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Office of HIV/AIDS Policy

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the availability of appropriations for the fiscal year involved to make the payments in such year. The preceding sentence may not be construed to establish a limitation on the number of grants under such subsection that may be made to an entity.

(n) TECHNICAL ASSISTANCE, AND SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.—

(1) TECHNICAL ASSISTANCE.—The Secretary may provide training and technical assistance to grantees under subsection (a) with respect to the planning, development, and operation of any program or service carried out under such subsection. The Secretary may provide such technical assistance directly or through grants or contracts.

(2) SUPPLIES, EQUIPMENT, AND EMPLOYEE DETAIL.—The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by—

(A) the fair market value of any supplies or equipment furnished the grant recipient; and

(B) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the grant recipient and the amount of any other costs incurred in connection with the detail of such officer or employee;

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such grant recipient and for the purpose of carrying out a program with respect to which the grant under subsection (a) is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

(o) EVALUATIONS AND REPORTS BY SECRETARY.—

(1) EVALUATIONS.—The Secretary shall, directly or through contracts with public or private entities, provide for annual evaluations of programs carried out pursuant to subsection (a) in order to determine the quality and effectiveness of the programs.

(2) REPORT TO CONGRESS.—Not later than 1 year after the date on which amounts are first appropriated pursuant to subsection (q), and biennially thereafter, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report—

(A) summarizing the information provided to the Secretary in reports made pursuant to subsection (j)(1), including information on the incidence of sexually transmitted diseases described in subsection (a); and

(B) summarizing evaluations carried out pursuant to paragraph (1) during the preceding fiscal year.

(p) COORDINATION OF FEDERAL PROGRAMS.—The Secretary shall coordinate the program carried out under this section with any similar programs administered by the Secretary (including coordination between the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health).

(q) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, other than subsections (o) and (r), there are authorized to be appropriated $25,000,000 for fiscal year 1993, and such sums as may be necessary for each of the fiscal years 1994 through 1998.

(r) SEPARATE GRANTS FOR RESEARCH ON DELIVERY OF SERVICES.—

(1) IN GENERAL.—The Secretary may make grants for the purpose of conducting research on the manner in which the delivery of services under subsection (a) may be improved. The Secretary may make such grants only to grantees under such subsection and to public and nonprofit private entities that are carrying out programs substantially similar to programs carried out under such subsection.

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1993 through 1998.

PUBLIC HEALTH EMERGENCIES

SEC. 319. [247d] (a) If the Secretary determines, after consultation with the Director of the National Institutes of Health, the Administrator of the Substance Abuse and Mental Health Services Administration, the Commissioner of the Food and Drug Administration, the Administrator of Health Resources and Services, or the Director of the Centers for Disease Control and Prevention, that—

(1) a disease or disorder presents a public health emergency, or

(2) a public health emergency otherwise exists and the Secretary has the authority to take action with respect to such emergency,

the Secretary, acting through such Directors, Administrator, or Commissioner, may take such action as may be appropriate to respond to the public health emergency, including making grants and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder described in paragraph (1).

(b)(1) There is established in the Treasury a fund designated the "Public Health Emergency Fund" to be available to the Secretary without fiscal year limitation to carry out subsection (a). There is authorized to be appropriated to the fund $30,000,000 for fiscal year 1984. For fiscal year 1985 and each fiscal year thereafter there is authorized to be appropriated to the fund such sums as may be necessary to have $45,000,000 in the fund at the beginning of such fiscal year.

(2) The Secretary shall report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate not later than ninety days after the end of a fiscal year—

TRENDS IN HIV/AIDS INFECTIONS

The HIV/AIDS epidemic among African Americans is severe and ongoing.

Since 1993, the absolute number of new AIDS cases reported among African Americans has declined, but African Americans account for a rising proportion of new AIDS cases.

Reported AIDS Cases by Race/Ethnicity 1992 - 1997

Year	Total Cases	White (%)	Black(%)	Hispanic (%)
1992	47,106	22,329 (47)	15,897 (34)	8,285 (17.5)
1993*	106,949	48,240 (45)	38,544 (36)	18,888 (18)
1994	80,691	33,193 (41)	31,485 (39)	15,066 (19)
1995	74,180	29,732 (40)	29,350 (40)	14,169 (19)
1996	69,151	26,327 (38)	28,775 (42)	13,111 (19)
1997	60,634	20,197 (33)	27,075 (44.6%)	12,466 (20.5)

* Case definition for AIDS changed
Source: CDC End-of-Year Reports 1992 through 1997

AIDS Case Rates per 100,000 Population, 1992 - 1997

Year	National Rate	White	Black	Hispanic
1992	18.2	11.7	52.2	29.9
1993	40.8	25.0	125.0	67.3
1994	30.5	17.2	100.8	51.0
1995	27.8	15.4	92.6	46.2
1996	25.6	13.5	89.7	41.3
1997	22.3	10.4	83.7	37.7

Number of Deaths Among Persons with AIDS by Race/Ethnicity

Race/Ethnicity	1995	1996	% Change
White	21,700	14,670	- 32%
Black	18,840	16,460	- 13%
Hispanic	9,010	7,220	- 20%

Source: MMWR Sept. 19, 1997

Trends in HIV Diagnoses in 25 States Reporting HIV Infections 1994 - June 1997

Year	White	Black	Hispanic
1995	85,093	8,569	971
1996	4,966	8,300	1070
% Change	-3%	-2%	+ 10%

Disease Status at Time of Initial HIV Diagnosis

Race	Total #	HIV (%)	AIDS (%)
White	27,100	17,929 (66)	9,171 (34)
Black	39,356	30,229 (76)	9,127 (23)
Hispanic	5,241	3,581 (68)	1,660 (31.6)

Source: MMWR April 24, 1998

AIDS Cases Among Females ≥ 13 Years of Age, 1993 - 1997

Year	Total #	White (%)	Black (%)	Hispanic (%)
1993	16,824	4,103 (24)	9,220 (55)	3,324 (19.7)
1994	14,081	3,148 (22.3)	8,016 (57)	2,814 (20)
1995	13,764	3,106 (22.5)	7,680 (56)	2,847 (20)
1996	13,820	2,888 (20.8)	8,147 (59)	2,629 (19)
1997	13,105	2,485 (19)	7,880 (60)	2,578 (19.6)

Source: CDC End-Of-Year HIV/AIDs Surveillance Reports, 1993-1997

Draft

Talking Points - Request for Declaration of a State of Emergency

- The status of the HIV/AIDS epidemic in the African American community is a severe and ongoing crisis which has developed over a period of years relative to the majority community. It requires a long term sustained commitment rather than a short term one as implied in a public health emergency declaration.

- The Department agrees that we are confronting a critical situation in many communities. But unlike a short term disaster relief intervention, we need a comprehensive approach and sustained commitment to overcome and effectively address this epidemic. Although this is not a new problem, it is an increasingly acute one as many African Americans are not benefitting from the advances in treatments and HIV prevention that have changed the face of AIDS in the general population.

- There is a clear and immediate need to support highly impacted communities of color as they wrestle with the many challenges of effective HIV prevention and increasing access to high quality care for people living with HIV. What will be most important in the long run is not whether we declare a formal emergency, but what we will actually do to make real and lasting changes to reduce the severe and urgent needs of many communities of color as they confront HIV/AIDS. The impact on many communities has gone beyond an emergency, to become a severe and chronic situation that is going to require sustained effort and commitment to turn around.

- Many of the mechanisms available to us for funding have not allowed us to sufficiently target resources in this epidemic. We are looking at options and new mechanisms to directly get funds out in a way they will most effectively address current needs and future challenges. It's necessary to recognize that no single approach will work for all communities, and a range of tailored strategies are needed.

- As a part of our action plan, the Department is ready to both commit new funds and to target additional resources to build the capacity of minority organizations to provide prevention and care in their neighborhoods.

- These resources will build upon the already substantial investment of HHS programs to deliver services to persons of color. A lot is being done, but it is not enough. Adding new targeted funds will have a much broader impact on our existing programs if they help prepare communities to access and use current resources more effectively. These targeted investments can leverage much broader change. One example of this is building the capacity of minority organizations to compete for federal funds to deliver services in their communities.

- We are prepared to put new funds into specific initiatives that will directly target increasing access to both care and prevention in communities heavily impacted by HIV,

and to build the capacity of minority organizations to play a central role in delivering services. Very specific initiatives are called for to address particularly vulnerable populations such as women with HIV and persons in prison, and we are committed to taking real action on these.

- As the epidemic has changed, there is a need to re-examine the way our programs are working and what outcomes we achieve with our investments. Some adjustments are necessary, such as making sure our prevention dollars follow the trends in the epidemic. The difficulty in getting new drug therapies to people of color reflect the chronic problems of poor access to quality and culturally sensitive health care for those communities.

- The data show us that we cannot do business as usual and get ahead of this epidemic. We are committed to looking at what real changes are needed.

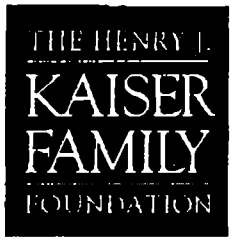
- Senior staff from the Department are prepared to come up and review with you the specifics of the action steps we are considering, to get your input and support as we move ahead. This is clearly an endeavor in which the Department needs to partner with the Congress, particularly in the area of some changes to existing programs and to gain support for targeted resources to address this crisis.

- It is also very clear that the Federal government cannot work alone to meet the needs of communities across the country. The CBC and the leadership of other national organizations will be critical in bringing state and local elected officials into the mix with resources and the necessary commitment to turn the tide of HIV in communities of color. The federal dollar must be used to leverage an equal investment by other partners, including new partners in the business, civic and nonprofit sectors.

- It is also critical to recognize that dollars alone won't do the job. If we are going to really reduce HIV infections and slow the rate of people dying from AIDS, we've got to engage all the institutions present in communities of color and build on the sea-change of awareness and acceptance that you and other leaders in the CBC have begun to achieve.

- Your leadership will be central in this. The Surgeon General will also make the HIV epidemic among communities of color his top priority for the elimination of disparities in health. We will work with you to make this a highly visible issue and to seek commitments from media leaders
to get the word out.

- We look forward to joining with you as a full partner in changing the course of the HIV epidemic within African American communities, and structuring new and effective responses to this serious crisis.



NEWS RELEASE

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DESPITE WIDESPREAD CONCERN ABOUT AIDS, FEW AFRICAN AMERICANS SEE "A LOT" OF ACTION FROM COMMUNITY GROUPS AND GOVERNMENT IN FIGHT AGAINST DISEASE

African Americans Want Practical Help on HIV/AIDS: How to Talk with Children and Partners, More Information About Testing andTreatment

Media Named As Most Important Resource on HIV/AIDS

BOSTON, MA -- As African Americans make up a growing percent of new AIDS cases in the United States -- 43 percent in 1996 -- a new national survey by the Kaiser Family Foundation finds many African Americans today extremely concerned about the AIDS crisis:

- One in two African Americans (50%) say they are *very concerned* about becoming infected by HIV, a level of worry that is twice that among a national sample of all Americans (24%); and, 40 percent of African Americans say their personal concern has heightened from just a few years ago;

- Most African Americans (56%) say AIDS is a *very serious* problem for the people they know, and in fact one in two (49%) *knows someone* who has HIV or AIDS or has died from AIDS. By comparison, only a third of a national sample of all Americans say they are or have been as personally impacted by the disease;

- According to a majority of African Americans (52%), the AIDS crisis is the leading health problem facing the nation today, one which three in five (58%) say has become *more urgent* in recent years;

- More than two in five African Americans -- 44 percent -- say the situation has also worsened in their local communities.

The Kaiser Family Foundation Survey of African Americans on HIV/AIDS is being presented today at a special conference organized by the W.E.B. Du Bois Institute for Afro-American Research at Harvard University: *The Untold Story: AIDS and Black Americans, A Briefing on the Crisis of AIDS Among African Americans*. The conference is co-sponsored by Leading for Life/Harvard AIDS Institute and the Kaiser Family Foundation.

- more -

The survey finds that African Americans are looking for answers and help on a very practical level: how to talk with children and partners about HIV/AIDS and where to go for treatment and testing. The large majority also wants to see government spending on prevention, treatments, and research for a vaccine.

"The challenge now is to convert this high level of awareness and concern into greater action by all those involved in the fight against AIDS," said Sophia Chang, M.D., M.P.H., Director of HIV Programs, Kaiser Family Foundation.

African Americans see more concern and action from communities than from government on HIV/AIDS, but see room for both to do more. Local health care providers are the group most likely to be seen as both "caring" (61%) and "doing" (40%) the most to address the AIDS crisis. About half of African Americans say local schools (49%) and churches or religious leaders (54%) care "a lot" about the problem of AIDS; by comparison, only a quarter say either actually do "a lot" (28% and 23%, respectively). The government gets lower marks: fewer African Americans say the government at any level -- local (17%), state (20%), or federal (22%) -- cares "a lot" about AIDS; almost the same percentages as say government does "a lot" in the fight against the disease (local: 14%; state: 17%; federal: 18%).

"In my opinion, this survey suggests a disturbing need for leadership within the African American community about an epidemic which is sixteen times more likely to strike its women and six times more likely to strike its men " said Professor Henry Louis Gates, Jr., Director of the W.E.B. Du Bois Institute and Chairman of the Department of Afro-American Studies at Harvard University. "Why is it that we are motivated to fight racism in the workplace and the civic square, but are not equally motivated to save the lives of our brothers and sisters from this horrible disease?" he asked.

African Americans and AIDS: The Facts. More than one third -- 35 percent -- of all reported AIDS cases and 43 percent of new AIDS cases are among African Americans, even though African Americans comprise only 12 percent of the U.S. population. African American women and youth have been particularly hard hit by the AIDS epidemic. African American women today make up 60 percent of all new AIDS cases reported among women. The annual AIDS case rate (cases of AIDS per 100,000 population) among African American women is sixteen times that of white women. Among new pediatric (13 years and younger) AIDS cases, two thirds (63%) are African American children. Heterosexual transmission is now the most common means of HIV transmission to African American women (38% of new cases), followed by injection drug use (32% of new cases). African American men are also disproportionately affected by the AIDS epidemic, representing 39 percent of new cases among all men, an annual case rate that is six times that of white men. While AIDS-related deaths have declined, due in large part to the availability of new drugs, the rate of decline has been much slower among African Americans: the number of deaths due to AIDS in 1996 decreased by 13 percent among African Americans as compared to a rate of 32 percent among whites. ***Sources: Centers for Disease Control and Prevention; National Center for Health Statistics; and U.S. Bureau of the Census.***

"The numbers alone cannot express the tragic impact of the HIV epidemic in the African American community. The threat of HIV has become a reality that each generation of young African American men and women must face", said Helene Gayle, M.D., M.P.H., Director, National Center for HIV, STD, and TB Prevention at the Centers for Disease Control and Prevention. "It has become increasingly clear that the government cannot alone successfully combat this threat", added Gayle, "Overcoming current barriers to HIV prevention will require that leaders from all sectors of the African American community play an even greater role."

African Americans' worries about HIV/AIDS are based on a high degree of knowledge about the disease. The vast majority knows how AIDS is transmitted (97%), including that a pregnant woman with HIV can pass it to her baby (91%). Most are aware there is no cure (73%) or vaccine (67%). Reflecting their heightened concern, most African Americans (56%) have been tested for HIV at some point in their lives; among the under 30 year olds, two thirds (65%) have been tested. (By comparison, 38 percent of a national sample of all Americans, and 51 percent of all 18-29 year olds in that sample, have been tested.)

Taking the Lead: What Should Be Done?

In response to the epidemic, African Americans strongly support stronger federal government efforts to fight the spread of the disease. Two thirds (66%) say the government does not spend enough on AIDS, and vast majorities favor investment in HIV/AIDS education and other prevention activities (95%), expanding access to new drug therapies (95%), and research to find more effective treatments (97%) and a vaccine (94%).

A majority of African Americans (59%) also favors needle exchange -- programs that offer clean needles to IV drug users in exchange for used ones. Opinions on the issue, however, appear to be influenced by how it is presented. When given an argument made by opponents of needle exchange -- that it gives tacit approval of illegal drug use -- support is lower among African Americans: 40 percent favor, 53 percent oppose.

Closing the Gap: Practical Help and Information Needs

The kind of help and information needs African Americans say they want when it comes to HIV/AIDS include the basics from what to talk about to where to go:

- Three quarters of African Americans (62%) want help talking with kids about AIDS prevention;
- Most (55%) want to know more about where to go for help if exposed to HIV;
- Close to half (46%) say more information about testing is needed;
- Two in five (40%) want help with talking to partners about sex; and
- A quarter (27%) need to know more about how to properly use a condom.

The media is the most important resource today for African Americans on the AIDS crisis: one in two adults (46%) cite the media, including TV, radio, newspapers, and/or magazines, as their leading source of information about HIV/AIDS in the month prior to the survey. Families and friends (30%), churches and other religious organizations (24%), and the workplace (22%) are also outlets for information named by some African Americans; less frequent recent resources are health care providers (11%) and AIDS advocacy organizations (2%).

Methodology

The Kaiser Family Foundation's *National Survey of Africans Americans on HIV/AIDS* is a random-sample national survey of 811 African American adults, 18 years and older. The survey was designed by staff at the Foundation and conducted by telephone by Princeton Survey Research Associates (PSRA) between September 19 and October 26, 1997. The margin of sampling error is plus or minus 4 percent. The margin of sampling error may be higher for some of the sub-sets in this analysis.

The Kaiser Family Foundation, based in Menlo Park, California, is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. The Foundation's work is focused on four main areas: health policy, reproductive health, and HIV in the United States, and health and development in South Africa.

The W.E.B. Du Bois Institute for Afro-American Research, founded at Harvard University in 1974, is the nation's oldest center for the study of the history and culture of Africans and people of African decent throughout the Diaspora. Under the directorship of Henry Louis Gates, Jr., the Institute sponsors conferences, working groups, and a Fellows program to further the study and focus on African and African American issues.

The Harvard AIDS Institute is dedicated to conducting and catalyzing research to end the worldwide AIDS epidemic. In response to the epidemic's increasing impact on communities of color, the Institute launched the Leading for Life campaign along with the W.E.B. Du Bois Institute, the Kaiser Family Foundation, and others. The campaign calls attention to the disproportionate number of AIDS cases in African American and Latino populations, raises awareness among African American and Latino leaders, and outlines specific steps to be taken nationally and locally to stop the increasing spread of HIV.

A summary of findings, including the questionnaire and top line data, is available by calling the Kaiser Family Foundation's publication request line at 1-800-656-4533 (Ask for #1372).

What Are African-Americans' HIV Prevention Needs?

Are African-American populations at risk?

Many African-American populations are at high risk for HIV infection, not because of their race or ethnicity, but because of the risk behaviors they may engage in. As with any population, it's not who you are, but what you do that puts you at risk for HIV. African-Americans are disproportionately affected by HIV: they account for 33% of total AIDS cases in the US, while comprising only 11% of the US population. (1)

In 1994, more than half (57%) of AIDS cases among women were among African-Americans. Likewise, African-Americans accounted for over half of all AIDS cases among injection drug users (IDUs). In 1994, 62% of all children with AIDS were African-American. (1)

Who are African-Americans at risk?

While African-Americans are often viewed as one group, there is, in fact, a wide variety of populations in the US included under this heading. (2) Upper class, lower class, Christian, Muslim, inner-city, suburban, descendants of slaves and recent Caribbean immigrants all come under the African-American heading. Current epidemiological surveillance does not record these social, cultural, economic, geographic, religious, and political differences that may more accurately predict risk. (3)

Although HIV transmission in African-American communities is primarily viewed as a problem among heterosexual IDUs and their sexual partners, the proportion of AIDS cases among African-Americans attributed to male homosexual/bisexual activity (36%) is almost equal to that attributed to injection drug use (38%). (1)

Injection drug use has played a major role in HIV infection among African-Americans. African-Americans are twice as likely as whites to have used drugs intravenously, and HIV infection is higher for black IDUs than white IDUs. (4) One reason may be the "ghettoization" of blacks in inner-city areas where drug trafficking, unemployment and poverty, among other factors, have assured that blacks suffer high rates of addiction. (5) Studies of drug users that describe significant association between health and race may be better explained by these characteristics of the social environment. (6)

What puts African-Americans at risk?

Very little information exists on risk factors specific to African-Americans, especially among IDUs, because until recently there has been a lack of research in this area. Funding agencies have not targeted African-Americans as a particular area of concern for research. Few non-minority researchers have demonstrated ongoing interest in intervention work with African-Americans, and currently less than 3% of National Institute of Health research grants are awarded to African-American researchers. (2)

In a survey of African-American gay and bisexual men in the San Francisco Bay Area, more than 50% reported unprotected anal intercourse, a considerably higher percentage than among white gay men. Those men were more likely to be poor, to have been paid for sex, or to have used injection

drugs; to engage in unprotected sex despite knowing risk of HIV infection; and to report less social support. Men with negative expectations and beliefs about condoms were less likely to use them. (7)

Among African-American adults living in cities with a high prevalence of AIDS cases, almost one-fifth (19%) reported having two or more sexual partners in the past year. More men (30%) than women (10%) reported multiple partners. Substantial proportions of blacks with multiple sex partners used no condoms with either their main (47%) or secondary partners (35%). (8)

What are obstacles to prevention?

Many members of the black community have held an underlying distrust of the white public health world, especially since the Tuskegee Syphilis Study. Some groups, including some African-Americans, believe that the effects of AIDS on the community are the results of deliberate efforts of the US government. Adding to this are persistent inadequacies in social benefits, health care, education and opportunities for African-Americans. Effective prevention programs must address these concerns. (9,10)

Among homosexually active African-American men, including those who self-identify as gay, fear of homophobia and strong attachment to the minority community may have been strong disincentives to respond to AIDS as a primarily gay issue. At the beginning of the epidemic, the absence of national gay leaders and large gay constituencies in the African-American population offered few opportunities to mobilize support. (11)

What's being done?

Not many prevention programs specific to African-Americans have been evaluated for effectiveness, but the number of programs is increasing and there are a few promising studies. An intervention aimed at African-American gay and bisexual men extensively pilot tested all materials including videos that depicted only black men and addressed issues related to the men's same-sex attitudes and behaviors addressed in their own words. Clients who participated in three weekly three hour group sessions greatly reduced (50%) their frequency of unprotected anal intercourse, and maintained the behavior change through an 18-month follow-up. (11)

African-American male adolescents in Philadelphia, PA took part in an intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and weaken problematic attitudes towards risky sexual behaviors. Educational materials included a video narrated by a black woman with a multiethnic cast and "AIDS basketball" where teams earned points for correctly answering AIDS questions. Participants reported less sexual intercourse, fewer partners, and greater use of condoms after the intervention. (12)

Men and women attending an STD clinic in the South Bronx, NY had access to either a video on condom use, or both the video and an interactive group session. Patients were given coupons for free condoms at a pharmacy several blocks from the clinic. Among African-American clients, condom acquisition increased substantially after the video and group session, but not after the video alone. One reason may be that the video primarily targeted behavior change among men. Also, clients who self-identified as Caribbean had lived in the US for a shorter amount of time, and the video may have been embedded in US culture. This study showed that interactive sessions combined with videos can personalize the prevention message and enhance behavior change. (13)

What needs to be done?

Researchers and service providers need a better understanding of the role of cultural and socioeconomic factors in the transmission of HIV, as well as the effect of racial inequality on public

health. In addition, public health officials should consider changing epidemiological surveillance to include other demographic information besides sex, age and ethnicity. These efforts need to influence the design of prevention messages, services and programs.

In the second decade of the AIDS epidemic, few studies of HIV prevention interventions specifically for African-Americans have been conducted or published. (14) Especially lacking are studies of African-American IDUs and gay/bisexual men. (15) A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Effective and equitable HIV research, policy, program and funding efforts are urgently needed in African-American communities. (5)

Says who?

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Prepared by Pamela DeCarlo and John Peterson, PhD

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CDC UPDATE

June 1998

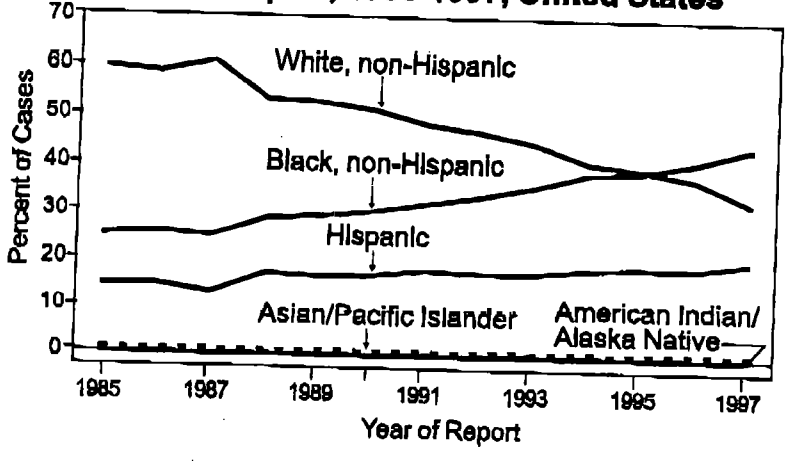
Critical Need to Pay Attention to HIV Prevention for African Americans

In the United States, African Americans have been disproportionately affected by HIV and AIDS. Through December 1997, CDC had received reports of 230,029 cases of AIDS among African Americans. Although that is 36% of the 641,086 cases reported, African Americans represent only an estimated 13% of the total U.S. population.

Researchers estimate that 240,000-325,000 African Americans are infected with HIV. Approximately 1 in 50 African-American men and 1 in 160 African-American women are believed to be infected with HIV. Of those infected with HIV, it is estimated that 93,000 African Americans are living with AIDS.

In 1997, more African Americans were reported with AIDS than any other racial/ethnic group. Of the total AIDS cases reported that year, 45% (27,075) were reported among African Americans, 33% (20,197) were reported among whites, and 21% (12,466) were reported among Hispanics. Among women and children with AIDS, African Americans have been especially affected, representing 60% of all women reported with AIDS in 1997 and 62% of reported pediatric AIDS cases for 1997.

Proportion of AIDS Cases by Race/Ethnicity and Year of Report, 1985-1997, United States



HIV Data Show These Trends Are Continuing

HIV data from a recent CDC study comparing HIV and AIDS diagnoses in 25 states with integrated reporting systems provide a much clearer picture of recent shifts in the epidemic, with a larger percentage of HIV than AIDS cases diagnosed among African Americans, especially women. During the period from January 1994 through June 1997, African Americans represented 45% of all AIDS diagnoses, but 57% of all HIV diagnoses. Among young people (ages 13 to 24), 63% of the HIV diagnoses were among African Americans.

CDC's HIV Prevention Efforts Targeting African Americans

The disproportionate impact of HIV/AIDS on African Americans underscores the importance of increasing prevention efforts in this community. HIV prevention efforts must take into account cultural issues, as well as social and economic factors – such as poverty, underemployment, and poor access to the health care system – that impact many U.S. minority communities. For over a decade, CDC has worked closely with national-, regional-, and community-based organizations to design and implement HIV prevention efforts directed to African Americans. Clearly, the most effective programs are those designed and implemented by the African-American community itself.

CDC is currently supporting, directly or indirectly, hundreds of community-based organizations across the United States in implementing programs and providing HIV prevention services to the African-American community. Programs focus on a wide range of activities, including risk-reduction counseling, street and community outreach, prevention case management services, and efforts to help individuals at risk gain access to HIV testing and treatment and related services.

Additionally, to help establish greater capacity within the African-American community to provide HIV prevention services, CDC has instituted a program to assist national and community-based organizations serving these communities in building the infrastructure needed to deliver HIV testing, counseling, health care, and support services. And because of the critical role the faith community plays in mobilizing community leaders and in reaching and serving the community at large, CDC established a collaboration with the faith community in 1987 as part of multi-sectoral program to encourage positive response to, and participation in, HIV prevention. While the effort began modestly, with direct funding to faith organizations of roughly $100,000 the first year, the program had grown to $500,000 annually by 1994 and to the current funding level of $900,000 in 1997. Roughly half of this initiative currently targets the African-American faith community.

CDC has several major initiatives and numerous research projects designed to reach the African-American community including:

- CDC currently provides $253 million in funding to state and local health departments for HIV prevention programs. Since December 1993, CDC has funded a process designed to put more of the decisions about how these prevention funds are directed in the hands of the communities affected. Under this process, HIV Prevention Community Planning, health

departments are required to establish priorities in conjunction with a planning group that brings together health department staff, representatives of affected populations, epidemiologists, behavioral scientists, service providers, and other community members to identify prevention needs and interventions to meet these needs.

This process helps ensure that HIV prevention efforts are locally relevant and address the unique epidemic and prevention needs of each community.

CDC has conducted several recent assessments to determine what proportion of these funds are used to reach minority populations. While not all programs are targeted by race (some, for example, target high-risk communities such as injection drug users or people being treated in STD clinics, which include individuals from multiple races), it is clear that a significant proportion of funding for major programs, such as counseling and testing and risk reduction programs, are targeted to African Americans. Of programs identified as specifically targeting a racial/ethnic group (representing $143 million), 36% of programs ($52 million) target African Americans. By comparison, 36% target Caucasians, and 22% target Hispanics.

- CDC also directly funds minority and other community-based organizations to design and implement HIV prevention programs that are highly targeted to high-risk individuals within racial and ethnic minority populations. Many serve gay and bisexual men of color or injection drug users as their primary focus. CDC currently provides $18 million to fund 94 community-based organizations through this program. Seventy-one (76%) of these organizations direct their programs to African Americans.

- CDC funds a $9 million program to assist National and Regional Minority Organizations in building capacity to deliver HIV prevention programs and services within these communities. Many of these organizations directly serve the African-American community. Organizations supported through this initiative include the National Organization of Black County Health Officials ($450,000), the National Minority AIDS Council ($455,000), the Association of Black Psychologists ($320,000), the National AIDS Minority Information and Education Program ($291,000), and the National Council of Negro Women ($451,000).

- Last year, to further evaluate the current capacity of community-based organizations serving minority organizations, CDC funded the Harlem AIDS Directors ($400,000) to conduct an assessment to identify unmet needs.

- Additionally, CDC conducts numerous behavioral research projects aimed at reducing HIV infection in the African-American community. For example, the prevention of HIV in Women and Infants Project is a community-level behavioral intervention research project targeting young women ages 15-34. The project is designed to improve the understanding of factors influencing women's behavior changes regarding condom and contraceptive use and to improve the development and delivery of prevention interventions. Another example is the Young African-American Men's Study. This study is a 2-year formative study to prevent HIV/AIDS in young African-American men. Data are being collected in Chicago and Atlanta through interviews, observations, and group discussions with community leaders, health care providers, and young men who have sex with men. In addition to these examples,

there are numerous research projects designed to better understand risk behaviors and design effective interventions for African Americans at highest risk for HIV infection, including injection drug users, women who are partners of injection drug users, individuals with high rates of STDs, and young gay and bisexual men of color.

There is no question that as long as the epidemic continues to spread in the African-American community, these programs must continue, and even more must be done. It is also clear that the public sector alone can not successfully combat HIV and AIDS in the African-American community. Overcoming the current barriers to HIV prevention and treatment requires that leaders in the community acknowledge the severity of the continuing epidemic among African Americans and play an even greater role in combating HIV/AIDS in their own communities.

Du Bois Institute

The Untold Story: AIDS and Black Americas, A Briefing on the Crisis of AIDS among African Americans

Dinner Presentation: Epidemic Update (5-8 minutes)

3/16

I. African Americans are disproportionately affected by HIV and AIDS.

It is estimated that 240,000-325,000 African Americans are infected with HIV. Researchers estimate that 1 in 50 African-American men and 1 in 160 African-American women are infected with HIV.

[Slide 1: AIDS Cases Reported in 1996 and Estimated 1996 Population by Race/Ethnicity, United States]

In 1996, African Americans accounted for about 12 per cent of this country's total population -- but 43 per cent of the reported AIDS cases for the year. At mid-year 1997, the proportion of the total U.S. AIDS epidemic among African Americans was still 43 per cent.

Since the epidemic began, 216,980 African Americans have been reported with AIDS. That is 35 per cent of the cumulative total of 612,078 AIDS cases reported to CDC.

Today it is estimated that, of those infected with HIV, 92,200 African Americans are living with AIDS.

[Slide 2: AIDS cases by race/ethnicity and year of report , 1985 - 1997, U.S.]

From 1985 to 1997, the number of AIDS cases in white, non-Hispanic persons in the U.S. went down. However, AIDS cases in African American and Hispanic persons in the U.S. went up.

II. Let's look at the epidemic broken out into more detailed sub-categories . .

[Slides 3 and 4: Adult/Adolescent AIDS Cases by Exposure Category, by Race/Ethnicity, Reported through 1996, United States]

Proportionately, the greatest number of AIDS cases among African Americans is due to injecting drug use, while exposure to HIV in men who have sex with men is second.

Among men, African Americans had the highest rate of reported AIDS cases in 1996: 177.6 per 100,000. That's 20,199 reported AIDS cases among African American men in 1996 alone.

The rate of reported AIDS cases among African American men in that year was nearly six times the rate among white men and twice the rate among Hispanic men.

[Slide 5: Cumulative AIDS Cases by Cause of Infection in U.S. Men, June

1997]

Since the beginning of the epidemic, the leading reported cause of AIDS among African American men -- 38 per cent - is exposure to HIV in men who have sex with men. A close second reported cause of AIDS in African American men (36 per cent of cases) is exposure to HIV through injecting drug use. Another 8 per cent of cases in African Americans are attributed to men who have sex with men and who also inject drugs.

[Slide 6: Current AIDS Cases by Cause of Infection in U.S. Men, July 1996 - June 1997]

From July 1996 to June 1997, men who have sex with men accounted for 32 per cent of AIDS cases among African American men, while injecting drug use accounted for 31 per cent of African American male AIDS cases.

These risk categories diverge from the causes of AIDS among all men in the U.S. in that the overall epidemic is much more heavily weighted toward men who have sex with men (58 per cent) than injecting drug users (22 per cent)

We are losing members of the African American community to AIDS at the prime of their life. AIDS is the leading cause of death among African American men ages 25-44.

[Slide 7: AIDS Cases in Women by Exposure Category by Race/Ethnicity, Reported through 1996, United States]

For African American women, the rate of AIDS cases is also high compared to their white counterparts. 61.7 of every 100,000 African American women has AIDS.

[Slide 8: Cumulative AIDS cases by Cause of Infection in U.S. Women, June 1997]

Among African American women, since the beginning of the epidemic, the leading reported cause of AIDS is injecting drug use (46 per cent of all cases). The second leading cause is exposure to HIV through heterosexual contact (36 per cent of all cases).

The effect of the AIDS epidemic on women of color in the U.S. (African American and Hispanic women) has been disproportionate compared to white women.

- Although they comprise less than 1/4 of all women in the U.S., women of color account for more than 3/4ths of all AIDS cases.

[Slide 9: Rate of AIDS Among African American Women]

Comparing rates of AIDS by race/ethnicity in U.S. women:

- The rate among African American women is approximately 20 times that of white women.
- The rate among Hispanic women is approximately 7 times that of white women.

And again, we are losing valued members of the African American community, for AIDS is the leading cause of death among African American women ages 25-44.

The effect of AIDS on children of color -- African American and Hispanic -- is also severely disproportionate to its effect on white children.

[Slide 10: Cumulative Pediatric AIDS Cases by Race and Ethnicity, June 1997]

Among children with AIDS, African Americans have been especially affected, representing 58 per cent of reported pediatric AIDS cases.

Among the 609 children (less than 13 years old) newly reported with AIDS from July 1996 through June 1997, 58 per cent were African American. Ninety percent of these cases were a result of mother-to-infant transmission.

[Slide 11: Declines in Death Rates through mid-year 1997]

Not only is the African American community disproportionately affected by AIDS. In addition, the community has not shared in the declining AIDS death rate to the extent that whites have.

From 1995 to 1996, deaths from AIDS declined 32 per cent among whites, but only 13 per cent among African Americans. This may reflect differences in access to care.

III. Why is the African American community so disproportionately affected by HIV and AIDS?

There are some socioeconomic issues at work here:

- Socioeconomic status
- Educational status
- Access to health care
- Substance abuse
- Lack of adequate drug treatment

There are also some cultural issues:

- Homosexuality tabus
- Church - can play an important role in educating community
- Historical mistrust of healthcare community

IV. I would like to talk briefly about CDC programs that specifically address prevention in the African American community:

The disproportionate impact of HIV/AIDS on African Americans underscores the importance of effective prevention programs for the African American community.

CDC has worked for more than a decade with communities to design and implement HIV prevention efforts targeting African Americans. In that time, we have learned that the most effective programs are those designed and implemented by the African American community itself.

Since December 1993, CDC has funded the **HIV Prevention Community Planning process**. This process is designed to put more decisions about prevention fund spending directly in the hands of affected communities. It currently provides $253 million dollars in funding to state and local health departments for HIV prevention programs.

As part of this process, health departments are required to establish priorities in conjunction with a planning group. The planning group brings together health department staff, representatives of affected populations, and others with HIV prevention and treatment expertise. Together, these groups identify prevention needs and interventions to meet the prioritized needs of their locality.

This process helps ensure that each area's HIV prevention efforts are locally relevant and address each community's unique epidemic and prevention needs.

Approximately 36 per cent of community planning dollars, or $52 million, goes to programs targeting African Americans.

This is impressive, but we know this is not enough.

We have tremendous unmet need in HIV prevention. Additional resources are vital – but more money by itself will not solve the problem.

We need to do everything possible to ensure that prevention programs do not

simply target the community – but are also ***from*** the community.

We need to devote more resources to building the capacity for prevention in our communities. And we need to ensure that prevention programs are not only locally designed and implemented – but also scientifically sound and culturally relevant. And we need to ensure that these programs address real needs – those identified through systematic planning.

Now, rather than go into more detail on CDC programs, I would like to leave you with the most important message I think I can give you.

And that is this:

We must all understand that doing something about AIDS in the African American community means taking responsibility, each of us taking ownership of the problem, mobilizing the community, and mobilizing individuals.

I realize that some people are frustrated with the progress that has been made in combating HIV in the African American community. It is hard not to be frustrated when you look at the numbers -- and worse, feel the devastation. I, too, experience frustration. I wish it were in my power to turn things around – but the public sector **alone** cannot successfully combat HIV in the African American community -- nor in any community.

Overcoming AIDS in the African American community will require that community leaders – religious leaders, business leaders, civic leaders, and the

media - acknowledge the severity of the continuing epidemic among African-Americans and play an even greater role in combating HIV/AIDS.

I urge you, as members of the media, to take part in this effort. You can be a driving force . . . by making the topic of AIDS in the African American community a priority, by using your voice and your access to help build trust in the community, by confronting myths and stigma, and by providing responsible and accurate information on the issues to individuals who need it most.

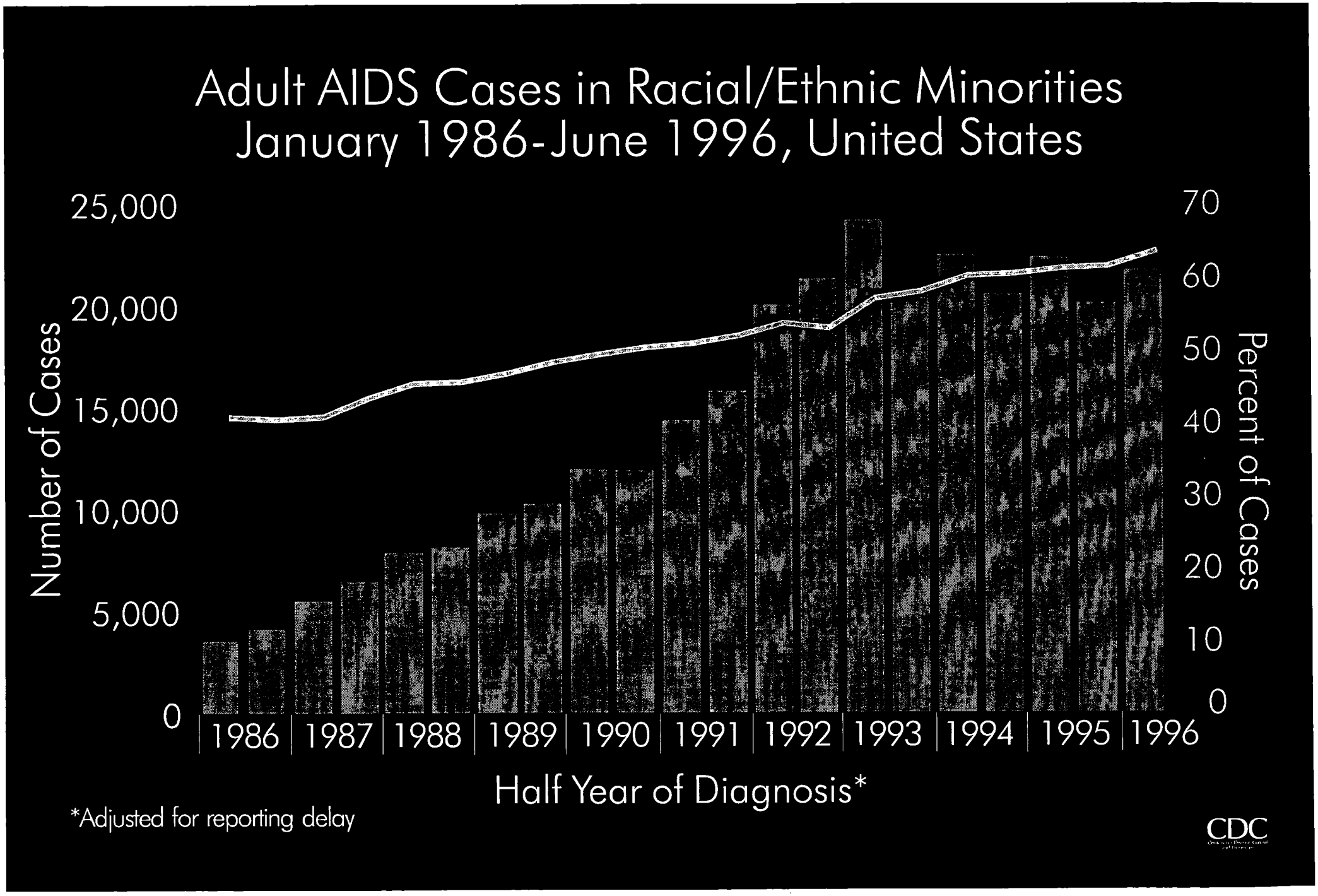
In closing, I would like to leave you with quote.

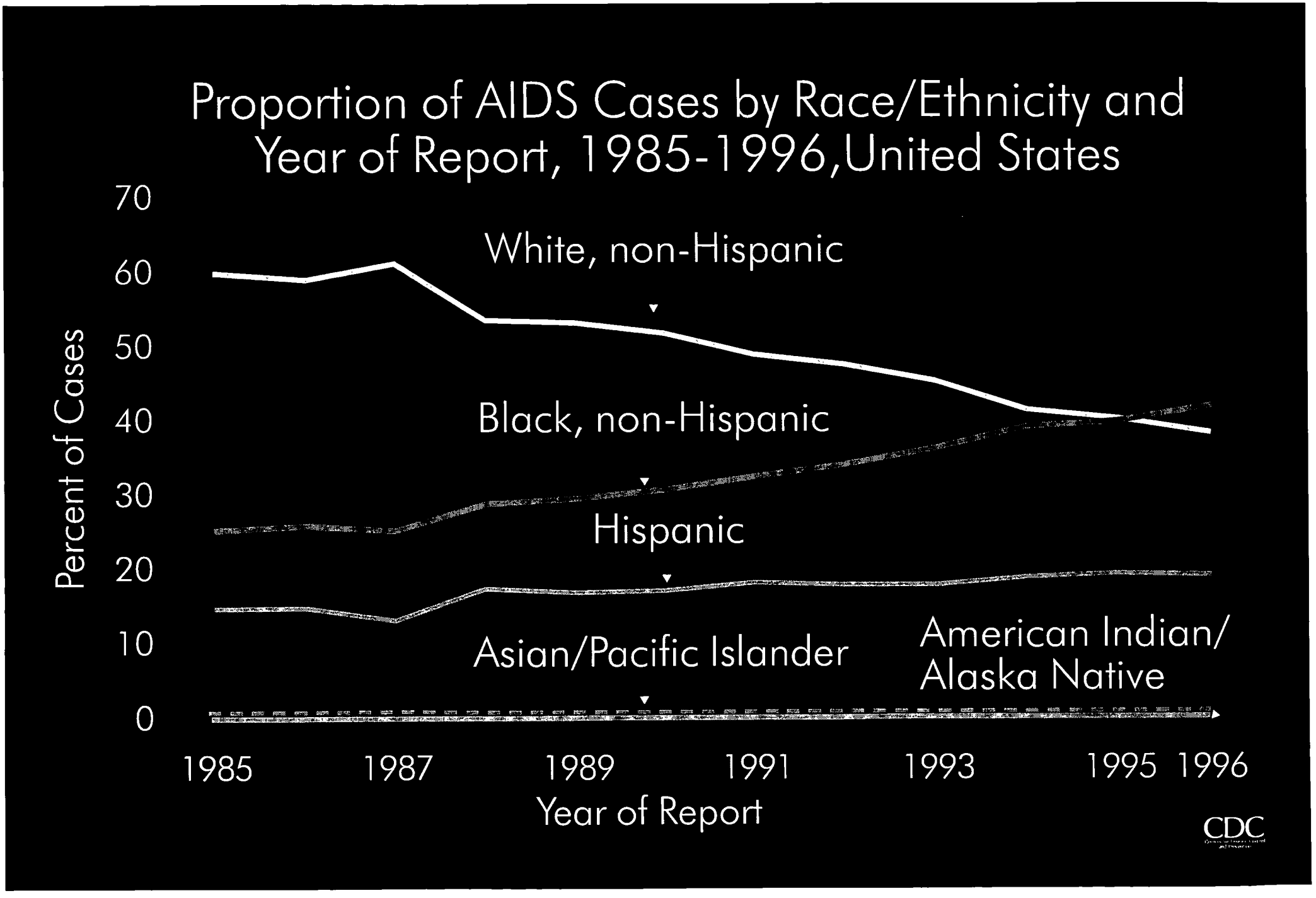
Frederick Douglas said, Without a struggle, there can be no progress."

I urge you to take this to heart as we work together to battle HIV/AIDS in the African American community. I urge you to fully participate in this meeting over the next day - to grasp the urgency of the situation - and to struggle with us to identify solutions.

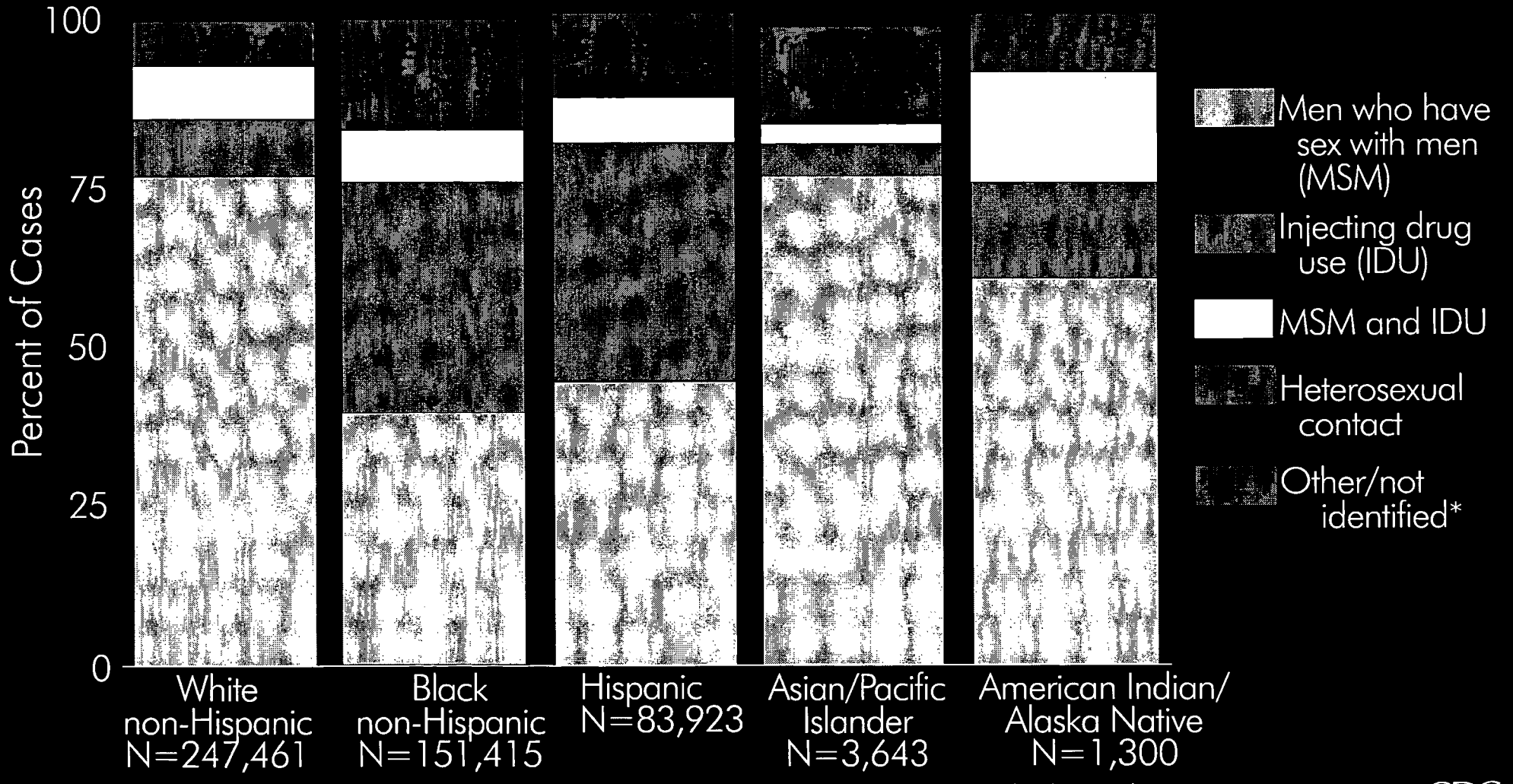
Out of the struggle can come remarkable progress.

Thank you.


Adult AIDS Cases in Racial/Ethnic Minorities
January 1986-June 1996, United States
Number of Cases
25,000
20,000
15,000
10,000
5,000
0
Percent of Cases
70
60
50
40
30
20
10
0
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
Half Year of Diagnosis*
*Adjusted for reporting delay
CDC


Proportion of AIDS Cases by Race/Ethnicity and Year of Report, 1985-1996, United States
Percent of Cases
70
60
50
40
30
20
10
0
White, non-Hispanic
Black, non-Hispanic
Hispanic
Asian/Pacific Islander
American Indian/ Alaska Native
1985
1987
1989
1991
1993
1995
1996
Year of Report
CDC

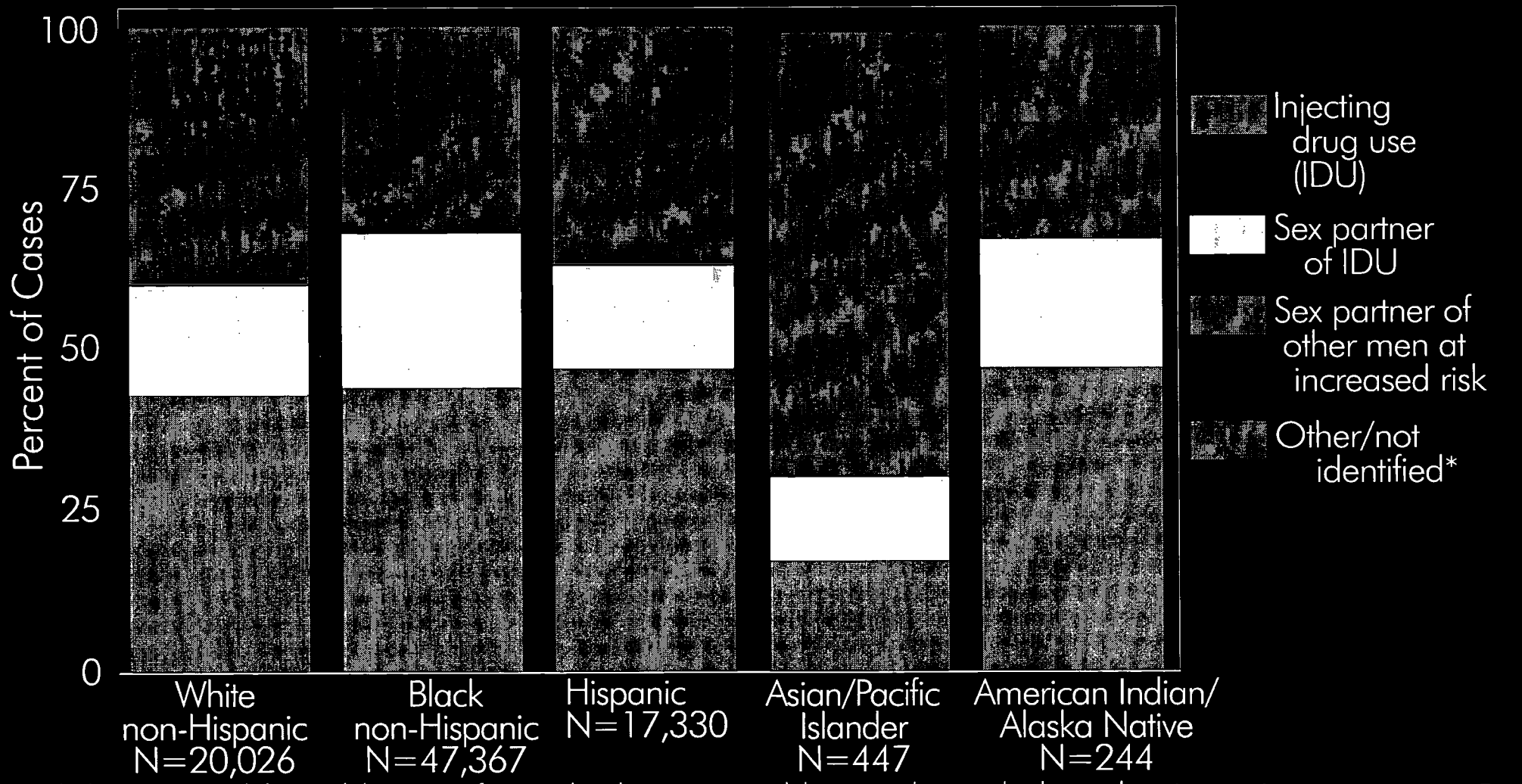
AIDS Cases in Men by Exposure Category by Race/Ethnicity, Reported through 1996, United States



*Includes patients with hemophilia or transfusion related exposures and those pending medical records review; patients who died, were lost to follow-up, or declined interview; and those with an undetermined mode of exposure

CDC

AIDS Cases in Women by Exposure Category by Race/Ethnicity, Reported through 1996, United States



*Includes patients with hemophilia or transfusion related exposures and those pending medical records review; patients who died, were lost to follow-up, or declined interview; and those with an undetermined mode of exposure

CDC

AIDS in Blacks and Hispanics

Of the 581,429 AIDS cases in U.S. residents reported to CDC through 1996, Blacks and Hispanics accounted for

53% of total
76% of women
79% of heterosexuals*
81% of children

Blacks and Hispanics accounted for 61% of AIDS cases reported in 1996.

*Heterosexual injecting drug users and persons with heterosexually acquired HIV

CDC

Adult/Adolescent AIDS Cases by Exposure Category, ! y Race/Ethnicity, Reported through 1996, United States

	White non-Hispanic		Black non-Hispanic		Hispanic	
Exposure category	Number	%	Number	%	Number	%
Men who have sex with men (MSM)	188,022	70	58,795	30	36,928	36
Injecting drug user (IDU)	30,494	11	76,527	38	38,621	38
MSM and IDU	19,590	7	11,568	6	5,635	6
Heterosexual contact	11,315	4	26,221	13	11,774	12
ther/not identified*	18,066	7	25,669	13	8,295	8
Total	267,487		198,780		101,253	

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

CDC

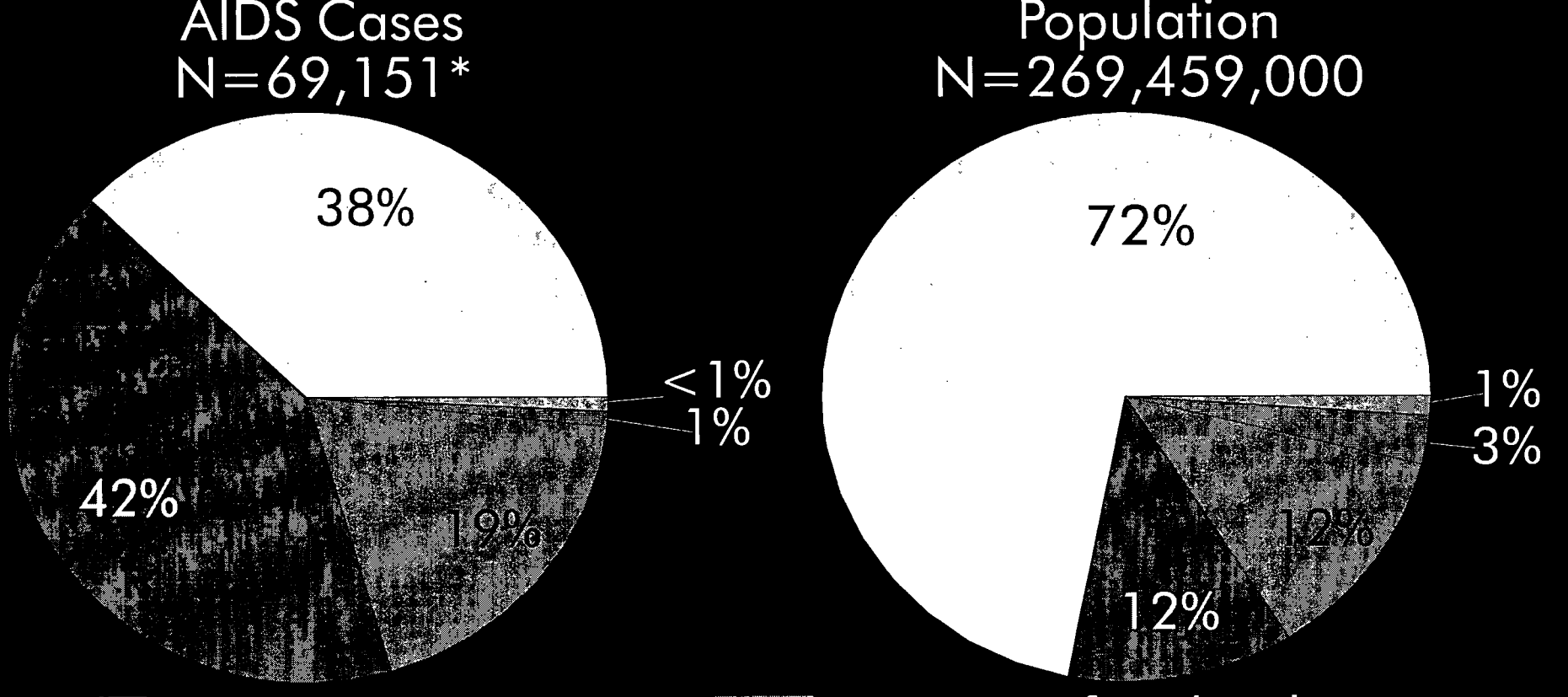
Adult/Adolescent AIDS Cases by Exposure Category, ! y Race/Ethnicity, Reported through 1996, United States

	Asian/Pacific Islander		American Indian/ Alaska Native	
Exposure category	Number	%	Number	%
Men who have sex with men (MSM)	2,768	68	778	50
Injecting drug user (IDU)	264	6	306	20
MSM and IDU	120	3	219	14
Heterosexual contact	296	7	118	8
Other/not identified*	642	16	123	8
Total	4,090		1,544	

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

CDC

AIDS Cases Reported in 1996 and Estimated 1996 Population by Race/Ethnicity, United States



*Includes 166 persons with unknown race/ethnicity

CDC

MEMORANDUM FOR THE VICE PRESIDENT

From: Sandra L. Thurman
Director, Office of National AIDS Policy

Date: July 9, 1998

Subject: **AIDS and the African-American Community**

HIV/AIDS Epidemic Overview

HIV/AIDS is disproportionately impacting African-Americans in the United States. New infections are related primarily to injection drug use (either directly by needle sharing or indirectly through sexual contact with someone who has used drugs). Most new pediatric cases can also be indirectly attributed to drug use among a parent. The stigmatization of young gay and bisexual African-Americans males is believed to contribute significantly to their high risk of infection. A few recent statistics clearly illustrate the problem:

HIV Infections

- 57% of new HIV infections are among African-Americans (these data come from 25 States that require reporting of HIV infections; these are generally low-incidence statesCthe situation is undoubtedly worse in high-incidence states like New York and California that report only AIDS cases)
- These same 25 states reported that recent HIV infections among 13-24 year olds were disproportionately among African-Americans (63%); among women in this age group, 70% of those newly infected were African-American

AIDS Cases

- AIDS is the leading cause of death for Blacks between 25 and 44 years of age
- African-Americans comprise 36% of cumulative AIDS cases and 45% of new AIDS cases in 1997, though they are only 13% of the US population
- 60% of new AIDS cases in women are among African-Americans
- 58% of cumulative pediatric AIDS cases are among African-Americans
- The rate of AIDS in 1997 was 20 times higher among Black women that the rate among white women (and 7 times higher in Hispanic women)

Political Overview

Over the past few months, there has been increasing attention by the Congressional Black Caucus (CBC) and mainstream African-American civil rights organizations on the impact of AIDS on their community. This has been fueled by the Administration's decision on needle exchange. Because injection drug-related infections occur disproportionately among African-Americans and Latinos, confirming that these programs save lives and then withholding Federal

funding for them was perceived as a lack of commitment to addressing AIDS among communities of color.

In a May 15, 1998 letter and press conference, members of the CBC requested that the Secretary of HHS "declare the HIV/AIDS crisis in the black community a 'public health emergency.'" Representatives Maxine Waters and Louis Stokes (who chairs CBC's health committee) have been strong proponents for visible Administrative action on these issues, and have been outspoken in their criticism of the status quo. In part, they believe that a declaration by the Administration of a public health emergency among African-Americans would help them to rally their colleagues and mainstream organizations to become more engaged on AIDS issues.

Julian Bond of the NAACP has subsequently echoed the need for action. In addition, the President's Advisory Council on HIV/AIDS has elevated the impact of HIV/AIDS on African-Americans and Latinos to its top priority at its June meeting.

It is important to recognize that Latino-Americans are also disproportionately impacted by HIV/AIDS, although on a national scale the epidemic is most severe among African-Americans. Other communities of color have been impacted by HIV/AIDS, but to a lesser degree than either African-Americans or Latino-Americans.

NOTE: It is extremely important that we develop a plan for realistically responding to the CBC's very valid concerns. Given the community's unmet expectations surrounding Medicaid expansion and the race initiative, it is imperative that we do not set ourselves up by appearing to either promise something we cannot deliver on or by attempting to do something that will be seen as purely symbolic. In addition, we want to ensure that while we seek to increase attention and resources on HIV/AIDS in the African-American community, we do not create a dynamic of the African-American community versus the gay community in a battle for AIDS funding.

HHS has been working internally to craft a comprehensive response. They have promised us a draft by Friday and I will be sure to update you as soon as the information is available.

Suggestions for the NAACP Speech

You may want to consider the following for inclusion in the upcoming speech to the NAACP:

- an acknowledgment of the disproportionate impact of HIV/AIDS on African-Americans
- a commitment to actively engage this issue and to dialogue with Congressional and community leaders on finding solutions
- a commitment to push for appropriate funding for HIV prevention and care programs serving African-Americans, though this should not be construed as an effort to inappropriately shift funding away from existing programs that are still addressing urgent needs
- a commitment to continue working on increasing the access of poor Americans to quality health care, including those that are living with HIV or AIDS.

HIV/AIDS in the Black and Latino Communities

OVERALL MESSAGE/THEME

The epidemic is not over. While the number of new infections has stabilized, some 40,000 people are newly infected with HIV every year in the U.S.

The epidemic continues to hit hardest in Black and Hispanic populations, and is making greater inroads into the younger population.

IV drug use is fueling the epidemic in Blacks and Hispanics, with sexual activity the second leading cause of infection.

There is no vaccine to prevent AIDS, and no vaccine to cure AIDS, although we are working hard on that.

Black and Hispanic leadership must take on this issue head-on if we are to ever reach our goal of no new infections and ensure that those who need treatment receive it.

We must put more resources and technical assistance in minority community based organizations.

The Administration is committed to addressing the HIV prevention and services needs of racial and ethnic communities.

- **STATISTICS** (from CDC)

Blacks comprise 13% of the U.S. population but 36% of all AIDS cases; Blacks accounted for 45% of all new AIDS cases reported in 1997 alone.

Hispanic comprise and estimated 10% of the U.S. population but 18% of all AIDS cases; Hispanics accounted for 21% of all new AIDS cases reported in 1997 alone.

Minority Hispanic women account for more than 75% of all AIDS cases in women and more than 80% of all AIDS cases in babies are in minority babies.

The epidemic continues to shift to minority individuals.

In the 25 states with HIV reporting in 1997, 45% of all AIDS diagnosis, but 57% of all new HIV diagnosis were in Blacks.

In those states with HIV reporting, the percent of cases in females aged 13 - 24 increased 44% from January 1994 - January 1997.

Of all HIV cases reported in 13 - 24 years old between 1994 and 1997, 63% were Black, and 55% were Hispanic.

Death rate decline vary by racial/ethnic populations. Between 1996 and 1997 the decline was 54% for whites, 37%, for blacks, and 42% for Hispanics.

- **PREVENTION FUNDING**

The U.S. government will spend $634 million on HIV prevention efforts in FY 1998.

CDC states that "prevention allocations are not yet mirroring the epidemic in terms of race/ethnicity or transmission risk".

Of all Counseling, Testing, Referral and Partner Notification funds spent by the States, only 23% was targeted to Blacks (who comprised 43% of all AIDS cases reported between 1996 and 1997).

Funding targeting men who have sex with men accounted for 23% of all funding, but 38% of AIDS cases reported between 1996 and 1997.

Funding targeting heterosexuals accounted for 25% of all funding, but only 14% of all AIDS cases reported between 1996 and 1997.

- **ACCESS TO CARE ISSUES**

Poor people with HIV, who tend to be minority, get into care later, do not get the same quality of care and do not have the same access to treatment as others:

Reasons include:

-- lack of health care insurance;
-- lack of culturally and linguistically sensitive medical professionals, including a lack of minority doctors;
-- lack of trust by minorities in the predominate medical establishment; and
-- belief on the part of doctors that patients will adhere to the treatment regimen.

- **LEADERSHIP ISSUES**

Black and Hispanic communities have been very slow in acknowledging that HIV is a concern.

Neither of the nation's two largest black civil rights groups (Urban League and NAACP) have made AIDS a top national priority.

Social taboos regarding the discussion of homosexuality and drug use means that HIV is not talked about in these communities, especially in Black and Hispanic churches.

HIV is only one of a myriad of issues facing blacks and Hispanics: poorer health in general, unemployment, housing issues, discrimination, drug problems, etc.

Both Black and Hispanic Congressional Caucuses have called for "state of emergency" on HIV/AIDS in minority communities.

Presidential Advisory Council on HIV/AIDS has called for a White House Conference on HIV/AIDS in Racial and Ethnic Populations.

Lack of infrastructure within Black and Hispanic communities to adequately develop and implement successful programs. Technical assistance, and funding, must be increased so that programs can be developed and delivered by organizations and individuals who have the greatest ties to and understanding of the target population.

- **FY 1998 FUNDING**

$634 million on HIV **prevention** efforts.

$1.15 billion on HIV related **services**, not including Medicaid and Medicare.

$1.6 billion on HIV-related **research**, including treatment and HIV prevention **vaccine** efforts.

$204 million for **housing** for people with AIDS.

$1.36 billion on **substance abuse** prevention and treatment (block grant).

- **RACE AND HEALTH INITIATIVE**

Goal is to eliminate by 2010 the disparities which exist between white and minority populations in five health areas:

Infant mortality
Cardiovascular disease
HIV/AIDS
Cancer screening and management
Diabetes

Compliments efforts of Healthy People 2010.

Funding of $400 million to be provided as a start, $30 million of which will go to the Centers for Disease Control and Prevention for grants to community-based organizations (not HIV specific).

Main goal is to make current programs work better, and to determine if the structure of existing efforts is the most appropriate way to address these issues.

Community/non-governmental participation is key to success.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 10 1998

The Honorable Maxine Waters, Chair
Congressional Black Caucus
U.S. House of Representatives
2344 Rayburn Building
Washington, DC 20515

Dear Representative Waters:

Thank you for your letter of May 15, 1998 in which you raised a number of issues concerning HIV/AIDS and its impact on the African-American community. I want to provide you and the Congressional Black Caucus with an update in response to the request that the Department re-examine its current response to the HIV/AIDS epidemic with a particular focus on the needs of the African-American community.

There is no question that the face of HIV/AIDS has changed, and that HIV/AIDS in the African-American and other minority communities, warrants a special and unique response. The Department is in the process of taking a hard look at all of its HIV/AIDS-related programs with a particular focus on CDC's HIV/AIDS/STD prevention initiatives, HRSA's Ryan White care and treatment programs, and SAMHSA's substance abuse prevention and treatment efforts in order to more accurately assess our response.

Our goal is a candid review and assessment of what is happening on the State, local and community levels given the changing nature and demographics of HIV/AIDS. In addition, the Department's review will take into consideration factors other than funding and infrastructure, such as those related to social conditions, economic and community resources, cultural beliefs and perceptions about the health care system in the African-American community. The linkages and collaborations between HIV/AIDS prevention, treatment and substance abuse providers will also be examined.

New technical assistance resources may need to be carefully designed in order to help community based organizations develop the necessary capacity to enhance services to those individuals infected and affected by HIV/AIDS in the African-American community. New partnerships and expanded community collaborations may need to be formed.

Within the next several weeks we plan to discuss with you a detailed strategy which will outline the Department's response. The response will include a two-pronged approach--those items immediately implementable and those items which will require more long-term planning. The scope of what we are undertaking is comprehensive and requires that we take the necessary time to accomplish our shared goals.

I look forward to continuing our dialogue and working with you and the Congressional Black Caucus as we address the HIV/AIDS crisis in the African-American community.

Sincerely,

Donna E. Shalala

Congressional Black Caucus

Congress of the United States

2344 Rayburn Building • Washington, DC 20515 • (202) 225-2201

105th Congress

June 29, 1998

The Honorable Donna Shalala
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

I am in receipt of your letter dated June 10, 1998 in response to our May 15, 1998 letter from the Congressional Black Caucus requesting that you declare the HIV/AIDS crisis in the black community a "public health emergency." In our phone conversation and your subsequent letter, you stated that you would be getting us a detailed response to our request within a few weeks. More than a month and a half has passed since we originally requested this designation.

I understand that you are trying to formulate a meaningful response, but the crisis is frightening and needs an immediate and comprehensive response. Attached please find a copy of an article I am sure you have already read in today's New York Times entitled "Eyes Shut, Black America is Being Ravaged by AIDS." Everyone recognizes that

HIV/AIDS in the black community is a crisis. Again, we request that you make a speedy public health emergency designation. The time to act is now.

Sincerely,

Maxine Waters

Maxine Waters, Chair
Congressional Black Caucus

cc: President William Clinton
Vice President Albert Gore
Surgeon General David Satcher
Mr. Erskine Bowles, Chief of Staff
Ms. Sandra Thurman, Director of AIDS Policy
Ms. Clara Bloom, Acting Director, CDC
Ms. Nelba Chavez, Director, SAMHSA
Mr. Rahm Emanuel, Senior Advisor to the President
Ms. Minyon Moore, Deputy Assistant for Political Affairs
Ms. Janet Murgia, Deputy Assistant for Legislative Affairs
Mr. Broderick Johnson, Special Assistant for Legislative Affairs
Ms. Maria Echaveste, Director of Public Liaison
Mr. Ben Johnson, Deputy Director for Public Liaison

Eyes Shut, Black America Is Being Ravaged by AIDS

By SHERYL GAY STOLBERG

WASHINGTON, June 28 — Seventeen years after AIDS was first recognized among gay white men in New York and San Francisco, the disease in this country is becoming largely an epidemic among black people, quietly devastating families and neighborhoods, yet all but ignored by leading black institutions.

African-Americans make up 13 percent of the United States population. But they account for about 57 percent of all new infections with human immunodeficiency virus, which causes AIDS, according to the Centers for Disease Control and Prevention. Among people age 13 to 24, the estimate, based on data collected from 25 states between January 1994 and June 1997, is even higher: 63 percent.

And while the death rate from AIDS is dropping over all, the disease remains the leading cause of death among black people age 25 to 44. "I don't think there is any question that the epidemic in this country is becoming increasingly an epidemic of color," said Dr. David Satcher, the new Surgeon General.

EPIDEMIC OF SILENCE

A special report.

As thousands of AIDS experts gather in Geneva for the 12th World AIDS Conference, much of the attention is being focused on Africa, where H.I.V. is so prevalent in some regions that one in four adults is infected. The situation in the United States is not nearly as dire; the recent demographic shifts in the domestic epidemic are due more to a sharp drop in cases among whites than an increase among blacks.

Nonetheless, as the racial disparities grow, many worry that AIDS will become marginalized, just another inner-city problem, like crime or drugs or graffiti.

AIDS services have not kept pace with the demographic changes. The lack of education about the disease among poor black people is profound, in large part because few prevention programs have been tailored to them. One prevailing myth is that Magic Johnson, the retired basketball star, has been cured. Another is that only gay men are at risk.

"There is still a disbelief that African-Americans are at risk," said Lisa Gray, who runs an AIDS education program for black women who live in public housing here. "A lot of people don't know how the virus is transmitted."

While ignorance is fueling the spread of the virus, public health experts like Dr. Satcher complain that the epidemic has been greeted with deafening silence by civil rights groups and by black ministers, long an important force in African-American society.

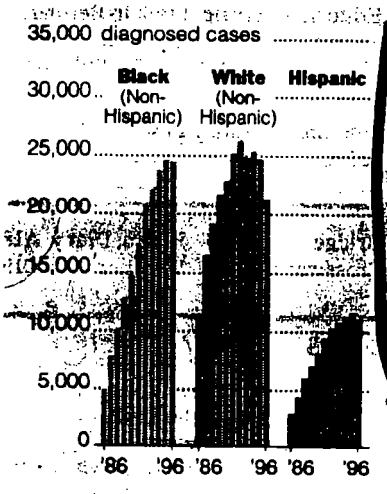
"I grew up in the black church," Dr. Satcher said. "I think the church has problems with the life style of homosexuality. A real problem has been getting ministers that are even willing to talk about it in their pulpits."

One of the few who does is the Rev. Kwabena Rainey Cheeks, the 46-year-old pastor of the Inner

Continued on Page A12

New Face of AIDS

Black Americans are only 13 percent of the population, but they make up nearly half of all AIDS cases.



Source: Centers for Disease Control and Prevention

The New York Times

Eyes Shut, Black Americans Bearing Disparate Share of AIDS Cases

Continued From Page A1

Light Unity Fellowship Church here. AIDS, said Mr. Cheeks, who has been H.I.V.-positive for 14 years, "is like the pink elephant that nobody wants to talk about."

That appears to be true among civil rights leaders as well. The nation's two largest black civil rights groups, the Urban League and the National Association for the Advancement of Colored People, will hold their annual conventions this summer; AIDS is on neither agenda.

"It's outside of our traditional purview," said Lee Daniels, a spokesman for the Urban League. The N.A.A.C.P., which recently declared AIDS a public health crisis, already has a health issue on its conference roster: cancer.

"It's exasperating," said Representative Louis Stokes, the Ohio Democrat who is chairman of the Congressional Black Caucus' health committee. The caucus recently asked the Clinton Administration to declare AIDS a national public health emergency among black people, a move Mr. Stokes said he hoped would rally civil rights leaders. "But," he said, "this is one that black leadership has shied away from."

And it is not only black leaders who are silent. Unlike white gay men, who are extremely open about AIDS and have raised millions of dollars to create powerful organizations to combat the epidemic, most black people who are infected tend to keep the diagnosis a secret, health experts agree. That is due to the disease's twin taboos, which are especially strong among African-Americans: homosexuality and drug abuse.

"When you deal with AIDS you have to deal with all of the issues, all of the -isms of our community," Mr. Cheeks said. "You can't touch AIDS and not deal with homophobia, drug abuse, homelessness. It touches all of the things that people don't want to talk about."

Those perceptions, however, can be misleading. Among black women, who represent 56 percent of the total AIDS cases among females, heterosexual sex has surpassed drug injections as the most common route of transmission. Many have no idea that they are at risk; often, they do not find out they are H.I.V.-positive until they become pregnant, when testing is routine.

They are women like Renee, a statuesque 22-year-old who insisted on being identified only by her middle name. She lives with her 5-year-old son on the top floor of a pretty brick building; the apartment marks her first step out of poverty. A high school dropout, she attends school to learn carpentry and obtain her equivalency diploma.

About a month ago, Renee visited a public health clinic, complaining of a yeast infection. A blood test revealed H.I.V. "This was the last thing on my mind," she said. "I know that I should have used protection, because you can't just look at somebody and know they're not positive. But I just thought, 'Not me.' "

And they are women like Tanya, an office worker who lives in a leafy, middle-class suburb in Prince Georges County, Md. She was tested for H.I.V. in 1994 when, at age 27, she became pregnant.

"Was my partner bisexual?" she asked, speaking on condition that only her first name be used. "Was he a drug user? I don't know because I don't know who infected me."

She guards her privacy. "My boyfriend knows, my mother knows, one or two close friends know," Tanya said. "It's not that I'm ashamed; it's that the stigma against H.I.V. and AIDS is so real."

The Stigma

When Secrecy Delays Treatment

To understand this stigma, and why it harms black people, one need only travel a few short miles from official Washington to the lively but tattered Anacostia neighborhood.

Here, about two blocks apart, are two H.I.V. clinics intended to serve black residents. One is an outpost of the Whitman-Walker Clinic, the city's largest AIDS service organization. Whitman-Walker was founded by gays for gays; about five years ago, it opened this satellite, calling it the Max Robinson Center, after the black newscaster who died of AIDS.

Patients have been slow to come for H.I.V. testing and medical care. The reasons are varied. Many blacks have a deep-seated — and, some experts would say, justified — mistrust of doctors, a legacy of the notorious Tuskegee experiments on black men with syphilis. Poverty is also at work.

"If you can't pay your rent, you can't put food on your table and you don't know how you are going to buy clothes when it's time for school," said Barbara Chinn, the center's executive director, "why do you need to know about another problem that you can't do anything about?"

But there is a third reason, Ms. Chinn acknowledged: Whitman-Walker is so closely associated with AIDS that some people do not want to be seen there. The unassuming clinic two blocks away, tellingly, is called Family & Medical Counseling Services.

"We try to create an environment where clients feel comfortable coming in," said Angela Fulwood, the clinic's director of social services. That is why Renee, the 22-year-old, came here instead of the local hospital, D.C. General. "Everything there was labeled," she said, "and I didn't want anyone seeing me."

That kind of hush-hush attitude, experts say, contributes to the high death rates from AIDS among African-Americans.

When black people delay treatment, they forgo the benefits of new drugs, like protease inhibitors, which do the most good when taken early in the course of infection and which have been credited with reducing deaths among white gay men, said Dr. Eric Goosby, who directs the Federal Office of H.I.V./AIDS Policy.

In addition to his Federal job, Dr. Goosby sees patients one day a week at D.C. General. All are African-American. "I tend to see late-stage disease," he said. "It's a situation where you have somebody you went to junior high school with who is the receptionist at the clinic. Or one of the nurses knows their sister. Or their mother works in the labor and delivery suite. All of this, I have seen at D.C. General."

The Street Fight

Curbing Infection Where It Begins

The public impression of African-Americans with H.I.V. does not include people like Renee or Tanya. Rather, it is that of what might be called the original AIDS epidemic in black people, the one that began in places like the dilapidated city park at the corner of Division and Foote in the southeast section of Washington, across town from the city's glittering monuments.

At this park, there are no tourists, only drug addicts; this is an "open-air market" for heroin. The ground is littered with syringes, broken bottles of cheap wine and crushed fast-food containers. The methadone maintenance clinic is down the block.

On a recent Thursday at noon, an unmarked mobile home pulled up alongside the park. The van is the roving headquarters of the D.C. Needle Exchange Program, one of 120 such programs in the nation and the only one in the District of Columbia.

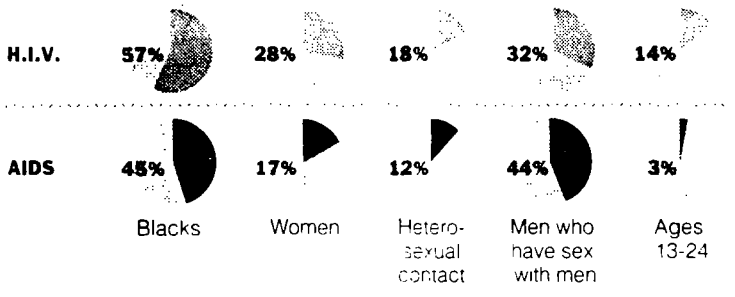
As the AIDS epidemic rages among African-Americans, fueled in part by the sharing of dirty needles, the Clinton Administration recently announced it will not pay for needle exchange programs because they might send mixed messages about drug use to children. The decision disappointed the Government's top scientists, including Dr. Satcher, who say that needle exchange can reduce the spread of H.I.V. and does not encourage drug abuse.

It is a policy that Mr. Stokes describes as "mean-spirited." Yet

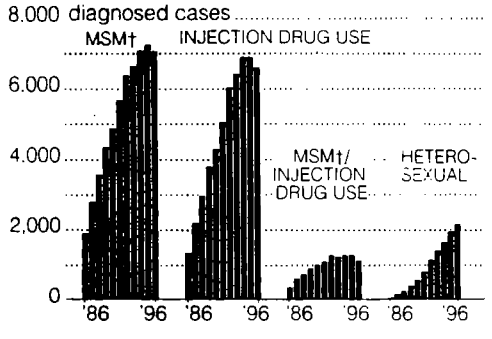
KEEPING TRACK

AIDS and H.I.V Diagnoses

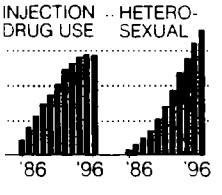
January 1994-June 1997. Percentages of total cases.



AIDS incidence in blacks by risk category in men ...



... and in women.



Source: Centers for Disease Control and Prevention

†Men who have sex with men

The New York Times

Congress is trying to pass a law that would make the financing ban permanent.

Although the van, run by the Whitman-Walker Clinic on behalf of the city, does not open until 1 P.M., dozens of people line up at noon, their pockets overflowing with used syringes. A heavy-set man in a red, blue and yellow jacket is roaming about, mumbling under his breath: "Puff Daddy. Puff Daddy. Puff Daddy." Jamal Spurlock, the van's H.I.V. counselor, explains: The man is selling heroin. Puff Daddy is his brand name.

Mr. Spurlock, a burly 46-year-old in blue jeans and a striped Oxford cloth shirt, tries to persuade the exchange participants to be tested. He performs the tests, using a new oral method. Last year, 220 people were tested; Mr. Spurlock estimates that 20 to 30 percent were H.I.V. positive. Many of the addicts, he says, share dirty needles in spite of the exchange. Others trade drugs for sex.

Among them is Raymond, who will give only his first name. This is his first time using the needle exchange; he stumbles onto the van, barely able to keep his head up and his eyes open. When Raymond agrees to be tested, Mr. Spurlock ushers him to the back of the van, shuts a curtain and begins running through his usual questions: Have you placed yourself in any risky situations? Any unprotected sex? Sharing needles? Ever exchanged drugs for sex?

Raymond's head bobs and weaves; his brow beads with sweat. "I'm starting back to a reckless life style," he confesses. He has been sharing needles, he says, and he does not use condoms. He would like to quit using heroin, but at 50, he thinks he is too old to change. "Sometimes," he said sadly, "it just seems so hopeless."

Testing and counseling people like Raymond is extremely important for the health of the entire community, AIDS experts say. H.I.V. is spread through sexual networks; as the cases of Renee and Tanya demonstrate, the epidemic is now ensnaring people far removed from the heroin trade. If Raymond can be persuaded to adopt safer sex practices, countless other infections might be prevented, said Dr. Ronald Stall, associate professor of epidemiology at the University of California at San Francisco.

"By stopping those infections," Dr. Stall said, "you are really keeping all those snowballs from going down the hill and causing an avalanche."

But a lot of snowballs have already gone down the hill in black America. One reason, Dr. Satcher said, is that the big AIDS organizations, groups with their roots in the gay community, still receive the lion's share of AIDS money because they are more sophisticated at writing grants. Small grass-roots organizations, which may be more effective at reaching minority groups, have trouble surviving. In Washington, three have folded in the past three years.

In an effort to correct this, the Centers for Disease Control, which gives $253 million a year to state and local governments for H.I.V. prevention, has for four years been bypassing its own rules to give directly to groups that focus on minorities. This year, $18 million was awarded; three-quarters of the recipients gear their programs to African-Americans.

But, the Surgeon General said: "Don't hear me as defending what we are doing as adequate. I think we have got to do better."

Spreading the Truth

Programs Bring The Lesson Home

Lisa Gray is trying to do better. She is the co-founder of a tiny group called Friends for Friends, which got its start three years ago handing out condoms in Washington subway stations. A stocky 33-year-old black woman, she was a retail manager for a local music chain when several friends and family members became infected with H.I.V. So she went to the Red Cross for training as a prevention counselor.

Last year, Ms. Gray's group won a grant from the disease control centers to teach black women who live in public housing how to prevent H.I.V. The grant is for $50,000, more than twice Friends for Friends' annual budget. The idea is to train the women to hold seminars, so that they can educate friends and neighbors. Ms. Gray calls this "infecting people with information."

And so, on a recent Friday morning, she has come to Capitol East Dwellings. Five women, age 22 to 51, are seated in metal chairs around a folding table in the recreation center, a downtrodden brick building with peeling paint and chipped tile floors. It is the third weekly session of a five-week course.

Hand-written posters are taped to the walls, bearing unfamiliar words: immunodeficiency, pneumocystic carinii pneumonia, seropositive. On a table behind Ms. Gray are condoms, wooden penises, for teaching the women how to put the condoms on, and a television, for watching a video that will teach the delicate art of "safe sex negotiation."

Each woman here knows at least one person infected with H.I.V. The oldest, Catherine Smith, a modest 51-year-old in a peach pantsuit, says she came to learn what to tell her children and grandchildren.

The youngest, Nureeah Brown, a 22-year-old with two children, ages 6 and 3, said the death of her daughter's father troubled her. "It was said he passed from AIDS," she said, although no one is really sure.

The previous week, she said, she cooked dinner for a young man she knows. He took his shoes off and began to get a little friendly. "He was like, 'What you be doing on Friday?' " Ms. Brown said. "I said, 'I'm glad you asked.' And then I went and got my little pamphlet" — a Friends for Friends brochure with a condom tucked inside and the saying, "No Glove, No Love."

Ms. Gray, upon hearing this, is clearly pleased. But neither she, nor anyone else, knows if the Friends for Friends program will work.

"We know that educating people about safe approaches to sex is very helpful," Dr. Satcher says. But few programs have been studied enough to be proved effective.

Over the next five years, as part of President Clinton's plan to eliminate racial disparities in disease by the year 2010, the Government has proposed spending $400 million on model community programs. Part of the money would be set aside for AIDS, although Dr. Satcher acknowledged that it may be too optimistic to think the epidemic's racial disparities can be eliminated in just 12 years.

"It is a long-term proposition," the Surgeon General said. "There is no immediate fix."

The Washington Spectator

Ben A. Franklin, Editor

(ISSN: 0887-428X)

July 1, 1998 Volume 24, No. 13

THE N.A.A.C.P.

The Oldest and Largest Civil Rights Organization Gets Going Again

Julian Bond, a son and grandson of black intellectuals and civil rights activists (his grandfather was born a slave) and a lifetime activist himself, spoke rapidly and eloquently at Washington's National Press Club a month ago. His view of where we're at on civil rights—and where we're not—is a comprehensive summary by someone who's been in the struggle for most of his 58 years.

It is particularly relevant because Bond, now gray-haired and a part-time professor of history and government at both the University of Virginia in Charlottesville and at American University in Washington, was elected chairman of the board of the National Association for the Advancement of Colored People (N.A.A.C.P.) in February.

Taking on that unpaid job has brought Bond back into the public eye. He'd gradually vanished from view after his nomination as a candidate for Vice President of the United States at the tumultuous Democratic National Convention in 1968. It was a '60s protest action. At 28, he could not have served, even if nominated and elected. The Constitution says he would have had to be 35.

The N.A.A.C.P. presents Bond with a serious challenge. Under the day-to-day supervision of former Representative Kweisi Mfume (D-MD), the association has begun to make a comeback from years of internal tumult and decline. Mfume, who was until 1996 the influential head of the Congressional Black Caucus and is now the N.A.A.C.P. president and chief executive, has ended its financial crisis and revived its voter turnout program. But as Bond points out in the following abstract of his hour-long talk, it has a way to go. "You can't rely on what you did in the '60s," he says. "In this fight you renew your credentials every day." Bond and Mfume are working together to renew the credentials of the N.A.A.C.P., now almost 90 years after its founding.

Bond covered some largely forgotten history in his talk. He gave it an ironic title that takes account of the meager ration of citizens' rights and human dignity given many black Americans today. He called it "Civil Rights, Now and Then"—not "Civil Rights, Then and Now."

By Julian Bond

At the turn of the century, the great scholar and activist W.E.B. DuBois predicted that the problem of the 20th century would be the problem of the color line. Not only was he right, but now—just short years away from the century's end—we regrettably conclude that it will also be the problem of the century to come. Everywhere we see clear racial fault-lines which divide American society as much now as at any time in the past. Those fault lines are everywhere.

My organization, the National Association for the Advancement of Colored People, the N.A.A.C.P., was founded in 1909, and we are fighting on today. But the picture we see is also not without its brighter side.

Taken over several decades, rather than in snapshot moments, the portrait we see shows clear progress through this century. No more do signs read "White" and "Colored." The voters' booth and schoolhouse door now swing open for everyone. Despite popular thinking to the contrary, the battle to preserve affirmative action is being won, not lost.

But for many, despite these successes, today's civil rights scene must seem like an echo of the past. Many stand now in reflection of that earlier movement's successes, confused about what the next steps ought to be. The task ahead of us is an enormous one, equal to, if not greater than, the job already done.

As we recall the struggles of the recent past, many of us are confused about what the movement's aims and goals were, what it accomplished, where it failed and what our responsibilities are to complete its unfinished business today. Seeking more than the removal of racial segregation, that movement did not want to be integrated into a burning house. Rather it wanted to build a better house for everyone.

The N.A.A.C.P.'s founding gave the movement an organized base. It soon developed an aggressive strategy of litigation aimed at striking down racial restrictions enshrined in law, triumphing in 1954 with the Supreme Court's decision, in *Brown v. Board of Education*, ending segregation in

N.A.A.C.P. Goals, Then and Now

"We propose to work. These are the things that we as black men must try to do: To press the matter of stopping the curtailment of our political rights; to urge Negroes to vote honestly and effectively; to push the matter of civil rights; to organize business cooperation; to build schoolhouses and increase the interest in education; to bring Negroes and labor unions into mutual understanding; to study Negro history; to attack crime among us; . . . to do all in our power, by word and deed, to increase the efficiency of our race, the enjoyment of its rights, and the performance of its just duties."

—W.E.B. DuBois, the noted black scholar, in 1905

public schools. That decision effectively ended segregation's legality. But it also gave a nonviolent army the license to challenge segregation's morality as well.

From 1954 forward, the movement expanded its targets, its tactics and its techniques. Its organizations and leadership expanded too. In Alabama, the Montgomery bus boycott in 1955 introduced a new leader, the Rev. Dr. Martin Luther King, Jr., and he began to articulate a new method of fighting segregation—nonviolent resistance.

The new method required mass participation. Reliance on slower appeals through the courts began to subside. In this period gains were won at lunch counters, movie theaters, bus stations, polling places and the fabric of legal segregation began to come undone. Before it slowed, it was our democracy's finest hour.

DISCRIMINATION PERSISTS—But despite impressive increases in the number of black people holding public office, despite our ability to sit, eat, ride, vote and go to school in places that used to bar black faces, in some important ways non-white Americans face problems more difficult to attack now than in all the years that went before.

Much of the origin of today's distresses are found in the recent past and came to climax in the 1980s. Over time, opposition to big government succeeded opposition to Communism as a secular religion. The United Nations, Washington bureaucracy, gays and lesbians, supporters of minority and women's rights—these replaced the Soviet Union as "the evil empire."

Together they drove the callous coalition that captured Congress in 1994. But as long ago as 1964, Republicans had begun to remake their party as the white people's party, and they found a winning formula at the intersection of race and opposition to activist government.

In the late 1960s, three-quarters of all black men were working. By the end of the 1980s, only 57 percent had a job. Today a significant portion of our population faces permanent privation. Today the net financial assets of black families in which one member has a post-graduate degree are lower than the assets of white families in which the highest level of education achieved is elementary school.

Within a few short years, the growing number of blacks, other minorities and women pushing for entry into, and power in, the academy, the media, business, government and other traditionally white male institutions created a backlash in the discourse on race. The previously privileged majority exploded in angry resentment at having to share space with the formerly excluded.

Opinion leaders began to reformulate and redefine the terms of the discussion. Any indictment of white America could be abandoned. Black people did it—did it to the country, did it to themselves. Black behavior, not white racism, become the reason why blacks and whites lived in separate worlds. The burden of racial problem-solving shifted from its creators to its victims.

AFFIRMATIVE ACTION—This exaggeration of "the other"—this blame-shifting and role reversal, where the victim becomes the perpetrator, where the minority becomes the majority—this perversion of reality occurred as a result of an organized campaign which continues until this day.

It is led by a curious mix of whites and a few blacks, academics and journalists. Its aim is the demobilization of effective insurgent politics and the adoption of reactionary and punitive social policy. Its adherents profess strong support for equal rights, while they oppose every tool designed to achieve that goal.

They attack and discredit affirmative action, not only because it threatens ancient white-skin privilege but because it serves as a handy symbol of despised government intervention. For these new racists, equal opportunity is the burden society can't afford to bear. Their less-than-subtle message is that including blacks and women excludes quality.

The strategies of the sixties movement were litigation, organization, mobilization—all aimed at creating a national constituency for civil rights advances. In the 1970s, electoral strategies began to dominate. The numbers of locally elected black officials began to multiply. And their multiplication coincided with the decline in political party organization.

The crucial tasks of registering and turning out the newly enfranchised electorate were left to organizations like the N.A.A.C.P. Other stalwarts of the 1960s—CORE, the Congress of Racial Equality; SNCC, the Student Nonviolent Coordinating Committee; and the S.C.L.C., the Southern Christian Leadership Conference—experienced decline or simply disappeared.

Dr. King lost his life supporting a garbage-workers' strike in Memphis. The right to decent work at decent pay remains as basic to human freedom as the right to vote. Negroes, King said in 1961, are almost entirely a working people. There were pitifully few Negro millionaires and few Negro employers. That there are many, many black millionaires today is a tribute to the movement King led. That there are proportionately fewer black people working today is an indictment of our times and our economic system, a reflection of our failure to keep the movement coming on.

Everywhere, black Americans face conditions different from but just as daunting as the back seats of the bus, the fire hoses and the billy clubs of three decades ago.

In America today, a black child is one and a half times

The Washington Spectator

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more likely to grow up in a family whose head did not finish high school than is a white child; two times as likely to be born to a teenage mother; two and a half times more likely to be born at low birth weight; three times more likely to live in a single parent home; four times more likely to have a mother who had no prenatal care; four and a half times more likely to live with neither parent; five times as likely to depend solely on a mother's earnings; and nine times as likely to be a victim of homicide as a teenager or a young adult.

Now, over the last 30 years—the period of the second Reconstruction—the most effective tool for advancing entry into the mainstream has been those two magic words, affirmative action. The opponents now try to tell us that it doesn't work, or it used to work but it doesn't work now. Or we used to need it, but we don't need it now. Or when it does work, it only helps people who don't need it at all.

Affirmative action isn't about preferential treatment for blacks; it's about removing preferential treatment whites have received through history and giving equal treatment to people who were denied equality in the past. And it's not a poverty program. It ought not be blamed for failing to solve problems it was not designed to solve. It's a program designed to counter racial discrimination, not poverty.

In the late 1960s the wages of black women in the textile industry tripled. From 1970 to 1990 the number of black police officers doubled, the number of black electricians tripled, the number of black bank tellers quadrupled.

These are not just numbers. They represent the growth and the spread of the tiny middle class I knew as a boy to a stable one-third of all black Americans today. Men and women with jobs and homes, productive tax-paying citizens able to provide for their families now and in the future.

Those who would have us believe otherwise, who argue for a return to a color-blind America that never was, who would have us believe that their opposition to affirmative action is rooted in a desire for fairness and equality—these people are engaged in justification, rationalization and downright prevarication.

These people just won't quit. They like to argue that affirmative action stigmatizes all black people, making the beneficiaries and all others feel as if they have received some benefit they don't deserve.

A LEGACY TO REMEMBER—We look back on the movement of yesterday—and one reason we're unable, seemingly, to "overcome" today is the way in which we examine that movement. For most of us, King is little more than a grainy image seen in black-and-white television pictures taken here in Washington three and a half decades ago, a gifted preacher who had a dream. But he of course was much more than that. And the movement was more than King.

He's not the only soldier missing from the freedom fight. He didn't march from Selma to Montgomery by himself. He didn't speak at the March on Washington to an empty field. There were thousands marching with him and before him, and thousands more who did the dirty work that preceded the triumphant march. That movement succeeded because the victims became their own best champions.

For too many people, the fight for equal justice has become a spectator sport, a kind of National Basketball Association, in which the players are black and the spectators are white.

The current civil rights scene in America is dismal but not without hope. The N.A.A.C.P. has revived itself. It is preparing for the challenges that lie ahead. The revival includes financial recovery and a reordering of internal procedures to make the board of directors I head into a more efficient and effective policy-making body.

We intend to do the old things better. Our charge is the same: to fight discrimination wherever it raises its ugly head—in the halls of government, in the schools or in the streets. We reaffirmed our commitment to an integrated education as the best education America's children can receive.

We joined the Congressional Black Caucus in asking President Clinton to declare the AIDS epidemic a national disaster. We asked the president to swiftly nominate, and Congress to swiftly consider, candidates for the appallingly large number of federal court vacancies.

We announced an employment-discrimination litigation project, a police–citizen anti-violence project, and anti-defamation initiatives.

African-Americans will soon no longer be the nation's largest minority, but by the year 2050 blacks and Hispanics together will make up 40 percent of the national population. Where there are others who share our condition, even if they do not share our history, we intend to make common cause with them.

There's a place for everyone in the N.A.A.C.P. There are no racial, gender or religious barriers to membership in this organization. Anyone who supports our values is more than welcome. Colored people come in all colors in this country. We move forward fastest when we move forward together. We can't afford to leave a single soul behind.

We agree, and readers interested in joining the N.A.A.C.P. can reach the national membership office at 1-800-622-2755, or by writing to 4805 Mt. Hope Drive, Baltimore, MD 21215. Basic membership is $10 a year, or $15 with a subscription to the magazine *Crisis*.

Congressional Black Caucus

Congress of the United States

2344 Rayburn Building • Washington, DC 20515 • (202) 225-2201

105th Congress

June 29, 1998

The Honorable Donna Shalala
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

I am in receipt of your letter dated June 10, 1998 in response to our May 15, 1998 letter from the Congressional Black Caucus requesting that you declare the HIV/AIDS crisis in the black community a "public health emergency." In our phone conversation and your subsequent letter, you stated that you would be getting us a detailed response to our request within a few weeks. More than a month and a half has passed since we originally requested this designation.

I understand that you are trying to formulate a meaningful response, but the crisis is frightening and needs an immediate and comprehensive response. Attached please find a copy of an article I am sure you have already read in today's New York Times entitled "Eyes Shut, Black America is Being Ravaged by AIDS." Everyone recognizes that

HIV/AIDS in the black community is a crisis. Again, we request that you make a speedy public health emergency designation. The time to act is now.

Sincerely,

Maxine Waters

Maxine Waters, Chair
Congressional Black Caucus

cc: President William Clinton
Vice President Albert Gore
Surgeon General David Satcher
Mr. Erskine Bowles, Chief of Staff
Ms. Sandra Thurman, Director of AIDS Policy
Ms. Clara Bloom, Acting Director, CDC
Ms. Nelba Chavez, Director, SAMHSA
Mr. Rahm Emanuel, Senior Advisor to the President
Ms. Minyon Moore, Deputy Assistant for Political Affairs
Ms. Janet Murgia, Deputy Assistant for Legislative Affairs
Mr. Broderick Johnson, Special Assistant for Legislative Affairs
Ms. Maria Echaveste, Director of Public Liaison
Mr. Ben Johnson, Deputy Director for Public Liaison

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 10 1998

The Honorable Maxine Waters, Chair
Congressional Black Caucus
U.S. House of Representatives
2344 Rayburn Building
Washington, DC 20515

Dear Representative Waters:

Thank you for your letter of May 15, 1998 in which you raised a number of issues concerning HIV/AIDS and its impact on the African-American community. I want to provide you and the Congressional Black Caucus with an update in response to the request that the Department re-examine its current response to the HIV/AIDS epidemic with a particular focus on the needs of the African-American community.

There is no question that the face of HIV/AIDS has changed, and that HIV/AIDS in the African-American and other minority communities, warrants a special and unique response. The Department is in the process of taking a hard look at all of its HIV/AIDS-related programs with a particular focus on CDC's HIV/AIDS/STD prevention initiatives, HRSA's Ryan White care and treatment programs, and SAMHSA's substance abuse prevention and treatment efforts in order to more accurately assess our response.

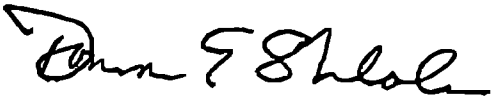
Our goal is a candid review and assessment of what is happening on the State, local and community levels given the changing nature and demographics of HIV/AIDS. In addition, the Department's review will take into consideration factors other than funding and infrastructure, such as those related to social conditions, economic and community resources, cultural beliefs and perceptions about the health care system in the African-American community. The linkages and collaborations between HIV/AIDS prevention, treatment and substance abuse providers will also be examined.

New technical assistance resources may need to be carefully designed in order to help community based organizations develop the necessary capacity to enhance services to those individuals infected and affected by HIV/AIDS in the African-American community. New partnerships and expanded community collaborations may need to be formed.

Within the next several weeks we plan to discuss with you a detailed strategy which will outline the Department's response. The response will include a two-pronged approach--those items immediately implementable and those items which will require more long-term planning. The scope of what we are undertaking is comprehensive and requires that we take the necessary time to accomplish our shared goals.

I look forward to continuing our dialogue and working with you and the Congressional Black Caucus as we address the HIV/AIDS crisis in the African-American community.

Sincerely,



Donna E. Shalala

Congressional Black Caucus

Congress of the United States

2344 Rayburn Building • Washington, DC 20515 • (202) 225-2201

105th Congress

June 1, 1998

The Honorable Donna Shalala
Secretary of Health & Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Secretary Shalala:

On May 15, 1998, we sent the attached formal request to you to request "that you declare the HIV/AIDS crisis in the black community a 'public health emergency'." To date, I have not received a response from your office.

Please advise me of your decision or when your decision will be made so that I may let the organizations know the results. As you can imagine, we are anxiously awaiting your response to this correspondence.

Thank you in advance for your swift attention to this matter.

Sincerely,

Maxine Waters

Maxine Waters, Chair
Congressional Black Caucus

Congressional Black Caucus

Congress of the United States

2344 Rayburn Building • Washington, DC 20515 • (202) 225-2201

May 15, 1998

The Honorable Donna Shalala
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

Pursuant to 42 U.S.C. § 247(d), the Congressional Black Caucus (CBC) hereby requests that you declare the HIV/AIDS crisis in the black community a "public health emergency." By making such a declaration, you, as the Secretary acting through your agency heads, "may take such action as may be appropriate to respond to the public health emergency...."

As discussed more fully below, the CBC in consultation with HIV/AIDS activists and HIV/AIDS healthcare providers nationwide, believe that the AIDS crisis in the black community must be addressed as a public health emergency.

The Crisis

AIDS is now the leading cause of death among African Americans, age 25 to 44. According to the Kaiser Family Foundation, blacks now represent 35 percent of all reported cases and 43 percent of new cases, even though African Americans comprise only 12 percent of the population. The annual AIDS case rate for African American men is 6 times that of white men and for African American women it is 16 times that of white women.

Moreover, an alarming 1 in 50 African American men and 1 in 60 African American women are infected with HIV. The numbers are even more devastating when we look at HIV infection from the use of tainted

needles. Of the 8 persons who are directly or indirectly infected with HIV through the use of contaminated needles every day, 5 are African Americans or Latinos.

Racial and ethnic minorities together account for over 54% of the total AIDS cases reported since the beginning of the epidemic. Latinos account for 18% of the total AIDS cases. Sixty-three percent of new AIDS cases in children under 13 years of age are African American.

CBC Meeting with AIDS/HIV Organizations

On May 11, 1998, the CBC called an emergency meeting with over 60 HIV/AIDS Activists and HIV/AIDS healthcare providers from around the country, including San Francisco, Los Angeles, Atlanta and New York, to hear first-hand the impact HIV/AIDS is having on our communities, the nature of their programs and the services they provide to their HIV/AIDS clients and the steps they believed were necessary to address the HIV/AIDS crisis in our communities.

The organizations were elated that the CBC called this national meeting to sound the alarm over the crisis. They all agreed with your assessment that there, indeed, is an emergency regarding the AIDS crisis in the black community. They also agreed that the statistics are consistent and reflect the experiences they encountered in trying to serve their clients.

We also identified the following problems in the AIDS healthcare delivery system that impede the ability to adequately address the crisis:

- There is a need to integrate substance abuse treatment with HIV prevention and care.
- There currently is no strategy to deal with HIV infected prison populations either inside of prison or after they are discharged.
- The resources are not connected with the epidemic. There needs to be technical assistance and a reform of the planning process so that the funding follows the epidemic.

- There is a need to spearhead a comprehensive strategy to engage our leadership and the federal government to combat anti-gay bias.

- African American women and children make up the fastest growing AIDS/HIV caseload. AIDS/HIV resources and strategies must be targeted towards them.

- There is an absence of healthcare professionals and researchers with an interest and commitment to serve African American communities.

Next Step

Our meeting concluded with 100 percent agreement that there is an HIV/AIDS emergency in our communities. Therefore, we believe it is urgent and necessary for a formal declaration of a public health emergency.

We are prepared to meet with you to further discuss what we believe are steps necessary to address the crisis.

Sincerely,

Maxine Waters

Maxine Waters, Chair
Congressional Black Caucus

cc: President Clinton
Vice President Gore
Members of Congress
Members of Black Leadership Forum
Meeting Attendees
Mr. Erskine Bowles
Mr. Thurgood Marshall, Jr.

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Congressional Black Caucus

Congress of the United States

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105th Congress

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U.S. Senate
Carol Moseley-Braun, IL - '93

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Washington, D.C. 20201

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cc: President Clinton
Vice President Gore
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Mr. Erskine Bowles
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LEVEL 1 - 1 OF 1 STORY

The New York Times

June 29, 1998, Monday, Late Edition - Final

SECTION: Section A; Page 1; Column 1; National Desk

LENGTH: 2725 words

HEADLINE: EPIDEMIC OF SILENCE: A special report.;
Eyes Shut, Black America Is Being Ravaged by AIDS

BYLINE: By SHERYL GAY STOLBERG

DATELINE: WASHINGTON, June 28

BODY:

Seventeen years after AIDS was first recognized among gay white men in New York and San Francisco, the disease in this country is becoming largely an epidemic among black people, quietly devastating families and neighborhoods, yet all but ignored by leading black institutions.

African-Americans make up 13 percent of the United States population. But they account for about 57 percent of all new infections with human immunodeficiency virus, which causes AIDS, according to the Centers for Disease Control and Prevention. Among people age 13 to 24, the estimate, based on data collected from 25 states between January 1994 and June 1997, is even higher: 63 percent.

And while the death rate from AIDS is dropping over all, the disease remains the leading cause of death among black people age 25 to 44. "I don't think there is any question that the epidemic in this country is becoming increasingly an epidemic of color," said Dr. David Satcher, the new Surgeon General.

As thousands of AIDS experts gather in Geneva for the 12th World AIDS Conference, much of the attention is being focused on Africa, where H.I.V. is so prevalent in some regions that one in four adults is infected. The situation in the United States is not nearly as dire; the recent demographic shifts in the domestic epidemic are due more to a sharp drop in cases among whites than an increase among blacks.

Nonetheless, as the racial disparities grow, many worry that AIDS will become marginalized, just another inner-city problem, like crime or drugs or graffiti.

AIDS services have not kept pace with the demographic changes. The lack of education about the disease among poor black people is profound, in large part because few prevention programs have been tailored to them. One prevailing myth is that Magic Johnson, the retired basketball star, has been cured. Another is that only gay men are at risk.

"There is still a disbelief that African-Americans are at risk," said Lisa Gray, who runs an AIDS education program for black women who live in public

housing here. "A lot of people don't know how the virus is transmitted."

While ignorance is fueling the spread of the virus, public health experts like Dr. Satcher complain that the epidemic has been greeted with deafening silence by civil rights groups and by black ministers, long an important force in African-American society.

"I grew up in the black church," Dr. Satcher said. "I think the church has problems with the life style of homosexuality. A real problem has been getting ministers that are even willing to talk about it in their pulpits."

One of the few who does is the Rev. Kwabena Rainey Cheeks, the 46-year-old pastor of the Inner Light Unity Fellowship Church here. AIDS, said Mr. Cheeks, who has been H.I.V.-positive for 14 years, "is like the pink elephant that nobody wants to talk about."

That appears to be true among civil rights leaders as well. The nation's two largest black civil rights groups, the Urban League and the National Association for the Advancement of Colored People, will hold their annual conventions this summer; AIDS is on neither agenda.

"It's outside of our traditional purview," said Lee Daniels, a spokesman for the Urban League. The N.A.A.C.P., which recently declared AIDS a public health crisis, already has a health issue on its conference roster: cancer.

"It's exasperating," said Representative Louis Stokes, the Ohio Democrat who is chairman of the Congressional Black Caucus' health committee. The caucus recently asked the Clinton Administration to declare AIDS a national public health emergency among black people, a move Mr. Stokes said he hoped would rally civil rights leaders. "But," he said, "this is one that black leadership has shied away from."

And it is not only black leaders who are silent. Unlike white gay men, who are extremely open about AIDS and have raised millions of dollars to create powerful organizations to combat the epidemic, most black people who are infected tend to keep the diagnosis a secret, health experts agree. That is due to the disease's twin taboos, which are especially strong among African-Americans: homosexuality and drug abuse.

"When you deal with AIDS you have to deal with all of the issues, all of the -isms of our community," Mr. Cheeks said. "You can't touch AIDS and not deal with homophobia, drug abuse, homelessness. It touches all of the things that people don't want to talk about."

Those perceptions, however, can be misleading. Among black women, who represent 56 percent of the total AIDS cases among females, heterosexual sex has surpassed drug injections as the most common route of transmission. Many have no idea that they are at risk; often, they do not find out they are H.I.V.-positive until they become pregnant, when testing is routine.

They are women like Renee, a statuesque 22-year-old who insisted on being identified only by her middle name. She lives with her 5-year-old son on the top floor of a pretty brick building; the apartment marks her first step out of poverty. A high school dropout, she attends school to learn carpentry and obtain her equivalency diploma.

About a month ago, Renee visited a public health clinic, complaining of a yeast infection. A blood test revealed H.I.V. "This was the last thing on my mind," she said. "I know that I should have used protection, because you can't just look at somebody and know they're not positive. But I just thought, 'Not me.' "

And they are women like Tanya, an office worker who lives in a leafy, middle-class suburb in Prince Georges County, Md. She was tested for H.I.V. in 1994 when, at age 27, she became pregnant.

"Was my partner bisexual?" she asked, speaking on condition that only her first name be used. "Was he a drug user? I don't know because I don't know who infected me."

She guards her privacy. "My boyfriend knows, my mother knows, one or two close friends know," Tanya said. "It's not that I'm ashamed; it's that the stigma against H.I.V. and AIDS is so real."

The Stigma
When Secrecy Delays Treatment

To understand this stigma, and why it harms black people, one need only travel a few short miles from official Washington to the lively but tattered Anacostia neighborhood.

Here, about two blocks apart, are two H.I.V. clinics intended to serve black residents. One is an outpost of the Whitman-Walker Clinic, the city's largest AIDS service organization. Whitman-Walker was founded by gays for gays; about five years ago, it opened this satellite, calling it the Max Robinson Center, after the black newscaster who died of AIDS.

Patients have been slow to come for H.I.V. testing and medical care. The reasons are varied. Many blacks have a deep-seated -- and, some experts would say, justified -- mistrust of doctors, a legacy of the notorious Tuskegee experiments on black men with syphilis. Poverty is also at work.

"If you can't pay your rent, you can't put food on your table and you don't know how you are going to buy clothes when it's time for school," said Barbara Chinn, the center's executive director, "why do you need to know about another problem that you can't do anything about?"

But there is a third reason, Ms. Chinn acknowledged: Whitman-Walker is so closely associated with AIDS that some people do not want to be seen there. The unassuming clinic two blocks away, tellingly., is called Family & Medical Counseling Services.

"We try to create an environment where clients feel comfortable coming in," said Angela Fulwood, the clinic's director of social services. That is why Renee, the 22-year-old, came here instead of the local hospital, D.C. General. "Everything there was labeled," she said, "and I didn't want anyone seeing me."

That kind of hush-hush attitude, experts say, contributes to the high death rates from AIDS among African-Americans.

When black people delay treatment, they forgo the benefits of new drugs, like

protease inhibitors, which do the most good when taken early in the course of infection and which have been credited with reducing deaths among white gay men, said Dr. Eric Goosby, who directs the Federal Office of H.I.V./AIDS Policy.

In addition to his Federal job, Dr. Goosby sees patients one day a week at D.C. General. All are African-American. "I tend to see late-stage disease," he said. "It's a situation where you have somebody you went to junior high school with who is the receptionist at the clinic. Or one of the nurses knows their sister. Or their mother works in the labor and delivery suite. All of this, I have seen at D.C. General."

The Street Fight
Curbing Infection Where It Began

The public impression of African-Americans with H.I.V. does not include people like Renee or Tanya. Rather, it is that of what might be called the original AIDS epidemic in black people, the one that began in places like the dilapidated city park at the corner of Division and Foote in the southeast section of Washington, across town from the city's glittering monuments.

At this park, there are no tourists, only drug addicts; this is an "open-air market" for heroin. The ground is littered with syringes, broken bottles of cheap wine and crushed fast-food containers. The methadone maintenance clinic is down the block.

On a recent Thursday at noon, an unmarked mobile home pulled up alongside the park. The van is the roving headquarters of the D.C. Needle Exchange Program, one of 120 such programs in the nation and the only one in the District of Columbia.

As the AIDS epidemic rages among African-Americans, fueled in part by the sharing of dirty needles, the Clinton Administration recently announced it will not pay for needle exchange programs because they might send mixed messages about drug use to children. The decision disappointed the Government's top scientists, including Dr. Satcher, who say that needle exchange can reduce the spread of H.I.V. and does not encourage drug abuse.

It is a policy that Mr. Stokes describes as "mean-spirited." Yet Congress is trying to pass a law that would make the financing ban permanent.

Although the van, run by the Whitman-Walker Clinic on behalf of the city, does not open until 1 P.M., dozens of people line up at noon, their pockets overflowing with used syringes. A heavy-set man in a red, blue and yellow jacket is roaming about, mumbling under his breath: "Puff Daddy. Puff Daddy. Puff Daddy." Jamal Spurlock, the van's H.I.V. counselor, explains: The man is selling heroin. Puff Daddy is his brand name.

Mr. Spurlock, a burly 46-year-old in blue jeans and a striped Oxford cloth shirt, tries to persuade the exchange participants to be tested. He performs the tests, using a new oral method. Last year, 220 people were tested; Mr. Spurlock estimates that 20 to 30 percent were H.I.V. positive. Many of the addicts, he says, share dirty needles in spite of the exchange. Others trade drugs for sex.

Among them is Raymond, who will give only his first name. This is his first

time using the needle exchange; he stumbles onto the van, barely able to keep his head up and his eyes open. When Raymond agrees to be tested, Mr. Spurlock ushers him to the back of the van, shuts a curtain and begins running through his usual questions: Have you placed yourself in any risky situations? Any unprotected sex? Sharing needles? Ever exchanged drugs for sex?

Raymond's head bobs and weaves; his brow beads with sweat. "I'm starting back to a reckless life style," he confesses. He has been sharing needles, he says, and he does not use condoms. He would like to quit using heroin, but at 50, he thinks he is too old to change. "Sometimes," he said sadly, "it just seems so hopeless."

Testing and counseling people like Raymond is extremely important for the health of the entire community, AIDS experts say. H.I.V. is spread through sexual networks; as the cases of Renee and Tanya demonstrate, the epidemic is now ensnaring people far removed from the heroin trade. If Raymond can be persuaded to adopt safer sex practices, countless other infections might be prevented, said Dr. Ronald Stall, associate professor of epidemiology at the University of California at San Francisco.

"By stopping those infections," Dr. Stall said, "you are really keeping all those snowballs from going down the hill and causing an avalanche."

But a lot of snowballs have already gone down the hill in black America. One reason, Dr. Satcher said, is that the big AIDS organizations, groups with their roots in the gay community, still receive the lion's share of AIDS money because they are more sophisticated at writing grants. Small grass-roots organizations, which may be more effective at reaching minority groups, have trouble surviving. In Washington, three have folded in the past three years.

In an effort to correct this, the Centers for Disease Control, which gives $253 million a year to state and local governments for H.I.V. prevention, has for four years been bypassing its own rules to give directly to groups that focus on minorities. This year, $18 million was awarded; three-quarters of the recipients gear their programs to African-Americans.

But, the Surgeon General said: "Don't hear me as defending what we are doing as adequate. I think we have got to do better."

Spreading the Truth
Programs Bring The Lesson Home

Lisa Gray is trying to do better. She is the co-founder of a tiny group called Friends for Friends, which got its start three years ago handing out condoms in Washington subway stations. A stocky 33-year-old black woman, she was a retail manager for a local music chain when several friends and family members became infected with H.I.V. So she went to the Red Cross for training as a prevention counselor.

Last year, Ms. Gray's group won a grant from the disease control centers to teach black women who live in public housing how to prevent H.I.V. The grant is for $50,000, more than twice Friends for Friends' annual budget. The idea is to train the women to hold seminars, so that they can educate friends and neighbors. Ms. Gray calls this "infecting people with information."

And so, on a recent Friday morning, she has come to Capitol East Dwellings. Five women, age 22 to 51, are seated in metal chairs around a folding table in the recreation center, a downtrodden brick building with peeling paint and chipped tile floors. It is the third weekly session of a five-week course.

Hand-written posters are taped to the walls, bearing unfamiliar words: immunodeficiency, pneumocystic carinii pneumonia, seropositive. On a table behind Ms. Gray are condoms, wooden penises, for teaching the women how to put the condoms on, and a television, for watching a video that will teach the delicate art of "safe sex negotiation."

Each woman here knows at least one person infected with H.I.V. The oldest, Catherine Smith, a modest 51-year-old in a peach pantsuit, says she came to learn what to tell her children and grandchildren.

The youngest, Nureeah Brown, a 22-year-old with two children, ages 6 and 3, said the death of her daughter's father troubled her. "It was said he passed from AIDS," she said, although no one is really sure.

The previous week, she said, she cooked dinner for a young man she knows. He took his shoes off and began to get a little friendly. "He was like, 'What you be doing on Friday?' " Ms. Brown said. "I said, 'I'm glad you asked.' And then I went and got my little pamphlet" -- a Friends for Friends brochure with a condom tucked inside and the saying, "No Glove, No Love."

Ms. Gray, upon hearing this, is clearly pleased. But neither she, nor anyone else, knows if the Friends for Friends program will work.

"We know that educating people about safe approaches to sex is very helpful," Dr. Satcher says. But few programs have been studied enough to be proved effective.

Over the next five years, as part of President Clinton's plan to eliminate racial disparities in disease by the year 2010, the Government has proposed spending $400 million on model community programs. Part of the money would be set aside for AIDS, although Dr. Satcher acknowledged that it may be too optimistic to think the epidemic's racial disparities can be eliminated in just 12 years.

"It is a long-term proposition," the Surgeon General said. "There is no immediate fix."

GRAPHIC: Photo: In a van in a Washington park, a woman was tested for the virus that causes AIDS. The van is the roving headquarters of the D.C. Needle Exchange Program, which provides clean needles for drug users. (Amy Toensing for The New York Times)(pg. A12)

Graphs: "New Face of AIDS"
Black Americans are only 13 percent of the population, but they make up nearly half of all AIDS cases. Graph tracks number of diagnosed cases among whites, blacks, and hispanics, from 1986 through 1996. (Source: Centers for Disease Control and Prevention)(pg. A1)

"KEEPING TRACK: AIDS and H.I.V. Diagnoses" shows percentage of total H.I.V and

AIDS cases with respect to various groups, January 1994-June 1997. Graph tracks AIDS incidence in blacks by risk category in men and in women, from 1986 through 1996. (Source: Centers for Disease Control and Prevention)(pg. A12)

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1998

THE WHITE HOUSE

WASHINGTON

SOUTHERN CHRISTIAN LEADERSHIP CONFERENCE (SCLC) BRIEFING

Wednesday, July 29, 1998, Indian Treaty Room, 12:00pm

AGENDA

INTRODUCTION

Ben Johnson
Deputy Assistant to the President and
Deputy Director, Office of Public Liaison

WELCOME

Minyon Moore
Assistant to the President and
Director, Office of Public Liaison

REMARKS

Christopher Edley, Jr.
Professor, Harvard Law School and
Consultant and Senior Advisor to the President for the Race Initiative

Sandra Thurman
Director
Office of National AIDS Policy

Joshua Gotbaum
Executive Associate Director
Office of Management and Budget

Karen Tramontano
Deputy Assistant to the President and
Counsel to the Office of the Chief of Staff

CLOSING

Ben Johnson

HOUSE BUDGET COMMITTEE
DEMOCRATIC CAUCUS

Congressman John M. Spratt, Jr., Ranking Democratic Member
222 O'Neill House Office Building, Washington, DC 20515 • 202-226-7200
www.house.gov/budget_democrats/

Overview of the Budget Picture

July 7, 1998

NOTE: All figures are five-year totals, fiscal years 1999-2003.

1. **Tax Cuts** — House = $101 billion.
   — Senate = $0 billion.

The Senate budget is widely thought to have included $30 billion in tax cuts, but it did not; the Senate revenue figures equaled CBO's estimate of current law. Senator Domenici's contention that he assumed a $30 billion tax cut really meant that he assumed a $30 billion *gross* tax cut, fully offset by $30 billion in unspecified revenue increases, for a *net* tax cut of zero.

2. **Discretionary cuts** — House = $45 billion relative to the discretionary "caps."
   — Senate = $ 7 billion, virtually all in 2003:*

In both the House and Senate, *all* the discretionary cuts apply to the non-defense portion of the budget.

The Balanced Budget Agreement of 1997 established a new set of "caps" or ceilings on discretionary programs — those controlled by the annual appropriations process. Those caps extend through 2002. CBO's "capped baseline" assumes that total discretionary spending will equal those caps through 2002 and will grow with inflation (by 2.8%) in 2003. The House budget is $45 billion in outlays below CBO's capped baseline; the House budget is therefore commonly said to be $45 billion below the "caps" or below the "BBA."

** The Senate also assumed discretionary increases in highways and mass transit (offset by entitlement cuts); those increases are not netted against the $7 billion discretionary cut.*

3. **Entitlement cuts** — House = $56 billion, of which $15 billion are used up.
— Senate = $0 billion*

The major House cuts are in low-income entitlements and Medicaid. **See the attached tables.**

$14 billion of the cuts in the House budget resolution have already been enacted in the Highway bill (TEA21) and the Agricultural Research bill. In addition, Rep. Kasich promised that he would drop the proposed $1.5 billion cut in federal employee health benefits. ***This leaves only $41 billion in entitlement cuts available to finance tax cuts.***

** excluding entitlement cuts the Senate assumed would finance a highway bill.*

4. **How Will Republicans Pay for a Tax Cut?**

A) They may fail to do so, thus decreasing the surplus. This would violate the President's call to "reserve every penny of any surplus for Social Security." It would also violate the Pay-As-You-Go rule of the Budget Enforcement Act, which was just extended through 2002 as part of the BBA. It would also violate the Senate's "10-year" pay-as-you-go rule.

B) Republicans are unlikely to use discretionary cuts to cover tax cuts for three reasons: Senator Domenici opposes discretionary cuts; using discretionary cuts violates the Budget Enforcement Act; and using discretionary cuts violates the Senate's "ten-year" rule and the Byrd Rule, so the reconciliation bill would require a 60-vote waiver in the Senate.

C) If the tax cuts must be covered solely by entitlement cuts, then $50 billion in tax cuts (for instance) implies *deeper* entitlement cuts than the $41 billion in cuts available for that purpose in the House budget.

D) Republicans may ultimately decide to use tobacco revenues to help cover a tax cut, although that position is not in conference.

Conclusion: The conferees are under pressure to agree to entitlement cuts at least as deep as those already in the House budget.

5. **The "1% Cut"** House Republicans claim their budget constitutes a mere 1% cut in federal spending. This figure is misleading for two reasons.

- First, the 1% figure represents the *average* depth of the cut over the five year period. But the cuts start small and end up very much deeper. The question is how deep they will be when fully effective.

- Second, the 1% figure spreads the cut over the whole budget, but large portions of the budget are clearly off the table. Areas exempt from cuts include interest, Social Security, Medicare, defense, farm income supports, and federal retirement. These programs alone total 71% of the federal budget.

As a result, the total outlay cut in 2003 — when the House plan is fully effective — is at least 7% of amounts available to be cut, not 1%. This is true both for entitlements and discretionary programs. The cuts would become even deeper than 7% if they were increased to cover a tax cut bigger than $41 billion, or if other programs, such as veterans benefits, were removed from the table.