs, unintended pregnancy, tobacco, nutrition, and physical activity should be integrated and ongoing for all students in kindergarten through high school. The specific scope and content of these school health programs should be locally determined and consistent with parental and community values. **Research has clearly shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior and provide information on how sexually active young people can protect themselves.** Evidence of prevention success can be seen in 6-year trends from the Youth Risk Behavior Survey, which show both a decline in sexual risk behaviors and an increase in condom use among sexually active youth. The percentage of sexually experienced high school students decreased from 54.1 percent in 1991 to 48.4 percent in 1997, while condom use among sexually active students increased from 46.2 percent to 56.8 percent. These findings represent a reversal in the trend toward increased sexual risk among teens that began in the 1970s and point to the success of comprehensive prevention efforts to both delay first intercourse among teens and increase condom use among young people who are sexually active.

- **Community-based programs reach youth not in schools.** Addressing the needs of adolescents who are most vulnerable to HIV infection, such as homeless or runaway youth, juvenile offenders, or school drop-outs, is critically important. For example, a 1993 serosurveillance survey of females in four juvenile detention centers found that between 1% and 5% were HIV infected (median 2.8%).

- **Prevention efforts for young gay and bisexual men must be sustained.** Targeted, sustained prevention efforts are urgently needed for young MSM as they come of age and initiate high-risk sexual behavior. Ongoing studies show that both HIV prevalence and risk behaviors remain high among young MSM. In a sample of young MSM ages 15-22 in six urban counties, researchers found that, overall, between 5% and 8% were infected with HIV, with higher prevalence among young African American (13%) and Hispanic (5%) men than among young white men (4%).

- **We must address sexual and drug-related risk.** Many students report using alcohol or drugs when they have sex, and 1 in 50 high school students reports having injected an illegal drug. Surveillance data from the 25 states with integrated HIV and AIDS reporting systems between January 1994 and June 1997 showed that drug injection led to 6% of HIV diagnoses reported among those aged 13-24 during that time period, with an additional 58% attributed to sexual transmission (both heterosexual and MSM).

- **STD treatment must play a role in prevention programs for young people.** An estimated 12 million cases of STDs other than HIV are diagnosed annually in the United States, and about two-thirds of those are among people under the age of 25. Research has shown that biological factors make people who are infected with an

STD more likely to become infected with HIV if exposed sexually; and HIV-infected people with STDs also are more likely to transmit HIV to their sex partners. Expanding STD treatment is critical to reducing the consequences of these diseases and helping to reduce risks of transmitting HIV among youth.

- **Ongoing evaluation of factors influencing risk behavior.** Both broad-based surveys of the extent of risk behaviors among young people and focused studies of the factors contributing to risk and behavioral intent among specific groups of adolescents must be conducted and analyzed.

For young people, it is critical to prevent patterns of risky behaviors before they start. HIV prevention efforts must be sustained and designed to reach each new generation of Americans.

**See Diagnosis and Reporting of HIV and AIDS in States with Integrated HIV and AIDS Surveillance--United States, January 1994-June 1997,* MMWR 1998, Vol. 47, No. 15 (April 24, 1998).

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Last Updated: August 1999
Centers for Disease Control & Prevention
National Center for HIV, STD, and TB Prevention
Divisions of HIV/AIDS Prevention
Please send comments/suggestions/requests to: hivmail@cdc.gov

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LONDON, 23 November 1999

en Español
en Français

AIDS NOT LOSING MOMENTUM HIV HAS INFECTED 50 MILLION, KILLED 16 MILLION, SINCE EPIDEMIC BEGAN

- In Africa HIV-positive women now outnumber infected men by 2 million -
- Countries of former Soviet Union see infection rates double in just two years -
- Strong prevention efforts, care programmes, find success in certain regions -

Since the beginning of the AIDS epidemic, 50 million individuals worldwide have been infected with HIV, of whom more than 33 million are still alive and over 16 million have died, according to a report issued today by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). The report, entitled AIDS Epidemic Update - December 1999, was released in advance of World AIDS Day, commemorated each year on 1 December. It shows that AIDS deaths reached a record 2.6 million this year and that new HIV infections continued unabated, with an estimated 5.6 million adults and children worldwide becoming infected in 1999.

"With an epidemic of this scale, every new infection adds to the ripple effect, impacting families, communities, households and increasingly, businesses and economies. AIDS has emerged as the single greatest threat to development in many countries of the world", said Peter Piot, Executive Director of UNAIDS.

"We have to ensure that health systems are capable of handling the increasing numbers of HIV-positive people who develop AIDS. De-stigmatization, access to health care and low-cost measures such as the treatment of opportunistic infections become important. WHO is working with Ministries of Health across the world to ensure that adequate facilities and resources are made available to the millions of people likely to develop AIDS in the coming years", said Gro Harlem

Brundtland, Director-General of WHO.

AIDS develops in an HIV-positive person after years of infection, as HIV steadily weakens the body's immune system and increases its vulnerability to pneumonia, tuberculosis, diarrhoea, tumours and other illnesses. With the number of people infected with HIV continuing to rise, the number of people falling sick and dying of AIDS will multiply.

HIV-positive women now outnumber HIV-positive men in Africa

In sub-Saharan Africa - still the global epicentre of the epidemic - new evidence shows clearly for the first time that women infected with HIV outnumber men. "Ten years ago, it was hard to make people listen when we were saying AIDS wasn't just a man's disease", said Dr Piot. "Today, we see the evidence of the terrible burden women now carry in Africa's epidemic."

- Fifty-five percent of infected adults in sub-Saharan Africa are women, which means more than six HIV-positive women for every five HIV-positive men. UNAIDS and WHO estimate that 12.2 million African women and 10.1 million African men aged 15-49 are living with HIV at the end of 1999.
- Studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age. Ease of male-to-female sexual transmission, and sex with older, infected men appear to be contributing factors to girls' greater vulnerability to HIV.

According to the United Nations Development Programme (UNDP), a number of African nations suffered downward changes this year in the Human Development Index, a ranking based on levels of health, wealth and education. Almost all of the major changes in rank could be attributed to declining life expectancy as a result of AIDS.

- Life expectancy at birth in southern Africa, which climbed from 44 in the early 1950s to 59 in the early 1990s, is expected to drop back to 45 sometime between 2005 and 2010.
- UNDP estimates that fewer than 50% of South Africans currently alive can expect to reach the age of 60, compared with an average of 70% for all developing countries and 90% for industrialized countries.
- According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service.

Yet there are reasons for optimism even in this most devastated region: a number of African countries have demonstrated a much stronger commitment to fighting AIDS

than ever before. "I believe we are now at a turning point in the 20-year history of the AIDS epidemic in Africa. Everywhere I go, I hear the top African leaders speaking out about AIDS as the major threat to the continent's development", said Dr Piot. "This gives me grounds for hope that in the coming years, we will see stronger, more effective responses to AIDS in many more sub-Saharan African nations - responses to complement the strong programmes that already exist."

Injecting drug use in former USSR fuels world's steepest HIV increases

The report further reveals that the world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between 1997 and 1999. In the larger region comprising these nations and the remainder of Central and Eastern Europe, the number of HIV-infected rose by more than a third in 1999 alone, to reach an estimated 360 000.

- In the Russian Federation, nearly half of all reported cases of HIV infection since the start of the epidemic were recorded in the first nine months of 1999 alone.
- In Moscow, three times as many cases were reported in the first nine months of 1999 as in all previous years combined. Towns around Moscow had even sharper rises in HIV, with over five times as many infections reported in the first nine months of 1999 as in all previous years combined.
- Preliminary studies suggest that injecting drug use is becoming increasingly common among unemployed young people in many of the industrial cities of the Russian Federation and Ukraine. HIV is not limited to Russia's major metropolitan regions; in the Siberian city of Irkutsk, nearly 1300 infections have been reported, most of them in 1999.
- Injecting drug use appears to be well established even among Russian schoolchildren. An outreach programme for drug injectors in St Petersburg reported that the caseload for clients under age 14 increased 20-fold between 1997 and the first quarter of 1999.

Strong prevention efforts, care programmes, find success in certain regions

In the report, UNAIDS and WHO also point to some countries and regions which are managing to keep down the number of new infections or improve the well-being of those already infected. For example, evidence continues to mount that the strong prevention programmes of Thailand and the Philippines have had sustained success in reducing HIV risk and lowering or stabilizing HIV rates.

- In India, major efforts to improve the tracking of the epidemic more than tripled the number of HIV

surveillance sites in 1998. Estimates now place total HIV infections in the country at around 4 million-more than in any other country, but fewer than projected on the basis of earlier surveillance estimates. Consequently, the regional estimate of HIV infections in Asia has been revised downward by 800 000.

- The AIDS Society in the Indian state of Tamil Nadu has enlisted the support of an advertising agency to encourage safer sexual behaviour, airing television advertisements during major sporting events. Casual sex among factory workers in the state reportedly fell by half between 1996 and 1998, while condom use with casual partners rose from 17% to 50%.
- Some Latin American countries have joined the ranks of those providing antiretroviral drugs to people infected with HIV. Brazil, for example, spent an estimated US $300 million to treat some 75 000 people in 1999. Brazilian health officials said the considerable expense was offset in part by savings in hospitalization and medical care; the country averted an estimated US $136 million in such costs between 1997 and 1998.

"Providing care to growing numbers of HIV-positive people when health systems are already overburdened is no straightforward task. But these examples show how countries around the world can make a difference in fighting the epidemic through both prevention and care. WHO has shown how relatively inexpensive modifications and additions to health-care systems can bring major benefits to people with HIV. Everyone, and every country, can learn and benefit from these examples", said Dr Brundtland.

No room for complacency

Releasing the report, UNAIDS Executive Director Peter Piot also urged industrialized nations to put more emphasis on HIV prevention efforts. "There is no room for complacency in any discussion of this epidemic. The threat of HIV has not diminished in any country. We have even seen evidence from North America and Western Europe suggesting that availability of life-prolonging therapies may be contributing to an erosion of safer sexual behaviour. This is tragic", Dr Piot said.

"While antiretrovirals have brought hope to many people with HIV who are fortunate enough to have access to them, they are not a panacea, and they are not available in most of the world", Dr Piot said. "The key to fighting AIDS is preventing new infections. For this more resources are needed - to implement the prevention strategies we have today, and to develop new and better tools, such as microbicides and a vaccine."

Dr Brundtland added, "While prevention is the most promising strategy for managing the AIDS epidemic in the long term, we cannot lose sight of the fact that millions of people are infected today. For them, we must do a much

better job of increasing access to health care and support, including inexpensive antibiotics that can add many months to the lives of people already sick with AIDS, to palliative therapies that can help increase comfort and reduce suffering, and to psychological and social support for patients and their families. WHO and UNAIDS will continue to engage the pharmaceutical industry to make new HIV-related drugs available at affordable prices for those in need. "

For more information on this press release, or any other UNAIDS press release, please click here for press contact information.

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OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FOR IMMEDIATE RELEASE
November 19, 1999

Contact: (202) 456-2437

AIDS Czar Thrilled With Funding Increases for AIDS Care, Prevention, and Research

WASHINGTON, DC – Commenting on the final budget bill just approved by Congress, Sandra Thurman, Director of the White House Office of National AIDS Policy, stated: "I am thrilled with the strong funding increases achieved across the board in our efforts to address the AIDS epidemic both here and across the globe. AIDS remains a very real crisis for America, and it is heartening to see bipartisan recognition of our need to remain vigilant in our prevention, care and research efforts."

"I am particularly pleased with the $80 million increase in funding for our Minority AIDS Initiative, which was launched by the President last fall in partnership with the Congressional Black Caucus," she added. "This initiative has helped catalyze efforts in racial and ethnic minority communities across this nation to expand their AIDS awareness and care efforts. This epidemic remains a severe and ongoing crisis in communities of color, and the Minority AIDS Initiative is bringing us together in new and exciting ways to end that crisis."

Other highlights of the budget bill as it relates to HIV/AIDS include:

- ✓ Funding for the Ryan White CARE Act, which helps cities and states care for those living with HIV and AIDS, is increased $184 million to $1,595 million (13% over last year and 338% since FY 1993)
- ✓ HIV prevention funding to the Centers for Disease Control and Prevention are increased by $73 million to $730 million (11% over last year and 47% since FY 1993)

- ✓ AIDS research funding to the National Institutes of Health will include an increase of $224 million for a total of $2.024 billion (this is a preliminary estimate, with final allocation to be determined by NIH)
- ✓ Funding for substance abuse services targeting those at highest risk of HIV infection, through the Substance Abuse and Mental Health Services Administration (SAMHSA) were increased by $29 million to $122 million (31% over last year and 122% since FY 1993)
- ✓ The Housing Opportunities for People With AIDS (HOPWA) Program at the Department of Housing and Urban Development was increased (in a separate bill) by $7 million to $232 million (3% over last year and 132% since FY 1993)
- ✓ Funding to enhance the Administration's efforts on global AIDS were increased by $100 million
- ✓ The Administration helped protect local authority over HIV prevention activities, successfully removing language from the DC appropriations bill that would have tied the hands of community health agencies in their ability to use needle exchange programs as part of their overall HIV prevention strategy
- ✓ Special provisions were included to protect AIDS nursing care facilities that were endangered by previously enacted changes in Medicare reimbursements.

See attached chart for specific information on AIDS program increases.

##30##

FUNDING FOR SELECTED FEDERAL AIDS PROGRAMS

Selected AIDS Programs *(in millions)*	FY93	FY99	FY00 *	Change Since FY99		Change Since FY93		Minority Initiative	Minority Initiative Change
Food and Drug Administration	$ 73.0	$ 77.0	$ 79.0	+ 2.0	3%	+ 6.0	8%		
Health Resources and Services Administration									
Ryan White	$ 364.4	$ 1,410.9	$ 1,594.6	+ 183.7	13%	+ 1,230.1	338%	$ 74.1	+ 49.5
Title I - Metropolitan Areas		$ 505.0	$ 546.5	+ 41.5	8%			$ 26.5	+ 21.5
Title II - AIDS Drug Assistance Program		$ 461.0	$ 528.0	+ 67.0	15%			$ -	
Title II - non-ADAP		$ 276.8	$ 296.0	+ 19.2	7%			$ -	
Title III - Early Intervention Clinics		$ 94.3	$ 138.4	+ 44.1	47%			$ 27.4	+ 24.4
Title IV - Pediatric and Youth		$ 46.0	$ 51.0	+ 5.0	11%			$ 12.2	+ 0.0
Title V - Dental		$ 7.8	$ 8.0	+ 0.2	3%				
AIDS Education and Training Centers		$ 20.0	$ 26.7	+ 6.7	33%			$ 6.8	+ 4.8
Other								$ 1.2	-1.2
HHS (OMH and OS)								$ 59.7	+ 0.0
Centers for Disease Control and Prevention	$ 498.0	$ 657.0	$ 730.0	+ 73.0	11%	+ 232.0	47%	$ 59.8	+ 12.5
Global AIDS Initiative		$ -	$ 35.0	+ 35.0					
Community Planning		$ 257.6	$ 277.6	+ 20.0	8%				
Minority AIDS Initiative		$ 47.3	$ 59.8	+ 12.5	26%				
Other Prevention		$ 352.1	$ 357.6	+ 5.5	2%				
National Institutes of Health - AIDS Research	$ 1,071.0	$ 1,798.0	$ **2,024.0	+ 226.0	13%	+ 953.0	89%	$ 3.0	-4.3)
Substance Abuse and Mental Health Services Admin.	$ 55.0	$ 93.0	$ ** 122.0	+ 29.0	31%	+ 67.0	122%	$ 48.8	+ 21.8
Housing and Urban Development - HOPWA	$ 100.0	$ 225.0	$ 232.0	+ 7.0	3%	+ 132.0	132%	$ -	
Total	$ 2,161.4	$ 4,260.9	$ 4,781.6	$ 520.7	12%	$ 2,620.1	121%	$ 245.4	+ 79.5

* FY2000 Numbers include funding for the minority initiative, detailed in the last two columns

**Estimates based on overall increase in funding – specific allocations to AIDS have not yet been finalized.

The Clinton/Gore Administration

A Record of Progress on HIV and AIDS

December 1999

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THE CLINTON-GORE ADMINISTRATION: A RECORD OF PROGRESS ON HIV AND AIDS

"How can we be one America if a ravaging disease like this is being brought under control in part of our population, but not in another?"

-- President Clinton, November 2, 1998

"We are united in the fight for research, care, and prevention. And we will not stop until all who need it have access to the treatment they need. We will not rest until we have a vaccine -- and a cure."

-- Vice President Gore, September 19, 1998

Providing National Leadership. President Clinton has worked hard to invigorate the response to HIV and AIDS, providing new national leadership, substantially greater resources and a closer working relationship with affected communities. During his administration, funding for AIDS research has increased by over 89 percent at the Department of Health and Human Services (HHS), while funding for HIV prevention has increased 47 percent. Funding for the Ryan White CARE Act has increased by over 338 percent.

Although much work remains to find a cure, progress has been made. In 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS declined. And between 1996 and 1997, HIV/AIDS mortality declined 42 percent, falling from the leading cause of death among 25-44 year olds in 1995 to the fifth leading cause of death in that age group. There has been a decline in the number of AIDS cases overall and a sharp decline in new AIDS cases in infants and children.

Leading the Global Fight Against HIV/AIDS. In July, 1999, the Administration announced a new global AIDS initiative entitled LIFE (Leadership and Investment in Fighting an Epidemic). The cornerstone of the initiative is a $100 million increase in US support for global AIDS efforts, with a particular focus on sub-Saharan Africa. The United States has invested over $1 billion in international AIDS relief since the start of the epidemic and funds 25% of UNAIDS. NIH represents the largest single public investment in AIDS research in the world. More than $62 million of NIH's international AIDS research in FY1999 is being conducted overseas in partnership with the global scientific community.

Historic Effort to Address HIV/AIDS in Communities of Color. While racial and ethnic groups account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. On October 28, 1998, President Clinton declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities and announced a comprehensive new initiative that invests an unprecedented $156 million to improve the nation's effectiveness in preventing and treating HIV/AIDS in the African-American, Hispanic, and other minority communities. Funding levels for Fiscal Year 2000 were increased to over $245 million.

This funding is spread across three broad categories: technical assistance and infrastructure support; increasing access to prevention and care, and building stronger linkages to address the needs of specific populations.

Fighting to Pass a Strong, Enforceable Patients' Bill of Rights. President Clinton has called on the Congress to pass a strong, enforceable patients' bill of rights that assures Americans the quality health care they need. The bill should include important patient protections such as: assuring direct access to specialists; real emergency room protections; continuity of care provisions that protect patients from abrupt changes in treatment; a fair, timely, and independent appeals process for patient grievances; and enforcement provisions to make these rights real.

Protecting Medicaid and Social Security Coverage. The President fought for and won the preservation of the Medicaid guarantee of coverage which serves more than 50 percent of people living with AIDS -- and 92 percent of children with AIDS -- who rely on Medicaid for health coverage. He also revised eligibility rules for Social Security Disability Insurance to increase the number persons living with HIV who qualify for benefits.

Focusing National Efforts on an AIDS Vaccine. On May 18, 1997, the President challenged the nation to develop an AIDS vaccine within the next ten years. He announced a number of initiatives to help fulfill this goal, including: dedicating an AIDS vaccine research center at the National Institutes of Health and encouraging domestic and international collaboration among governments, medical communities and service organizations. On June 9, 1999, President Clinton dedicated the new Dale and Betty Bumpers Vaccine Research Center at the National Institutes of Health and announced that the primary work of this new Center will be HIV vaccine research.

Dramatically Increasing Overall AIDS Funding. The Clinton Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention and treatment. President Clinton has increased overall funding for major HIV/AIDS programs by 121 percent (primarily within HHS), funding for the Ryan White CARE programs has increased 338 percent and support for AIDS-related research has increased by over 89 percent.

Increasing AIDS Drug Assistance and Accelerating AIDS Drug Approvals. Funding for AIDS drug assistance has increased from $52 million per year to $528 million per year during the Clinton Administration. This program provides new life-prolonging drugs to people with HIV and AIDS. In addition, President Clinton convened the National Task Force on AIDS Drug Development, and removed dozens of bureaucratic obstacles to the effective and decent treatment of people with AIDS. Since 1993, the Food and Drug Administration has approved dozens of new AIDS drugs for AIDS-related conditions and new diagnostic tests.

Making Research a Priority. In one of his first acts in office, President Clinton signed the National Institutes of Health Revitalization Act of 1993, placing full responsibility for planning, budgeting and evaluation of the AIDS research program at NIH in the Office of AIDS Research. The Administration has increased NIH AIDS research funds by 89% in five years.

Building Partnerships to Optimize HIV Care. In March, 1997 Vice-President Gore approved the creation of the Forum for Collaborative HIV Research, a unique coalition of federal government agencies, health care providers, pharmaceutical companies, HIV researchers, and patient advocates. The Forum builds collaboration between these stakeholders to address emerging issues in HIV clinical research and care. In its first two years, the Forum has focused issues such as adherence to HIV therapy, side effects of HIV drugs, HIV treatment education, and the development of new methods to treat HIV.

Focusing on Prevention: Supporting the Centers for Disease Control and Prevention. The Administration has increased funds for HIV prevention at the CDC by 47%. Under the leadership of the Clinton/Gore Administration, the CDC reorganized its AIDS prevention efforts to foster greater overall coordination and enhance efforts to reduce sexually transmitted diseases and tuberculosis.

Educating Young People about the Dangers of AIDS. The Clinton/Gore Administration launched the Prevention Marketing Initiative, focusing on the risk to young adults (18-25) with frank public service announcements recommending the correct and consistent use of latex condoms for those who are sexually active.

Requiring the Federal Workforce to Understand AIDS. The Administration issued a directive on September 30, 1993 that requires every Federal employee to receive comprehensive education on HIV/AIDS.

Established a White House AIDS Office and Created a Presidential Advisory Council. President Clinton created a White House Office of National AIDS Policy to bring greater direction and visibility to the war on AIDS. Sandy Thurman, the current director of the office, has broad experience in both domestic and international AIDS services. At the same time, the Administration has sharpened the focus of its AIDS programs. The President also created the Presidential Advisory Council on HIV and AIDS to provide him and his Administration with expert outside advice on the ways in which the Federal government should respond to the HIV/AIDS epidemic. Dr. R. Scott Hitt, a California physician specializing in HIV/AIDS care, chairs the panel.

Convened the First Ever White House Conference on HIV and AIDS. On December 6, 1995, the President convened the first White House Conference on HIV and AIDS in the history of the epidemic, bringing together more than 300 experts, activists and citizens from across the country for a discussion of key issues.

SELECTED HIV/AIDS INVESTMENTS	FY2000	Increase from FY99	Increase from FY93
Ryan White CARE Act *AIDS Drug Assistance*	**$1.6 billion** *$528 million*	**13%** *61%*	**338%**
HIV Prevention (CDC)	**$730 million**	**11%**	**47%**
AIDS Research (NIH) *Vaccine Research (FY99)*	**$2.0 billion**** *$200 million*	**13%** *33%*	**89%** *145%*
Housing (HUD)	**$232 million**	**3%**	**132%**
International (USAID)	**$200 million****	**48%**	**75%**

*since FY96, when separate program established
** estimated

the National Association of People with AIDS

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FAX 202-898-0435
www.napwa.org

December 6, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

We are writing to express our deep appreciation and gratitude for your continuing efforts in the fight against HIV and AIDS. Your leadership has contributed to significant gains in our attempts to end this deadly epidemic at home and abroad. We are writing to request your continued support of our efforts to enhance and expand the capacity of African-American communities to better respond to this escalating crisis by including $500 million for the Congressional Black Caucus sponsored HIV/AIDS health emergency initiative in your fiscal year 2001 budget.

The Centers for Disease Control and Prevention reported in August that the AIDS death rates in 1998 remained nearly 10 times higher in African Americans than among whites. Similarly, the rate of AIDS incidence is almost 10 times higher among African Americans than whites. It is estimated that 60% of all new HIV infections are in African Americans. The percentage is especially high among African American women heterosexually exposed. Alarmingly, a report from the New York State Department of Health AIDS Institute found that African American injection drug users had an HIV prevalence rate of 19% in 1998, nearly four times that of whites.

We are especially concerned about the devastating impact of HIV among African American and Latino youth. A recent study from the Sacramento Department of Health indicated that young gay African American men were at 2.8 times greater risk for HIV infection than other young gay men. It is estimated that as many as 100,000 young people in the United States between the ages of 13 and 21 are infected with HIV and most don't know they have a life threatening disease. And, as such, they are not receiving the necessary life-prolonging health care treatment and related services that they so desperately need.

Sadly, despite our progress of the last few years the HIV epidemic continues unabated in African American communities. As you are keenly aware, this health crisis is due to longstanding vestiges of poverty, delayed diagnosis and treatment because of inadequate access to quality health care, culturally irresponsive health care providers, insufficient access to effective substance abuse prevention and treatment – the list goes on and on.

While we know and appreciate your commitment to improving the economic and social well being of our community. We must strongly urge you to expand our nation's investment in the health of our people by doubling our current capacity building efforts to respond to the HIV epidemic. The fiscal year 2001 budget must include $500 million to strengthen the capacity in communities of color if we are to successfully meet this challenge.

Again, we thank you for your steadfast commitment, and we look forward to working closely with you to turn the tide of this life threatening disease in the African American community.

Respectfully yours,

A. Cornelius Baker, National Association of People with AIDS
Debra Frazier-Howze, National Black Leadership Commission on AIDS
Patricia Carter, Leading for Life Project, Harvard AIDS Institute, Cambridge
Rev. Yvette Flunder, Ark of Refuge, San Francisco
Ernest Hopkins, San Francisco AIDS Foundation, San Francisco
Sandra McDonald, Outreach, Inc., Atlanta
Beny Primm, M.D., Addiction Research and Treatment Corporation, New York
Rev. Edwin Sanders, Metropolitan Interdominational Church, Nashville
Mildred Williamson, Woodlawn Adult Health Center, Dallas

December 15, 1999

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

We the undersigned Latinos, living with HIV/AIDS, service providers, advocates and community leaders, are writing to thank you for your strong leadership and longstanding commitment in the fight against AIDS domestically and internationally. We are also writing to ask you to sustain and expand your support of efforts to respond to the growing challenges posed by HIV/AIDS in communities of color.

Specifically we urge you to increase the current funding for the Minority AIDS Initiative of the Congressional Black and the Congressional Hispanic Caucuses to $500 million in your FY 2001 budget request. This investment will provide our communities with the opportunity and resources to strengthen our organizational infrastructure, leadership and capacity to address the challenges of HIV/AIDS among Latinos and improve the health and well being of our communities.

Despite the advances this country has made in improving the health status of the total population, ethnic and racial minorities continue to experience significant health disparities. These disparities are particularly glaring in HIV/AIDS. While ethnic and racial minority groups in the U.S. make up 25% of the U.S. population they accounted for 67% of the new AIDS cases in 1998 reported to the Centers for Disease Control and Prevention (CDC).

We are particularly concerned about the impact of the HIV/AIDS epidemic in the Latino community. The Latino population is the second most highly impacted ethnic/racial minority group in the United States (U.S.). Latinos make up about 13% of the U.S. population yet account for 20% of the nation's new AIDS cases. In 1998, CDC reported that the rate of AIDS deaths per 100,000 population for Latinos was nearly four times that of whites. While males account for the largest proportion (82%) of cumulative AIDS cases reported among Latinos in the United States, the proportion of cases among women is rising, particularly as a result of heterosexual transmission.

Women represent 18% of cumulative AIDS cases among Latinos, but account for 21% of cases reported in 1998 alone. For adult and adolescent Latinas heterosexual contact accounts for the largest proportion (47%) of cumulative AIDS cases, most of which are linked to sex with an injection drug user (IDU). Female IDUs account for an additional 41% of AIDS cases among U.S. Latinas.

We are deeply troubled by the disproportionate impact of HIV/AIDS on Latino youth and young adults. Latino youth made up 20% of the 3,423 cases of AIDS reported through 1998 among young people ages 13 to 19. Moreover, Latino young men and women made up 21% of the 24,437 cases of AIDS reported among young adults ages 20-24, and 20% of the 93,280 cases reported among those ages 25-29. The Latino population is relatively young and will soon be the largest minority group in the country. Our communities will face severe consequences in the new millennium if the spread of HIV/AIDS is not curbed now among adolescents and young adults.

We applaud your efforts, in partnership with the Congressional Black Caucus, to invest significant targeted resources to address the severity of the AIDS epidemic among African Americans and other minority populations in FY 1999. While the $245 million investment made for FY 2000 for the Minority AIDS Initiative will provide the opportunity to expand the initiative to the Latino community, and target needed resources, it is not nearly enough to address the severity of the problem and high needs in communities of color.

Despite the important advances that have been made, unabated HIV continues to spread in communities that are already experiencing the consequences of pervasive poverty, substance abuse, high rates of adolescent pregnancies and sexually transmitted diseases, and fragile health care systems. By doubling the funding for the Minority AIDS Initiative in FY 2001 your administration will go a long way towards addressing the rapidly expanding epidemic in the Latino community and preventing major crises in HIV/AIDS among Asian and Pacific Islanders and Native Americans.

Because of our communities' reliance on all federal HIV programs, we also urge your support for substantial increases in base funding for all domestic and international programs in FY 2001. This includes the programs funded through the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Please direct any questions or responses to this letter to Miguelina Maldonado, Director of Government Relations and Public Policy, National Minority AIDS Council, 1931 13th Street NW, Washington, DC, 20009, 202-483-6622, fax # 202-483-1135.

Thank you for your consideration of our request.

Respectfully,

Hortensia Amaro, Professor, Boston University School of Public Health, Boston, MA

Regina Aragon, Deputy Director Public Policy, San Francisco AIDS Foundation, San Francisco, CA

Oscar De La O, Executive Director, Bienestar Human Services, East Los Angeles, CA

Frank Beadle De Palomo, Vice President and Director, AED Center for Community-Based Health Strategies, Washington, DC

Dennis deLeon, Executive Director, Latino Commission on AIDS, New York, NY

Catherine M. Lins, Executive Director, Midwest Hispanic AIDS Coalition, Chicago, IL

Miguelina Maldonado, Director, Government Relations and Public Policy, National Minority AIDS Council, Washington, DC

Hilda Melore, Voices of Women of Color Against HIV/AIDS, Brooklyn, NY

David Ernesto Munar, Director of Public Policy, AIDS Foundation of Chicago, Chicago, IL

Jose Martin Garcia Orduna, Technical Assistance Manager, The National Latina/o Lesbian, Gay, Bisexual & Transgender Organization, Washington, DC

Omar Perez, Founder, National Coalition of Latinos and Latinas Living with HIV/AIDS, Washington, DC

Rebeca Ramos, Technical Cooperation Director, U.S./Mexico Border Health Association, El Paso, TX

Elsa Rios, Esq., Executive Director, HIV Law Project, New York, NY

Heriberto Sanchez-Soto, Executive Director, Hispanic AIDS Forum, Inc., New York, NY

Jose Toro-Alfonso, PhD, Associate Director, Latino HIV/AIDS Research Training Program, San Juan, PR

Vivian L. Torres, Founder, National Coalition of Latinos/as Living with HIV/AIDS, Washington, DC

Washington Post, Front Page June 22, 1999

Facing Delicate Issues Of Life, Love and HIV

Black Women Cope With Rise in AIDS

By Lisa Frazier
Washington Post Staff Writer

The first time Nikiya saw the gold diamond cluster and matching wedding band displayed in a Georgetown jewelry store, she told herself she had to have them.

She bought the rings right then, slid them on her left finger and promised to wear them forever. But Nikiya wasn't married, engaged or even dating.

She wanted the rings to ward off potential suitors. Maybe then, she figured, she would never have to face telling a lover her most painful secret: She is among the thousands of black women infected with HIV, the virus that causes AIDS, which is spreading at an alarming rate among young women of color.

"When I saw the ring, I thought, 'Oh, this is so pretty,' " said Nikiya, 25. "Then I thought, a wedding ring—that should do the trick."

Seven years ago, Nikiya—who asked to be identified only by her middle name—was a high school senior planning her future when she learned that her boyfriend had infected her with HIV.

She felt she was the only young woman on earth experiencing such horror. The reality is much grimmer.

In just over a decade, the number of women with AIDS has increased dramatically—from 7 percent of the total number of AIDS cases in 1985 to 22 percent in 1997, according to the federal Centers for Disease Control and Prevention.

African American women have been especially hard hit, accounting for 60 percent of the AIDS cases reported among women in 1997. In recent years, sex has replaced intravenous drug use as the main source of exposure for women, the CDC data indicate.

Federal health officials say the trend shows no signs of abating. A CDC analysis of HIV and AIDS data collected in 25 states over three years shows that women make up a greater proportion of

See WOMEN, A8, Col. 1

BY DUDLEY M. BROOKS—THE WASHINGTON POST

Nikiya, 25, learned when she was in high school that she had the AIDS virus.

Mother Russia's Poisoned Land

Polluted Cities Must Choose Between Hunger and Disease

By Sharon LaFraniere
Washington Post Foreign Service

KARABASH, Russia—The mind-set of the residents of this small town in the birch-dotted foothills of the Urals Mountains is summed up by a big black headline in the multicolored brochure that city fathers hand out to visitors: "Karabash—Black Spot on the Planet."

Their log dwellings and small apartment buildings are literally surrounded by black heaps of industrial waste 45 feet high. Vegetation is sparse, the air smells acrid, and in the winter the snow is flecked with black grit.

More than the landscape is devastated. Two-thirds of the children suffer from lead, arsenic or cadmium poisoning, according to health experts here, near Russia's southern border with Kazakhstan. Studies also show high rates of congenital defects, central nervous system disorders, cancer and other major diseases.

BY SHARON LAFRANIERE—THE WASHINGTON POST

Yana Fomina, 8, suffers from mental retardation and a nervous system disorder possibly caused by pollution.

Regional officials blame all this on a 90-year-old copper-smelting plant, whose five tall chimneys loom over a polluted pond that schoolchildren trek over when it is frozen. The plant's emissions are so hazardous that the government shut it down in 1987.

See KARABASH, A11, Col. 2

Wallets Op For Bush I

Fund-Raiser Pushes F

By Susan B. Glasser
Washington Post Staff Writer

The Republican political establishment is throwing Texas Gov. George W. Bush a coming-out party in Washington tonight that will be the largest presidential fund-raiser ever here, but it is just one particularly lucrative stop on a cross-country money tour that is expected to boost his campaign over the $20 million mark by the end of June.

From Florida to Michigan to South Carolina, Bush will touch down this week at a dozen fund-raising events aimed at solidifying his pack-leading status while his GOP rivals struggle to finish even a distant second. Bush's allure is especially potent here in

Facing Life and Love Amid HIV

WOMEN, From A1

newly diagnosed HIV infections than AIDS cases. Between January 1994 and June 1997, women in those states represented 17 percent of the total AIDS cases but 28 percent of HIV infections.

That means that women probably will make up a larger proportion of future AIDS cases. In the District and its suburbs, the situation is even more severe, with African American women accounting for 86 percent of the AIDS cases among women.

"That is why we are focusing more of our prevention initiatives on women," said Ronald Lewis, administrator for the D.C. Department of Health's Administration for HIV/AIDS. "There is still a lot of denial in the community from people who think [women] don't have anything to worry about."

With the increased availability of powerful new drugs, the AIDS death rate nationally has declined across the board. But for African American women, as well as African American men, ages 25 to 44, AIDS still is the leading cause of death.

After her diagnosis, Nikiya prayed for a quick death. But her life began to change when she sought counseling at Family And Medical Counseling Service Inc. in Anacostia, one of the few black-owned clinics that provides a full range of medical and mental health services.

The clinic excludes no one, but its patient population is about 99 percent black. Nikiya said she felt less alone when she saw the black, brown and beige faces of other HIV-positive women at the clinic. With their support, she is learning to live with HIV.

But some of the scariest parts of her new life, she said, are the delicate issues she never imagined facing again—like dating, sexual intimacy, falling in love.

Barbara Dorman, who works for an Anacostia counseling service, h

Women's AIDS Fi
Condoms on the

By Lisa Frazier
Washington Post Staff Writer

Their first stop this sunny Saturday morning is a methadone clinic on Bladensburg Road NE. The women are working the block when Bessie Wilkes, a stout 45-year-old with warm brown skin, recognizes an old friend.

"Hey baby," Wilkes says, offering a warm embrace. Wilkes reaches into her canvas bag and pulls out a row of 10 latex condoms wrapped in shiny black paper.

"Take these condoms, baby," Wilkes says. "We're out here promoting safe sex."

For Wilkes, a recovering heroin addict who is HIV-positive, the streets are painfully familiar. But these days, when she returns, she is trying to save lives.

As an AIDS prevention education specialist for Family And Medical Counseling Service, an Anacostia health clinic, she heads a peer education program called "Healthy Choices, Healthy Sisters," aimed at training the clinic's female patients to educate other women about safe sex.

HIV and AIDS are growing faster among African American women than any other group. The federal Centers for Disease Control and Prevention has encouraged agencies to target women in their education and prevention programs.

Family And Medical's 10-week training program takes Wilkes and other trainees to drug rehabilitation houses and community groups across the city to sponsor safe sex parties for women. The participants munch on snacks as Wilkes discusses issues such as how to negotiate condom use with a partner.

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NATION IN BRIEF

White Boston Students Allege Discrimination

BOSTON—Twenty-five years after court-ordered busing tore this city apart, the parents of four white children and a local advocacy group yesterday filed a lawsuit against Boston public schools alleging reverse

legislation making the state the first in the nation to offer a statewide program of vouchers to help parents of students in failing schools offset the cost of private education.

Florida's House and Senate approved the controversial plan in April. It fulfills a major campaign promise made by Bush during his run for governor last fall.

Bystander Slain Outside Home,

SHOOTING, From A1

Two investigators said that the shooting appeared to be the result of a feud between rival groups of young men and that the victim was an innocent bystander.

"The two bandits were having a gun

homicide detective, said angrily. "There are a lot of rounds there, 23 probably."

Foster, according to neighbors, had done domestic work but had health problems and wore a pacemaker. She was identified in D.C. voting records as Helen E. Foster-El. One neighbor said Foster belonged to a church around the corner on

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Another that Foste children bullets wh "All the those who she was tr

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mid-day and five more at night. It was time for him to know.

But, given the AIDS paranoia she sometimes witnessed among fellow African Americans, she wondered how he would react. Even her doting grandmother still boils the dishes after Nikiya eats a meal.

"I knew if I ever got in a relationship, I would tell," Nikiya said. "Once I got to the point where I felt like the relationship was going somewhere, I just knew I would tell."

So, as they were driving to dinner one spring afternoon, she blurted it out.

"I'm positive," she said from the passenger seat. "I'm HIV-positive."

He seemed more hurt than angry: "Why didn't you tell me?" he asked.

"Well, I'm telling you now," she retorted in her feisty mode.

Tension filled the car like gunpowder. But the mechanic moved quickly to defuse the moment.

"So, when are you moving in with me?" he asked.

They never discussed it again, Nikiya said. Instead, he began babying her, giving in to her every demand.

"I was like, yell at me or something," she said. "I'm not gonna break."

"He changed," Nikiya said. "He turned into such a sucker."

In May, Nikiya asked him to stop calling. She had been weak once, after Steven died, when she was so despondent she couldn't lift herself out of bed. But she is that woman no more.

With Social Security income and money Steven left, Nikiya and her daughter, now 6, live comfortably. She earned an education degree from the University of Maryland, and she expects to receive a master's in child psychology from Howard University next year.

It took years before Nikiya allowed herself to imagine a future. But she is trying hard to live up to the Swahili middle name that her mother chose with such care: Nikiya, "Little Warrior."

"I'm thinking of starting my own private practice counseling kids," she says with ease.

That is what motivated Nikiya to do the thing she never believed she would be able to do: Stand in front of a crowd and tell her story.

On a scorching recent Tuesday morning, she sat behind a desk in a stuffy classroom at Phelps Senior High School in Northeast Washington. The teenagers were wide-eyed as Nikiya rose to tell them how she got infected with the virus that causes AIDS.

She didn't tell them to avoid sex—convinced that that advice would fall on deaf ears. But she believes that she—someone who looks like them and is young enough to relate to them—has a better chance of planting information that could save lives.

"Half of y'all guys in here were trying to talk to me when I came in here," she said.

A few students giggled.

"What you don't know is I'm HIV-positive," she added. "And I have been positive for 10 years. You can't look at somebody and tell if they're positive. . . . Use a condom. Don't let decisions you make today ruin your life tomorrow."

When she was finished, the students applauded. Nikiya strolled out, climbed into her green Ford pickup truck and headed home. It was a long journey to get to that stage, she realized, and there are still miles to go.

Her small hands rested in her lap. And there, she saw the tool that she hopes will protect her from too much pain.

BY SUSAN BIDDLE—THE WASHINGTON POST

Barbara Dorman, who works for an Anacostia counseling service, hands condoms to a motorist.

Women's AIDS Fight Pu s Condoms on the Streets

By Lisa Frazier
Washington Post Staff Writer

Their first stop this sunny Saturday morning is a methadone clinic on Bladensburg Road NE. The women are working the block when Bessie Wilkes, a stout 45-year-old with warm brown skin, recognizes an old friend.

"Hey baby," Wilkes says, offering a warm embrace. Wilkes reaches into her canvas bag and pulls out a row of 10 latex condoms wrapped in shiny black paper.

"Take these condoms, baby," Wilkes says. "We're out here promoting safe sex."

For Wilkes, a recovering heroin addict who is HIV-positive, the streets are painfully familiar. But these days, when she returns, she is trying to save lives.

As an AIDS prevention education specialist for Family And Medical Counseling Service, an Anacostia health clinic, she heads a peer education program called "Healthy Choices, Healthy Sisters," aimed at training the clinic's female patients to educate other women about safe sex.

HIV and AIDS are growing faster among African American women than any other group. The federal Centers for Disease Control and Prevention has encouraged agencies to target women in their education and prevention programs.

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A prison doctor brought reality home. For five years, Wilkes told no one she was HIV-positive and avoided counseling or medical treatment. In 1993, she joined a support group in the D.C. jail; in 1995, she entered an 18-month drug rehabilitation program.

"I was just tired, and I realized I didn't want to die," Wilkes said. "In treatment, I realized I had nothing to show for my time here on earth. I never knew what my purpose was until I came here."

She is talking about Family And Medical Counseling in Anacostia, where she has been a consultant since last year. She was the clinic's paid community liaison until the grant that paid her salary ran out. Wilkes worked unpaid until the clinic could put her back on the payroll.

For the first time, Wilkes felt her life had meaning.

"So many of the women I knew," Wilkes said. "They were in the same environment I was in. They were in transition houses, shelters, and many of them were HIV-positive. But they acted like they didn't care."

So, Wilkes goes back to her old haunts to offer hugs, encouragement, condoms.

It's about 10:45 a.m., and the women are canvassing the area around Minnesota Avenue and 51st Street NE. A middle-aged woman wearing sunglasses and black stretch pants with huge neon flowers calls to them from a bus stop. "Hey, here come my girls," she says. "Come on and give me my issue."

A volunteer rushes over, opens the canvas bag, and the woman walks away with condom-filled hands.

At a grocery store counter, a young man, no older than 20, with drooping jeans and a baggy red T-shirt, slips up to Wilkes.

"Hey, y'all got some rubbers?" he says softly.

"Sure, baby," Wilkes responds, digging into her bag.

Outside, a police officer watches as they make exchanges with strangers. He moves his cruiser to a lane nearer the sidewalk and slowly keeps pace with the women.

Wilkes reaches into her bag and pulls out shiny black packages, then waves them into the air.

"Want some?" she asks. "Police officers need to practice safe sex, too."

Their mission ends on New York Avenue NW near Hanover Street, where people with glassy eyes hover, passing time. The women stop, join the talk, hand out condoms.

Before leaving, the volunteers huddle to discuss their day. One woman's eyes fill with tears.

"On the one hand, I feel like we did something good," says Wanda, wearing a blue baseball cap over her curly brown hair. "But on the other, I feel hurt because all we can do for them is give them a condom."

"Yea, but some people don't get that much," Wilkes says.

The women say goodbye. Their bags, stuffed with 2,000 condoms at the start of the day, are empty. Wilkes lingers a bit, pulling out a cigarette.

"A lot of times when we see people, we see ourselves," she says. "That's why I always say good morning and give them a hug. Giving them condoms might not seem like much, but a condom might have saved any one of our lives."

the National Association of People with AIDS

FAX

Date: 11/8/99

To: Sandy Thurman

From: Cornelius Baker

Page(s): 5

MEMO: F.Y.I.

Please contact me if you do not receive a complete facsimile. Thank you.

1413 K Street, NW, 7th Floor
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the National Association of People with AIDS

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November 8, 1999

The President
The White House
Washington, DC 20510

Dear Mr. President:

Thank you for all your efforts to improve the health of our nation's people, especially racial and ethnic minority populations who have often suffered a high level of sickness, disease and early death as a result, in part, to a lack of access to quality, health care services. I want to particularly recognize your efforts to increase funding for HIV/AIDS services in order to meet the needs of this ongoing crisis in our communities. Your leadership is much appreciated.

I am writing this letter to encourage your continuing work to secure the full amount of funding requested by the Congressional Black Caucus to expand its initiative on HIV/AIDS in communities of color and to request your support for additional funding to eliminate syphilis in the United States. The CDC has estimated that an additional $27 million is necessary through 2005 to accomplish elimination. Both of these initiatives are currently underfunded in the proposed fiscal year 2000 budget bills to be considered this week.

I need not tell you the importance of the CBC/African-American HIV/AIDS funding initiative that you and Secretary Shalala were instrumental in launching last year. This initiative has already had a tremendous impact in galvanizing communities across the country in responding to the HIV epidemic. Continuation of this initiative is essential to our nation's efforts to end AIDS.

As you know, syphilis has a sad and devastating history in this country and has left a lasting legacy of despair in many communities. You have rightly, apologized to the survivors of the Study of Syphilis in Negro Men at Tuskegee for the U.S. Government's part in prolonging this awful condition in them and in black communities across the South. Even now infectious syphilis rates among African Americans in this country are 34 times higher than among white Americans. Syphilis still causes substantial morbidity and mortality in the form of cardiac and neurologic disease, stillbirth and developmental disability from congenital syphilis, and by facilitating transmission of HIV. Fortunately, reported cases of syphilis are at an all time low and 50% of all the new cases were reported from just 28 (less than 1%) U.S. counties.

In America today, we have an opportunity to eliminate syphilis, something that several other industrialized nations have already accomplished. However, that window of opportunity is about to slam shut. Since the early part of this century, syphilis has occurred in 7-10 year cycles. In the year 2000, we will again be on the verge of another peak cycle in the U.S. New funding in Year 2001 may be too late to take advantage of the opportunity we have to eliminate this disease.

I hope you will use your leadership to insist that congress find the funds to continue to fight AIDS by fully funding the CBC initiative on HIV/AIDS and finding additional funds to eliminate syphilis.

Respectfully yours,

A. Cornelius Baker
Executive Director

Attachments (2)

cc: Mr. Jack Lew, Director
Office of Management & Budget

Ms. Sandra Thurman, Director
Office of National AIDS Policy

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

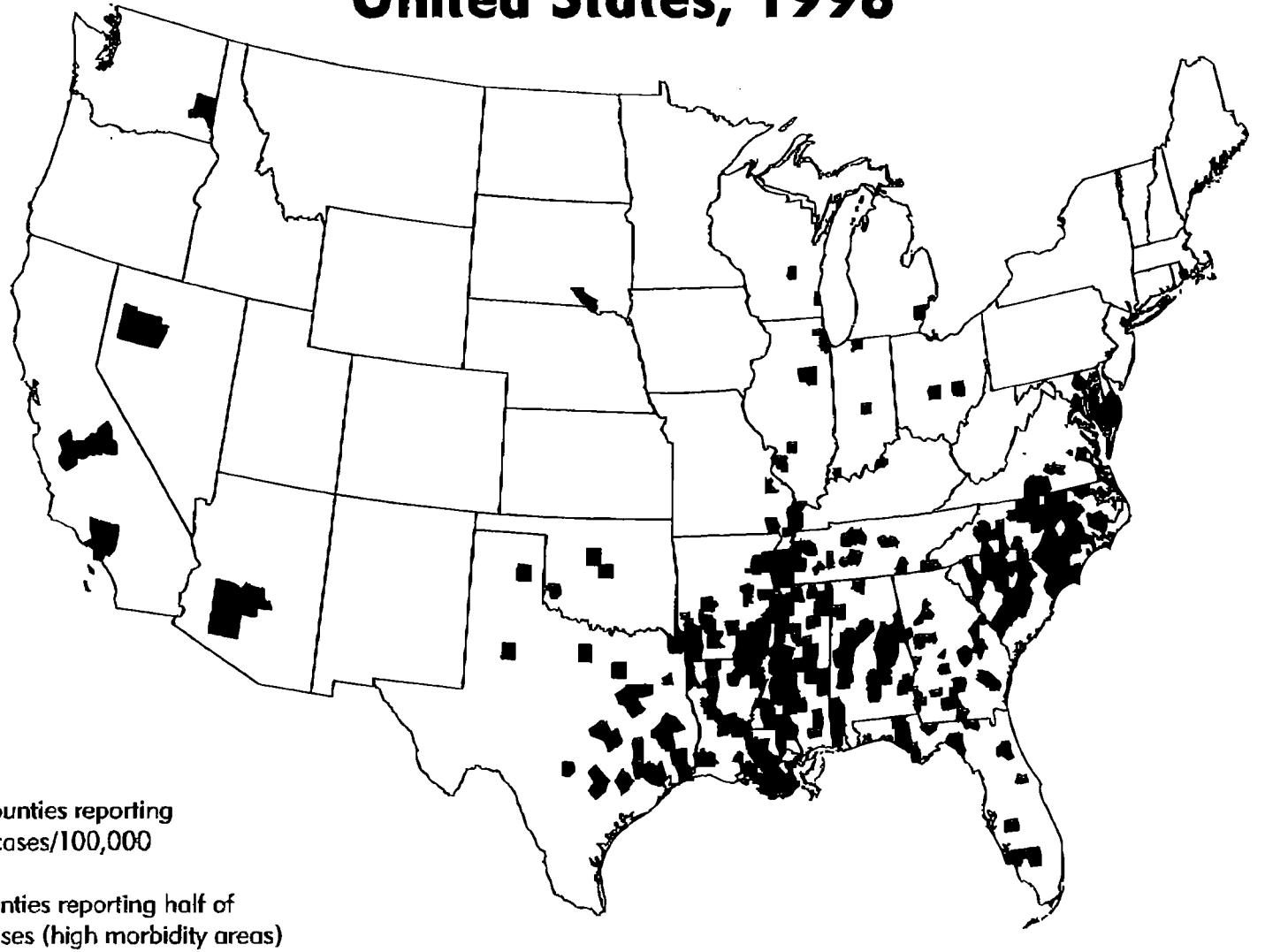
Syphilis Elimination | History in the Making

Embargoed for Release: Thursday October 7, 1999 4 P.M. EST
Contact: NCHSTP Office of Communications 404-639-8895

28 Counties Reporting 50% of P&S Syphilis Cases - United States, 1998

County (Major Cities)	1997	1998	% change
1. Baltimore County, MD (Baltimore)	665	456	-31
2. Cook County, IL (Chicago)	379	364	-4
3. Shelby County, TN (Memphis)	343	260	-24
4. Davidson County, TN (Nashville)	203	210	3
5. Maricopa County, AZ (Phoenix)	118	173	47
6. Wayne County, MI (Detroit)	101	169	67
7. Marion County, IN (Indianapolis)	64	161	152
8. Fulton County, GA (Atlanta)	190	151	-21
9. Dallas County, TX (Dallas)	148	126	-15
10. Los Angeles County, CA (LA)	134	108	-19
11. Orleans County, LA (New Orleans)	132	105	-20
12. Harris County, TX (Houston)	180	99	-45
13. Guilford County, NC (Greensboro)	149	98	-34
14. Jefferson County, KY (Louisville)	107	91	-15
15. Philadelphia County, PA (Philadelphia)	109	89	-18
16. Washington DC	117	81	-31
17. Tuscaloosa County, AL	63	74	17
18. Mecklenburg County, NC	49	73	49
19. Oklahoma County, OK (Okla. City)	37	71	92
20. St. Louis County, MO (St. Louis)	60	58	-3
21. Franklin County, OH (Columbus)	54	56	4
22. Forsyth County, NC	79	54	-32
23. Prince Georges County, MD (Balt. Metro)	86	51	-41
24. Hinds County, MS (Jackson)	61	51	-16
25. Milwaukee County, WI (Milwaukee)	92	51	-45
26. Wake County, NC (Raleigh/Durham)	40	49	23
27. Lancaster County, SC	33	47	42
28. Robeson County, NC	34	46	35

Primary and Secondary Syphilis--
United States, 1998*



312 counties reporting
>4.0 cases/100,000

28 counties reporting half of
new cases (high morbidity areas)

*Note: 1998 P&S rate for the U.S. is 2.6 per 100,000

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Syphilis Elimination | History in the Making

CDC: AIDS spirals among minority gays

By Steve Sternberg
USA TODAY

AIDS cases among black and Latino gay men have surpassed those among gay whites for the first time — indicating that in these groups, the epidemic has spiraled out of control, a study out today shows.

The study, by the Centers for Disease Control and Prevention (CDC) in Atlanta focuses on men who have sex with men. In 1998, within that group, 51% of the men with AIDS were black or Latino, up from 31% in 1989. Cases among white gay men declined from 69% to 48% during that period.

"The African-American and Latino communities must recognize that this is not a disease that only affects white, gay men," says Helene Gayle, director of the CDC's AIDS prevention program.

The shift began years ago, Gayle notes, but many policymakers and black and Latino leaders ignored it.

At least 85% of infected black and Latino men were in cities with more than half a million people, especially New York (12%), Los Angeles (9%), Miami (5%), Washington, D.C., (4%) and Chicago (3%).

"This news is alarming for all Americans," says Rafael Campo of Harvard Medical School. He notes that Latinos are the USA's fastest-growing minority, with the youngest median age.

"While we are 13% of the U.S. population, we account for 20% of cumulative AIDS cases," Campo says. "Today's shocking data are a harbinger of worse to come, unless we act now."

> "The African-American and Latino communities must recognize that this is not a disease that only affects white, gay men."
>
> — Helene Gayle, CDC

Phill Wilson, director of the University of Southern California's African-American AIDS Policy & Training Institute, asserts that the persistent stigma against homosexuality among minorities promotes AIDS spread among black and Hispanic men and women.

The stigma inhibits black and Hispanic men from identifying themselves as gay or bisexual, though they have sex with men, he says.

One survey of 8,780 HIV-positive men found that one in four black men and one in six Latino men say they are heterosexual, even though they have sex with other men.

Many of these men also have sex with wives and girlfriends, potentially exposing them to AIDS, too.

"They are a bridge to women and children," Gayle says, adding they may account for the higher rates of heterosexual spread in these communities.

Among other findings:

▶ One-third of AIDS cases in gays and bisexuals occurred among black men; another 18% was among Hispanics.

▶ Black and Hispanic gay and bisexual men are being infected at younger ages than their white counterparts. A study of men in 25 states from 1996 to 1998 found that 16% of blacks and 13% of Hispanics were 13 to 24 years old. Nine percent of white gay men were in that age category.

Roughly 45% of the 703,000 AIDS cases reported in the USA since 1981 have occurred in men who have sex with men, the CDC reports.