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LEADING FOR LIFE:
**THE AIDS CRISIS AMONG
AFRICAN AMERICANS**



A report from the first
**Leading for Life
Summit**

October 22, 1996

HARVARD AIDS INSTITUTE
NATIONAL MINORITY AIDS COUNCIL
THE BARRY M. GREGG FOUNDATION
WILLIAM DU BOIS INSTITUTE FOR
AFRICAN-AMERICAN RESEARCH
HENRY J. KAISER FAMILY FOUNDATION

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**THE AIDS CRISIS AMONG
AFRICAN AMERICANS**



MADE BY ROXANNE A.

A report from the first
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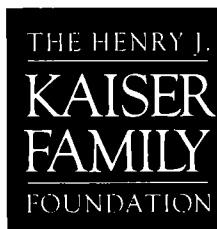


March 31, 1998

The enclosed survey by the Kaiser Family Foundation was presented earlier this month at a special conference at Harvard University organized by the W.E.B. Du Bois Institute for Afro-American Research to examine *The Untold Story: AIDS and Black Americans*. The conference was co-sponsored by Leading for Life/Harvard AIDS Institute and the Kaiser Family Foundation.

The survey documents the high level of concern that exists among African Americans about the AIDS epidemic. This deadly disease disproportionately affects African Americans, who make up a growing percent of new AIDS cases in this country.

Additional single copies of this report are available by calling the Kaiser Family Foundation's publication request line at 1 (800) 656-4533 (ask for document #1372).



NEWS RELEASE

Harvard AIDS Institute

**EMBARGOED FOR RELEASE UNTIL:
9:00 am, ET, Tuesday, March 17, 1998**

For further information contact:

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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 and Treatment**

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).

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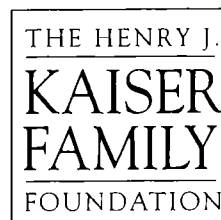
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CHART PACK

National Survey of African Americans on HIV/AIDS



March 1998

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ERRATA

Kaiser Family Foundation

National Survey of African Americans on HIV/AIDS

Summary of Findings/Topline, March 1998

Page 3, paragraph 1, correction to text:

The number of AIDS deaths in 1996 as compared to the previous year declined by **13** percent among African Americans.

Page 7, correction to chart:

Sources of News and Information on HIV/AIDS in the Past Month
Magazines: **43%** of all African Americans

Page 13, corrections to chart:

Sources of News and Information on HIV/AIDS in the Past Month
Magazines: **43%** of all African Americans
Health Care Provider: **35%** of all African Americans
AIDS Organization: **18%** of all African Americans

Page xvii and xviii, corrections to topline:

- 40. f. Magazines: **43%** of AfrAm.
- 40. k. Your doctor or another health care provider: **35%** of AfrAm.

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Kaiser Family Foundation

National Survey of African Americans on HIV/AIDS

Prepared for:

THE UNTOLD STORY:

AIDS AND BLACK AMERICANS,

A Briefing on the Crisis of AIDS
among African Americans

Conference presented by:

- The W.E.B. Du Bois Institute for Afro-American Research at Harvard University

Co-sponsors:

- Leading for Life/Harvard AIDS Institute
- Kaiser Family Foundation

March 16-17, 1998
Harvard University

One in two African Americans are very concerned about getting HIV. Two in five say they are more worried today than a few years ago.

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

FOR IMMEDIATE RELEASE

May 11, 1998

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(202) 225-2201

CBC Calls for Secretary Shalala to Declare "Public Health Emergency" to Combat HIV/AIDS Crisis in Minority Communities

Rise of Minority HIV/AIDS Infection Alarming

Washington, D.C. -- Today, Congresswoman Maxine Waters, Chair of the Congressional Black Caucus (CBC) and CBC Members, alarmed at the rate of increase of HIV/AIDS in the black community, called for Secretary Donna Shalala to declare a "public health emergency" to eliminate HIV/AIDS crisis in the African American community.

"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. AIDS is now the leading cause of death among African Americans, age 25 to 44," stated Rep. Waters.

"Today, the CBC brought together over 20 public health workers, AIDS activists and representatives from all over the country, including from Los Angeles, San Francisco, New York, and Atlanta, and the Department of Health and Human Services to assess where we are and what steps we need to take to deal with this crisis," added Rep. Waters.

"During our meeting, we agreed to call on Department of Health and Human Services Secretary, Donna Shalala, to declare HIV/AIDS a public health emergency in this country. 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."

"This is only the beginning of our efforts," stated Rep. Waters. "Enough is enough. We must exert the political will necessary to take on HIV/AIDS in those communities where it is reaching epidemic proportions. This is a national crisis. We will not rest until the crisis is acknowledged and strategies and resources are directed to eliminate it."

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National Survey of African Americans on HIV/AIDS

March 16-17, 1998
Harvard University

One in two African Americans are very concerned about getting HIV. 52% of African Americans say AIDS is the nation's most urgent health problem. One in three African Americans say the country is losing ground in the battle against AIDS. One in five African Americans are very worried today than a few years ago.

STORY:
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AFRICAN AMERICAN AIDS TREATMENT TEAM

**A Strategy for Bringing African Americans with HIV/AIDS
into High-Quality Care**

**DRAFT:
NOT FOR CIRCULATION**

February 25, 1998

*None of this is addressed
to Todd directly (or cc'd)*

*(Most recent on bottom
of stack)*

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EXECUTIVE SUMMARY

Black Americans bear the brunt of the U.S. AIDS epidemic, accounting for almost 45 percent all new cases, a far greater proportion than any other racial group. And yet, they have benefited the least from the powerful new combination therapies. Throughout the epidemic, African Americans have fared worse than whites and other groups on every health-care measure: Blacks are diagnosed later in the course of disease, receive worse care, benefit last from new advances in treatment, and die faster. Unfortunately, this has not changed with the advent of protease inhibitors and other potent new therapies. Although the new drugs are cutting death rates among all races, the decline in deaths among blacks lags behind the declines among whites and other groups. And thousands of blacks are continuing to get infected every year, and they will need high-quality care.

Indeed, now that effective AIDS therapies are available, one of the most critical challenges is to bring marginalized communities, especially African Americans, into care. So urgent is the need that President Clinton, Surgeon General David Satcher, and Health and Human Services Secretary Donna Shalala recently targeted HIV/AIDS as one of the six most critical health areas in which minorities suffer an intolerable gap. The Administration has vowed to close this gap, and has committed \$400 million to help bring all Americans to health parity. It has asked the private sector to contribute an additional \$600 million to this historic effort.

This concept paper maps out a strategy to bring African Americans with HIV/AIDS into high-quality care. The proposed strategy is a comprehensive program to train, place, and support a cadre of highly-trained African-American peer treatment educators who will arm patients with information, help them develop individualized treatment plans, and assist them in advocating for better care. Because the first step into treatment is getting tested, they will also promote HIV testing among African Americans. Finally, through a train-the-trainer process, the program will generate more than 1,000 new African American treatment advocates in two years.

Patient information is important for all diseases, but it is arguably more important for HIV/AIDS than for any other. The new drugs do not cure AIDS. They merely make it "manageable"—and, ultimately, it is patients who are responsible for managing their illness. While doctors play a critical role, patients are the ones who must adhere to the regimen, swallowing up to 20 pills a day on a strict schedule, often with special dietary requirements. Patients also have to cope with side effects, which can include chronic diarrhea and nausea. In short, quality AIDS care requires the active participation of the patient for many years, perhaps for life. Such involvement simply won't happen if patients don't understand *why* they need to shoulder these responsibilities. So patients need information—about the science and treatment of

HIV, about practical ways to improve adherence in the context of their particular lives, and about many other related issues.

Unfortunately, African American patients often have few opportunities to learn what they need to know to maximize their care, because many obstacles stymie them. The barriers include poverty, distrust of the medical establishment, stigma, lack of education, and substance abuse.

As severe as these problems are, they could be dealt with if not for another problem: the lack of an infrastructure to support treatment education. There is a dearth of African American AIDS doctors, researchers, and peer educators. Moreover, very few community-based organizations possess the combination of expertise, commitment and, above all, resources to train, employ, and support peer educators. Of course, previous attempts to bring African-Americans into AIDS care have achieved some success, and this program incorporates their best practices, especially the proven concept of peer education. But, unfortunately, many programs have foundered because they have lacked the resources to overcome the many barriers that block African Americans from getting care.

Therefore, just as monotherapy fails against HIV, so too will one-dimensional methods fail against this multi-faceted problem. What's needed is the equivalent of combination therapy.

This program will provide exactly that. It will create a cadre of highly-trained peer educators to bring African Americans into care, and to educate them about the complexities of HIV treatment, the critical importance of adherence to their regimens, and the need to communicate with physicians to develop individualized treatment plans. These peer-educators will be superbly trained and supported through a comprehensive, two-year working internship. And their participation will depend on their meeting certain benchmarks—both academic and professional—throughout the program. In short, the standards will be high.

Like triple-combination therapy, the program consists of three interlocking elements, each of which is vital to the success of the whole.

1. **AIDS Treatment College.** Fifty, competitively-chosen peer educators will participate in a full month of intensive, state-of-the-art training in the science and treatment of HIV disease, as well as in relevant social issues such as drug adherence, substance abuse treatment, self-esteem building, HIV prevention, and presentation skills. To earn a graduation diploma from the college, the peer educators will have to pass a battery of tests. Leaders from many fields have already agreed to commit their training services. Some of these individuals include:

- Researchers: Anthony Fauci

- Doctors: Keith Rawlings, Eric Goosby
 - Community educators: Phill Wilson
2. **Working Internships.** Graduates will be dispatched into a dozen epicenter cities, where they will be supervised by carefully chosen community-based AIDS Service Organizations (ASOs). The peer educators will focus on the hardest-hit sectors of the African-American community, conducting one-on-one counseling and holding educational forums. They will reach clients at venues such as public hospitals, community clinics, STD clinics, substance abuse centers, and free clinics. In their second year, when they have field experience as well as classroom education under their belt, they will organize train-the-trainer programs. Each peer educator will commit to training an additional 10 peer educators.
 3. **Support.** Treatment education is emotionally grueling and intellectually demanding. Many programs have failed because they have not offered support during the critical first years of work. This program will solve this problem in three ways:
 - A. Continuing Education. The peer educators will reconvene for three advanced and intensive in-service trainings. These trainings will deepen their knowledge of all relevant issues, and keep them abreast of the latest scientific developments. Like the Treatment College, these update sessions will also feature final examinations, which participants will be required to pass.
 - B. Mentoring. Each peer educator will be linked with a local mentor—a doctor, researcher, or experienced community treatment educator—who will commit to meeting with the peer educator regularly for two years. In addition, the mentor will be "on call" to answer questions during that period.
 - C. Buddies. The program will link participants from the same city to form a peer-support "buddy" system. This will help participants avoid emotional "burn-out." It will also bolster their self-confidence as they work together to solve common problems.

While this program targets African Americans, it could serve as a pilot for other disenfranchised communities, such as Hispanics/Latinos.

This is a concept paper. While considerable research and planning have gone into it, this is a working document. The budget is provisional, as are some details of the program. The purpose of this paper is to explain the broad idea so that interested parties can decide how to contribute their resources and expertise.

This project was conceived by Phill Wilson, director of the University of Southern California AIDS Social Policy Archive and director of the AIDS Prevention Team of the National Black Gay and Lesbian Leadership Forum, which he founded. Mr. Wilson, who has been living with HIV for more than 15 years, has also served as the AIDS coordinator for the City of Los Angeles and as policy director for AIDS Project Los Angeles.

THE NEED

The facts about African Americans and AIDS are shocking. According to the federal Centers for Disease Control:

- Blacks comprise just 12 percent of the U S. population but 40 percent of all AIDS cases. Blacks now account for more cases than any other racial group, whites included.
- For new cases of AIDS, the picture is even worse, with African Americans accounting for 43 percent of newly-diagnosed cases
- Blacks make up more than half of all cases among women, and more than 60 percent of all children with AIDS.
- Black men are seven times more likely to contract AIDS than white men, and black women are a staggering 20 times more likely than white women to get AIDS.
- Between 300,000 and 500,000 African Americans are estimated to be infected with HIV. More than 120,000 black Americans have died from AIDS. That's more than twice as many Americans, of all races, who died in the Vietnam War.

Based on these facts, leading black AIDS advocate Mario Cooper declared: "Except possibly for slavery, nothing in our history will have killed so many black people in such a short time as AIDS."

Combination therapy might help avert this dire fate—but only if aggressive action is taken to assure that African Americans benefit from the drugs. The new therapies have dramatically cut the death rate among all people with AIDS, African-Americans included. But a whole battery of studies document that blacks are benefiting less from these drugs, in large measure because they are not getting the drugs at all, or are getting them in substandard regimens. Consider the following:

- The CDC reports that AIDS deaths declined from 1995 to 1996 by 32 percent among whites, but only 13 percent among blacks.
- The New York City Health Department finds that death declines were about 20 percent less for blacks than for whites—and New York is widely considered to have one of the best public HIV care systems in the nation.

- A recent CDC study of more than 2000 AIDS patients found that blacks were much less likely than any other racial group to receive viral load tests. Proper use of combination therapy is impossible without monitoring viral load; therefore, access to viral load tests is a telling marker for overall access to quality care. In the study, 63 percent of white patients had received a viral load test but only 39 percent of African Americans.
- In a study conducted by the Columbia University School of Public Health, a third of whites were receiving protease inhibitors, but only 12 percent of blacks. Clearly, blacks were less likely to be receiving the best therapies, but the study found another fact that is just as tragic: Blacks were more likely to be receiving no therapy whatsoever. More than half of the African Americans had never been on any antiretroviral medication; by contrast, only a third of whites had never been on therapy.
- The latest CDC mortality statistics are especially sobering: Even with the advances in therapy, AIDS remains the leading cause of death for blacks in the prime of their lives, age 25-44. Among men in this age group, AIDS takes more than twice as many lives as the second leading cause of death, homicide.

Many experts believe that the decline in death rates may soon level off. Mary Ann Chiasson, head of AIDS surveillance for the City of New York, says that AIDS deaths in that city appear to be stabilizing at six per day. Renslow Sherer, director of the AIDS Center at Chicago's Cook County Hospital, says that after a long decline, "We're starting to see a plateau" in the inpatient census. Partly, that's because only 60 percent of Cook County Hospital patients—most of whom are people of color—are on combination therapy. It would be tragic if the AIDS deaths leveled off in a way that left blacks to dying faster and more frequently than other races.

Look deeper, and there are more disturbing trends, especially for the long-term success of blacks who are lucky enough to receive therapy. The new drugs depend on adherence; in other words, they are effective *only* if taken on a strict schedule for years. Such adherence is not possible if patients are not prepared—intellectually, emotionally, and logistically. They also need to enlist the support of their family, friends, and medical providers. An individually-tailored, holistic treatment plan is essential for therapeutic success. Yet:

- A study from the University of Texas Health Science Center found that African Americans were half as likely as whites to discuss treatment options with their physicians.

These statistics are made vivid by the real-life stories of African Americans living with the disease. Jeannine M. Scott sought AIDS treatment in 1993. There was only one infectious disease clinic in her city of Wilmington, Delaware, and to see a doctor she would always have to wait at least an hour and a half. Sometimes she would just leave. When she stuck it out, "The doctor would see me for five minutes. He'd weigh me, take my vitals, and say, 'Here's more AZT.' I didn't feel comfortable asking questions, 'cause he was in a hurry to get me out." She also lacked the confidence to ask questions, considering her doctor "someone above me." When she left those appointments, "I felt angry with myself. I also felt helpless, very helpless. If I couldn't turn to my doctor, who could I turn to?"

Scott moved to Philadelphia, where she hooked up with an AIDS advocacy group. Now she makes her doctor explain everything to her "in words I can understand." For the drugs to work, this is the kind of transformation that must happen in patient after patient.

Unfortunately, there is a torrent of new patients. While death rates have dropped, infection rates have not. The CDC estimates that about 40,000 Americans get infected with HIV each year. That means between 16,000 and 20,000 African Americans contract the virus each year, or about two every hour.

Needle exchange has been shamefully neglected, dooming thousands of injection drug users—a disproportionate number of whom are black—to contract HIV. But even in communities with strong prevention programs, blacks have benefited least. For example, a survey of African-American gay and bisexual men in the San Francisco Bay Area found that more than half reported unprotected anal intercourse—a considerably higher percentage than among white gay men.

A plethora signs indicate that HIV will continue to infect African Americans at high rates. One of the strongest portents is the incidence of other sexually-transmitted diseases. According to the CDC, rates of gonorrhea in blacks are almost 32 times greater than in whites; for syphilis they are a whopping 50 times greater. Clearly, African Americans are going to continue to get HIV in very high numbers. Thus, the demand for high-quality treatment will not diminish, but will steeply increase.

BARRIERS TO CARE

In 1994, the CDC's *Morbidity and Mortality Weekly Report* succinctly explained why blacks suffer disproportionately from AIDS.

Although race and ethnicity are not risk factors for HIV transmission, they are markers for underlying social, economic and cultural factors and personal behaviors that affect health. Socioeconomic status in particular is associated with premature morbidity and mortality. Unemployment, poverty and illiteracy are correlated with decreased access to health education, preventive services and medical care, resulting in an increased risk for disease. In 1992, 33 percent of Blacks and 29 percent of Hispanics lived below the federal poverty level, compared to 13 percent of Asian/Pacific Islanders and 10 percent of whites. Therefore, the social, economic, and cultural context of HIV infection should be considered when designing and implementing prevention (and care) programs . . .

The context of the passage above was prevention, but it applies with equal force to care. Many barriers block African Americans with HIV from accessing care, but the main ones are poverty, distrust, stigma, and lack of infrastructure.

Poverty

This document will not belabor the exhaustively-documented harms caused by poverty. But it is worth highlighting a recent CDC study of more than 2,000 HIV patients in three cities: Being on Medicaid—a clear marker for poverty—was a major predictor of substandard antiretroviral care. And African Americans are more likely to be poor than any other racial group.

Too often, poverty is conceptualized in terms of an individual: A particular person is poor, therefore he or she cannot afford good care. In fact, poverty is usually a communal phenomenon. Most poor people live in poor neighborhoods—for many urban African Americans, this means ghettos. When a person is trapped in the web of communal poverty, access to good care is especially difficult: There are fewer top hospitals and doctors, fewer information and education resources, fewer nearby ASOs (and certainly fewer well-funded ones). At the same time, there are more hassles—such as bad housing, higher crime, unemployment, and constant financial scrambling—that make it logistically and psychologically harder to take charge of one's health.

Unfortunately, a battery of studies shows that African Americans with HIV are most likely to be mired in communal poverty. For example, an epidemiological map of

New York, indicating which areas of the city are worst hit, shows that the South Bronx, Harlem, and East New York are epicenters of the city's epidemic. They are also three of the poorest neighborhoods, with extremely high minority populations. Similarly, a study from Los Angeles showed that living in a poor zip code was a very high predictor of contracting HIV.

One of poverty's main effects on people with HIV/AIDS is that it restricts their access to information about the disease. The internet, a major source of HIV information for middle-class white gay men, is rarely available to poor people. Basic literacy—not to mention familiarity with medical terminology—is often a problem, because schools in poor neighborhoods are often substandard. Thus newsletters, another major source of HIV information for gay white men, may be of limited value—not to mention that there are few which target African Americans. In addition, because African American ASOs are generally much smaller than their white gay counterparts, there is critical shortage of peer educators to conduct community forums or one-on-one counseling.

How severe is AIDS ignorance among African Americans? AZT is so well-known that it is featured in the lyrics of the Broadway musical *Rent*. But a study out of Los Angeles found that 12 percent of patients in a public health clinic, the vast majority of whom were people of color, had never even heard of AZT.

As for doctors—another major source of AIDS education—African Americans are more likely to receive care at a public hospital or clinic, where doctors are often overwhelmed, lacking the time to talk to patients. And there is a feedback loop: People without proper education and sense of self-worth will be less likely to risk appearing stupid by asking questions. Studies have documented that getting care from an experienced HIV specialist dramatically reduces the patient's risk of death—yet few such experts serve African American areas, especially poor ghettos. Indeed, many of the best doctors have set up private "consulting" practices, avoiding the restrictions of managed care, not to mention Medicaid. These doctors charge patients directly, effectively barring vast numbers of African Americans.

Finally, clinical trials—a source of state-of-the-art care for many gay men—have consistently enrolled low numbers of minorities. Few trials make a concerted effort to enroll African Americans. And black patients—often trapped in communal poverty, where their neighbors and peers are far less likely to hold professional jobs—lack the word-of-mouth network that enables many gay white men to learn about trials, good doctors, and advances in AIDS medicine.

Distrust

African American distrust of the medical establishment existed long before AIDS, but the epidemic has focused that mistrust. Emory University professor Steven Thomas has conducted numerous surveys. In a study of more than a thousand African

American church members, 35 percent believed that HIV was deployed by the government to genocidally destroy African Americans, and another 30 percent would not rule it out. Similarly, more than a third thought that HIV had been concocted in a germ-warfare laboratory—an opinion shared by 40 percent of black college students polled in Washington, DC. Another of Thomas's surveys found that 36 percent of black Americans thought it "very likely" they would be used as guinea pigs; only 16 percent of whites felt the same.

These fears and opinions are rooted in very real history—and not only the infamous Tuskegee experiment, in which federally-funded investigators allowed black men with syphilis to die of the disease. Bloodbanks used to segregate blood given by blacks from that given by whites. Until the civil rights movement, southern hospitals were segregated—and white hospitals would turn away even critically ill African Americans. Forced sterilization—which occurred in this country until the 1970s—was inflicted disproportionately on blacks.

In the AIDS epidemic, blacks have been underrepresented in almost every clinical trial, which has fueled the notion that mainstream therapies are "white medicine." And, tragically, a 1991 study reported that AZT may have had "harmful" effects in black patients. Finally, there is a dearth of black physicians and researchers, which alienates many black patients.

Some African American leaders reinforce the distrust of mainstream medicine. On ABC's *20/20* in 1994, the Nation of Islam's Louis Farrakhan said, "Do you know where the AIDS virus was developed? Right outside of Washington. It is my feeling that the US government is deliberately spreading AIDS." The Nation of Islam still markets Kemron (alpha interferon), even though it has been proven to be ineffective, and the group actively discourages African Americans from using "white" medicine.

Farrakhan is certainly not representative of all African Americans, but distrust of and ambivalence toward mainstream medicine are real. However, the proven, undeniable success of combination therapy heralds a new opportunity for bringing African Americans into care.

Consider the story of one black AIDS activist, the Reverend Kwavena Rainey Cheeks, pastor of Interlight Unity Fellowship Church in Washington, DC. As recounted in *Positively Aware*, the newsletter of Test Positive Aware Network, a Chicago ASO, Cheeks was diagnosed with HIV in 1985. That same year, he founded Us Helping Us, an African American ASO that aggressively promoted alternative therapies and discouraged its clients from using AZT. But recently, when Cheeks himself lost 50 pounds after suffering successive bouts of PCP and CMV, he tried combination therapy. The drugs worked—his T-cells leapt by more than 160, his viral load went to undetectable, and he started training for a bicycle marathon. Recently, Cheeks appeared as a keynote speaker at a pharmaceutical company-sponsored

African American treatment conference in Oakland, California, where he talked about access to treatment, the value of the new drugs, and his journey into care.

Cheeks' story underscores the importance of peer educators. First, distrust of white medicine makes it imperative for medical information to be disseminated by black educators. But second, most peer educators trained in this program will themselves be HIV-positive. Thus, they will be able to back up their biological arguments with the power of personal testimony. In short, black Americans may have "healthy paranoia," but that distrust can be pierced by peer educators bearing news of truly effective drugs.

Stigma

Stigma interferes with care in two basic ways.

First, the health care system, dominated by white middle-class doctors, may not understand African American cultural norms. Some providers may deem African Americans—particularly IV drug users, or those who are homeless or incarcerated—as hard to deal with or even unworthy of treatment. Some doctors have reportedly been withholding combination therapy from patients based on superficial assessments of whether those patients will be able to adhere to the regimen. The CDC has found that injection drug users are more likely to receive substandard care than patients who acquired the virus sexually.

Second, stigma from within the community makes individuals with HIV afraid of seeking care. Having a lethal illness—especially an infectious one—carries a stigma on its own, turning people into pariahs. In addition, AIDS carries many more meanings, most negative. Men with HIV are assumed to be addicts or homosexuals; women with AIDS are presumed to be promiscuous or prostitutes. No wonder that, among case workers and activists, stories abound of blacks with HIV who do not seek care for fear that someone will see them walking into the clinic.

Here, too, peer educators can make a difference. By speaking openly of HIV, they can help mitigate the stigma. And since many will themselves be HIV-positive, they will provide positive role models for living successfully with HIV.

Indeed, merely seeing people with AIDS who are healthy can be a magnet into care for African Americans. Before effective therapies were developed, people with HIV usually sickened and died. The subliminal message was that having HIV was hopeless. But the new image of AIDS—personified by peer educators—is one of health, vitality, and hope.

Lack of Infrastructure

The problems listed above are severe, but not insurmountable. The cruelest twist, then, is that the African American community lacks the infrastructure to cope with AIDS.

There is a well-known shortage of African-American doctors and researchers, and despite long-standing epidemiological evidence that AIDS was becoming "blacker and browner," government contracts have continued to go to the largest ASOs, most of which are rooted in the gay white community.

Consider just one example: A recent report commissioned by the Pennsylvania Department of Health concluded that many people of color in Pennsylvania "do not have good access to care, information, clinical trials or related support services." Why? One of the main reasons is "the minimal amount of funding that people of color organizations receive for services and for improving their organizational capacities."

Indeed, most black ASOs are small. Located in poor neighborhoods, they lack a strong donor base. They must bid against better funded, more experienced white organizations. And many funders don't understand the African American community. The result? Many black ASOs flounder or fail. At least three went out of business last year.

In sum, African Americans face many imposing barriers to care and to information about AIDS. Even worse, there is an inadequate infrastructure to confront these problems.

PROGRAM PHILOSOPHY

Stated simply, the goal of this program is to bring African Americans with HIV/AIDS into care, and to improve the quality of care for those who are already receiving treatment.

In order to accomplish this goal, the program must address the key barriers that block African Americans from obtaining quality care. No program can be a panacea: Poverty will not vanish, and thousands of black doctors will not suddenly materialize. But there are pragmatic, workable strategies to greatly improve the HIV care of thousands of African Americans.

The best strategy is to arm patients with information about AIDS and current therapies so that they can begin to actively participate in their medical care. Patient information is always important, but it is arguably more important for HIV/AIDS than for any other disease. The available drugs do not cure AIDS. They merely make it "manageable"—and, ultimately, it is patients who are responsible for managing their illness. While doctors play a critical role, patients are the ones who must adhere to the regimen, swallowing up to 20 pills a day on a strict schedule, often with special dietary requirements. Patients also have to cope with side effects—which can include chronic diarrhea and nausea. They must navigate the maze of public-assistance benefits, which can be stressful and overwhelming; they must be careful to avoid dangerous foods, such as raw eggs or contaminated water; and they must remember what secondary drugs cause harmful interactions whenever they receive medication from a doctor who isn't an HIV specialist.

In short, AIDS care is much, much more than prescribing combination therapy. It requires the active participation of the patient for many years, perhaps for life. Such involvement simply won't happen if patients don't understand *why* they need to shoulder these responsibilities. So patients need information—about the science and treatment of HIV, about practical ways to improve adherence in the context of their particular lives, and about many other related issues.

Unfortunately, those black Americans who don't actively distrust the mainstream medical establishment often feel intimidated by it. Doctors are typically well-educated and well-heeled, whereas many African American AIDS patients are not. As Jeannine Scott, a person with AIDS, put it, patients see doctors as someone "above" them—so they're not likely to ask questions and learn what they need to know.

All this explains why peer education has been so successful: Education is critical for quality care, and peers are the best educators. A mountain of studies from many different contexts all show that peer education is effective—and this holds true for AIDS treatment education, too.

However, peer education can fail. Mainly, it can be torpedoed by inadequate training and support. Educating people about HIV is particularly difficult, for educators must master a large—and swiftly advancing—body of scientific knowledge, as well as knowledge about a wide variety of social issues that play an important role in the lives of their clients. Inevitably, they will encounter clients who ask questions to which they don't know the answers; the educators must have resources they can draw on to find those answers. Educators must also learn to cope with the emotional burden of dealing with a client population that is poor and struggling with many problems.

To ensure success, this program will accept only the most qualified and motivated applicants who have committed to the full two-year program. It will provide them with the best possible training, and it will require them to pass tests at each stage of that training. Finally, it will support participants through a working internship program that includes work supervision, continuing education, mentoring, and a peer-support buddy system.

THE PROGRAM

The African American AIDS Treatment Team will comprise 50 highly-trained peer educators who will bring African Americans with HIV/AIDS into care and help those patients already in care maximize their treatment. At least 60 percent of the peer educators will themselves be HIV-positive. Through train-the-trainer programs, each of these peer educators will commit to training an additional 10 educators.

Participants

In 15 of the top epicenter cities, the program will solicit applications from community-based counselors, advocates, and other individuals working in the field of HIV disease. (The cities are New York, Los Angeles, Chicago, Newark, Atlanta, Baltimore, Detroit, Washington, Oakland, Dallas, Jackson, San Francisco, St. Louis, Philadelphia, and Houston.) The program will be publicized through targeted advertising and by active recruitment through a network of selected ASOs that serve the African American community.

Each applicant will have to be sponsored by a community-based ASO, which will provide the first level of screening. In addition, the applicant will have to prepare an application packet which will include:

- Curriculum vitae, including education and work experience. Special emphasis will be placed on involvement in community-based AIDS work, either through paid employment or volunteer work.
- An essay explaining why the applicant wants to participate in the program, and what the applicant plans to accomplish for his or her community. The essay will help evaluate the written communication skills of the applicant.
- A brief and basic questionnaire about HIV science and treatment.
- Three letters of reference, with at least two from people working in the field of HIV.
- Applicants will be invited—but not required—to disclose their HIV status. Special consideration will be given to applicants who are HIV-positive.

The applications will be reviewed by an admissions committee comprising veteran community educators, doctors, and researchers. Finalists will be interviewed.

All participants must commit in writing to a two-year commitment that includes:

- The AIDS Treatment College
- Supervised field work with specific goals and requirements
- Continuing education through three update sessions
- Participation in mentoring and buddy programs

In addition, all participants must agree in writing that their participation in the program depends on achieving certain benchmarks throughout the two-year program. The AIDS Treatment College and each of the three update sessions will feature final examinations, which participants will be required to pass. In addition, their field work will be subject to the supervision of a certified ASO. These high standards will ensure that the program develops a cadre of superbly trained, highly motivated, and extremely effective educators.

The program will support 50 participants. However, additional participants may choose to attend the Treatment College. They will be required to pay a registration fee and cover their own travel and living expenses. These extra participants will also have to be accepted by the admissions committee.

AIDS Treatment College

For those applicants who are accepted, the first component of the program will be a month-long, intensive training called the AIDS Treatment College. It will be held on the campus of the University of Southern California (USC). Participants would be housed in the university dorms, thus lowering living expenses.

Overview

The College will be rigorous, like an AIDS education boot camp. To make sure that all students are fully prepared and get the most out of the experience, they will be assigned a College counselor, a faculty member who will live on campus with the students and whose job will be to shepherd students through the training program. No more than five students will be assigned to any one counselor. Each student will also be "buddied" with another student, from the same city if possible.

Before students arrive, they will have been sent introductory material, which they will be required to read. Buddies will meet each other, and the counselors will telephone their students (or meet in person, if they are in the same city) at least twice before the students arrive. During these pre-College phone calls, the counselor will identify

questions or concerns the student has. The counselor will also make sure the student understands the introductory material and that the buddies have met.

At the College, the counselors will meet with the students on a daily basis, track their performance on tests, tutor them in troublesome subjects (or arrange for tutoring if the subject is out of the counselor's area of expertise), and assist with any other needs that arise.

For each of the four weeks that the College is in session, Monday-Friday will be devoted to education on a variety of subjects. Saturday will be reserved for tutoring in subjects where students are having trouble, and Sunday will be a general free day, with optional group recreational activities.

The middle of last week will be devoted to final exams. These exams will include written and oral tests, a role-play in which a patient is counseled, and a one-hour treatment presentation. In order to graduate, students will have to score at least 85 percent on all these exams. The end of the final week will be used for tutoring students who fail to pass, and they will be retested. Students will also provide evaluations of the Treatment College and suggestions for how to improve it.

The College will conclude with graduation ceremonies, at which each student who passed the final exams will receive a diploma. These graduates will form the African American AIDS Treatment Team.

Faculty

Multi-disciplinary faculty will be recruited to develop the curriculum and teach at the College. Every effort will be made to recruit top researchers and doctors, such as Anthony Fauci, who has already agreed to commit his training expertise. In addition, at least 20 percent of the faculty will be African American—and here, too, top names will be sought, such as Houston doctor Keith Rawlings. A special effort will be made to ensure that all the counselors are African American, or at least people of color. While many of the faculty will be scientists or doctors, many will be experts in other areas, such as substance abuse treatment and HIV prevention. About a third will be veteran community educators from such organizations as Treatment Action Group (TAG), National Minority AIDS Council, AIDS Treatment News, and Project Inform.

At the college, there will be core faculty, who will teach over the entire one-month college, and visiting faculty, who will come for a short time. Faculty will be reimbursed accordingly. Many of the core faculty will live on campus with the students, and part of their job will be to tutor students during off-hours. Enough faculty will be hired to ensure a small student-teacher ratio.

All faculty, whether visiting or core, will agree to be available to graduates of the AIDS Treatment College for information and advice during the College *and afterwards*. The goal here is to create a lasting network of experts that the peer educators can rely on as they encounter questions and challenges in the field.

Individuals who have already agreed to serve on the AIDS Treatment College Faculty include:

- Researchers: Anthony Fauci
- Doctors: Keith Rawlings, Eric Goosby
- Community educators: Phill Wilson

Curriculum

A small, multidisciplinary team from the faculty will create the curriculum. It will cover topics such as the following:

- Basic biology of HIV disease and the immune system
- HIV treatment, including:
 - Principles of antiretroviral treatment
 - Specific drugs, including efficacy, drug-drug interactions, side effects, and on-going clinical trials
 - Pediatric treatment: principles and practice
- Adherence, including:
 - HIV resistance
 - Practical tips to help clients adhere
- Opportunistic infections, with an emphasis on prophylaxis and treatment
- Clinical trials, including:
 - Scientific theory, such as control arms, blinding, placebos, and ethics

- Successful strategies to enroll African Americans
- Experimental therapies, including therapeutic vaccines, hydroxyurea, immune boosters such as IL2 or CD3 antibody, and new drugs such as integrase inhibitors and zinc-finger inhibitors
- Countering fringe AIDS theories, including:
 - How we know HIV is the cause of AIDS, and how to respond to the most common arguments that it is not
 - How we know that therapies like alpha interferon or DHEA don't work
- Practical peer-education advice, including:
 - How to outreach: venues and techniques
 - How to deal with challenging clients, such as those who are addicted, homeless, living in abusive situations, and those who have a history of non-adherence
 - Common questions and answers
- Epidemiology, including
 - How AIDS is affecting African Americans
 - What proportion of African Americans with AIDS acquired their infection through injection drug use, homosexual sex, heterosexual sex, or vertical transmission
 - The link between STDs and AIDS
- Substance abuse treatment, with an emphasis on:
 - Harm reduction techniques
 - The effect of drug abuse on the immune system and on other diseases
- Building self-esteem, including:
 - The link between self-esteem and adherence

- Racism, homophobia, sexism, and negative stereotypes of addicts
 - The importance of non-judgmental, empathetic, client-focused education
- Optimizing the doctor-patient relationship, including:
 - How to find an HIV specialist
 - How to prepare for appointments
- Presentation skills, emphasizing
 - One-on-one counseling, including listening and trust-building skills
 - Public presentations
- Computer skills, including how to use the internet to obtain the latest HIV information
- Public assistance, including:
 - An overview of federal programs, such as ADAP and Ryan White
 - How to learn about state and local programs
 - How to learn how to link clients to local case management services
- HIV Prevention, including:
 - Vertical transmission and prophylaxis
 - The importance of HIV-positive people protecting themselves from other viruses, such as hepatitis and herpes
 - Safer sex guidelines, and how to negotiate safer sex
 - Safer drug use

In addition to the mandatory curriculum, there will also be the opportunity to "major" in particular elective fields, such as pediatric care, research advocacy, legislative issues, prevention, or substance abuse treatment.

The curriculum will be codified into a binder, including worksheets and self-tests, so that participants will have a comprehensive, written resource that they can refer to throughout their training and afterwards.

Education techniques will involve traditional lectures, multi-media presentations, small group seminars, and, where appropriate, role-playing.

Working Internships

Graduates of the AIDS Treatment College will immediately begin bringing African Americans with HIV/AIDS into care, through working internships at selected ASOs.

The ASOs will be responsible for supervising the treatment educators. They will manage them, provide administrative and logistical support, and log their accomplishments (for example, keep records of how many clients were served.)

Most of the peer educators will be employed by the ASOs, with their salaries split 50-50 between the ASO and this program. But some peer educators, especially those who are themselves HIV-positive, may want to volunteer rather than work for a salary, in order to preserve their health and public-assistance benefits. Either way, however, their work will be supervised and logged by the ASOs.

The ASOs will be chosen before the AIDS Treatment College begins, so that the peer educators can start their working internships immediately after graduation.

The ASOs will be selected through two separate processes, which together will guarantee placing the treatment educators. First, program organizers will select one or two highly-qualified, African American-based ASOs in each of the 15 target cities. These ASOs will have agreed to use graduates of the Treatment College as peer educators.

Second, a request for proposals (RFP) will be sent to all major ASOs serving the African American community in the target cities. The RFP will ask the ASOs to detail how they will use one or more of the peer educators who graduate from the Treatment College.

In either case, during the first year, the salary will be split 50-50 between the ASO and this program. In the second year, the ASO will assume responsibility for the full salary.

During the first year after graduation, peer educators will concentrate on educating African Americans with HIV/AIDS about treatment, adherence, the importance of getting into care, and so forth. They would accomplish this through:

- One-on-one counseling
- Community forums
- facilitating support groups
- Organizing treatment hotlines

They would find clients through outreach at venues such as:

- Public hospitals
- Community clinics
- STD clinics and HIV testing sites
- Substance-abuse centers
- Free clinics
- Homeless shelters

If each of the 50 peer educators shepherds just one person a week into care, then 2,500 African Americans will be brought into care during the first year alone. If each peer educator helps just one patient a week adhere to therapy for an extra six months, then they will probably have added 1,250 person-years of life to the African American community.

During the peer educators' second year, when they have had a year of experience and two additional update-training sessions under their belts, they would conduct train-the-trainer courses, using the AIDS Treatment College Curriculum. Each peer educator would commit to training a minimum of 10 additional peer educators. Thus, the graduating classes of the first two AIDS Treatment Colleges would train an additional 1,000 African American peer educators, an invaluable resource for an information-starved community.

Support

Treatment education is emotionally grueling and intellectually demanding. Especially during the first years, ongoing support is crucial. Many programs have failed because,

when the initial training program was completed, they left employees to sink or swim. Not this program. It will leverage the investment in the Treatment College through three kinds of on-going support: Continuing education, mentoring, and peer-support buddies.

Continuing Education

Graduates of the Treatment College will reconvene three times for in-service update training sessions. These will occur at 6, 12, and 24 months after the College. They will be structured as mini-versions of the original Treatment College: Students will receive intensive trainings by top faculty, and students will be required to pass tests on the material. These updates review key subjects, present new scientific and treatment information, and plan the next update session.

At months 12 and 24, the update session will coincide with the next class of the Treatment College. The experienced peer educators will receive an update session, and they will help train the next class of peer educators. At month 24, qualified graduates may be hired as full faculty members for the Treatment College.

Mentoring

Each graduate of the Treatment College will be linked with a doctor, researcher, or veteran community educator in the graduate's home city. It is expected that most mentors will have also served as faculty, to enhance continuity. Mentors will commit to meeting regularly with their peer educators. Mentors would also agree to be "on call" to answer any questions the peer educator might have. Finally, the mentor will complete a quarterly progress report.

Buddies

Countless studies have documented the power of peer-support to help people learn, work productively, and, in short, maximize their effectiveness. The buddies formed during Treatment College will continue to work together during the two-year internship program. They will commit to meeting once a month for both years, and they will each submit quarterly reports on what they have learned from each other, which will help in program evaluation. In the second year, buddies will be urged to work together on the train-the-trainer program.

CONCLUSION

This program attacks one of the main challenges of the AIDS epidemic—bringing African Americans into care. So great is this challenge that the President has identified it as one of the six most important racial health-care gaps, launching a billion-dollar public-private initiative to close it. This program can play a major part in that endeavor.

Finally there are other communities that also need special attention. This program could serve as a pilot program for other marginalized populations, such as Hispanics/Latinos (especially those who do not speak English) and Native Americans. We therefore that observers participate in the first Treatment College, so that they might create similar programs.

END

Budget Summary and Budgets for Management and Internship Matching Grants

Budget Summary		
Description	Cost	Total Cost
YEAR ONE		
Management	\$175,000	
AIDS Treatment College	\$470,650	
Internship Matching Grants	\$750,000	
6-Month Update Training Session	\$73,710	
12-Month Update Training Session	\$113,790	
TOTAL YEAR ONE PROGRAM COST		\$1,583,150
YEAR TWO		
Management	\$175,000	
Second AIDS Treatment College	\$470,650	
Internship Matching Grants (for grads of 2nd Treatment College)	\$750,000	
6-Month Update Training Session (for grads of 2nd Treatment College)	\$73,710	
12-Month Update Training Session (for grads of 2nd Treatment College)	\$113,790	
24-Month Update Training Session (for grads of 1st Treatment College)	\$113,790	
TOTAL YEAR TWO PROGRAM COST		\$1,696,940
Management		
One program director, full-time	\$50,000	
One meeting planner, full-time	\$25,000	
One Administrative assistant, part-time	\$20,000	
Payroll, health insurance, etc.	\$20,000	
Two program consultants	\$12,000	
One fiscal agent	\$10,000	
Office equipment (computers, fax, copier) and supplies	\$20,000	
Rent (\$1,500 per month)	\$18,000	
Total Management Cost		\$175,000
Working Internship Matching Grants		
(Half of first-year salary)		
50 interns @ \$15,000	\$750,000	\$750,000

NOTE: These budgets are provisional

Budget for the AIDS Treatment College

Page 1

Description	Cost	Total Cost
Advertising & Recruitment		
15 cities, \$10,000 per city	\$150,000	\$150,000
Materials		
Design (logo, letterhead, signage, binders, etc.)	\$6,000	
Printing	\$10,000	
Postage	\$5,000	
Total Materials		\$21,000
Audio Visual		
Projectors, screens, video, audio, technical time	\$15,000	\$15,000
Classroom Rental		
University classrooms	\$5,000	\$5,000
Curriculum Development		
6 faculty @ \$500 per person	\$3,000	\$3,000
Honoraria		
(Visiting faculty: \$200 per day. Core faculty: \$300 per day)		
8 visiting faculty for 3 days	\$4,800	
4 visiting faculty for 5 days	\$4,000	
4 visiting faculty for 12 days	\$9,600	
10 core faculty for 28 days	\$84,000	
Total honoraria		\$102,400
Travel		
(Air: one round-trip coach ticket)		
25 students @ \$700 each	\$17,500	
25 students @ \$400 each	\$10,000	
13 faculty @ \$700 each	\$9,100	
13 faculty @ \$400 each	\$5,200	
4 staff @ 700	\$2,800	
Ground transfers: 80 people @ \$30 each	\$2,400	
Total Travel		\$47,000
Accommodations		
(University dorm rooms: \$30 per day, per person)		
50 students for 28 nights	\$42,000	
8 faculty for 3 nights	\$720	
4 faculty for 5 nights	\$600	
4 faculty for 12 nights	\$1,440	
10 faculty for 28 nights	\$8,400	
4 staff for 32 nights	\$3,840	
Total Accomodations		\$57,000

NOTE: This budget is provisional

Budget for the AIDS Treatment College

Page 2

Meals		
(\$35 per day per person)		
50 students for 28 days	\$49,000	
8 faculty for 3 days	\$840	
4 faculty for 5 days	\$700	
4 faculty for 12 days	\$1,680	
10 faculty for 28 days	\$9,800	
4 staff for 32 days	\$4,480	
Graduation banquet: 75 people at \$50 per person	\$3,750	
Total Meals		\$70,250
TOTAL TREATMENT COLLEGE COST		\$470,650

NOTE: This budget is provisional

Budget for the 6-Month Update Training

NOTE: The 6-month update will last for four days.

Description	Cost	Total Cost
Materials		
Design (logo, signage, binders, etc.)	\$2,000	
Printing	\$5,000	
Postage	\$2,500	
Total Materials		\$9,500
Audio Visual		
Projectors, screens, video, audio, technical time	\$5,000	\$5,000
Classroom Rental		
University classrooms	\$1,500	\$1,500
Curriculum Development		
3 faculty @ \$250 per person	\$750	\$750
Honoraria		
(All honoraria: \$200 per day)		
6 faculty for 4 days	\$4,800	\$4,800
Travel		
(Air: one round-trip coach ticket)		
25 students @ \$700 each	\$17,500	
25 students @ \$400 each	\$10,000	
6 faculty @ \$700 each	\$4,200	
4 staff @ 700	\$2,800	
Ground transfers: 60 people @ \$30 each	\$1,800	
Total Travel		\$36,300
Accommodations		
(University dorm rooms: \$30 per day, per person)		
50 students for 4 nights	\$6,000	
6 faculty for 4 nights	\$720	
4 staff for 5 nights	\$600	
Total Accommodations		\$7,320
Meals		
(\$35 per day per person)		
50 students for 4 days	\$7,000	
6 faculty for 4 days	\$840	
4 staff for 5 days	\$700	
Total Meals		\$8,540
TOTAL 6-MONTH UPDATE COST		\$73,710

NOTE: This budget is provisional

Budget for the 12-Month Update Training

NOTE: The 12-month update will coincide with the second Treatment College. First-year graduates will spend one week participating in their own update training, and one week tutoring the new Treatment College students.

Description	Cost	Total Cost
Materials		
Design (logo, signage, binders, etc.)	\$2,000	
Printing	\$5,000	
Postage	\$2,500	
Total Materials		\$9,500
Audio Visual		
Projectors, screens, video, audio, technical time	\$5,000	\$5,000
Classroom Rental		
University classrooms	\$2,500	\$2,500
Curriculum Development		
3 faculty @ \$250 per person	\$750	\$750
Honoraria		
(All honoraria: \$200 per day)		
8 faculty for 5 days	\$8,000	\$8,000
Travel		
(Air: one round-trip coach ticket)		
25 students @ \$700 each	\$17,500	
25 students @ \$400 each	\$10,000	
8 faculty @ \$700 each	\$5,600	
2 staff @ 700	\$1,400	
Ground transfers: 60 people @ \$30 each	\$1,800	
Total Travel		\$36,300
Accommodations		
(University dorm rooms: \$30 per day, per person)		
50 students for 14 nights	\$21,000	
8 faculty for 5 nights	\$1,200	
2 staff for 28 nights	\$1,680	
Total Accommodations		\$23,880
Meals		
(\$35 per day per person)		
50 students for 14 days	\$24,500	
8 faculty for 5 days	\$1,400	
2 staff for 28 days	\$1,960	
Total Meals		\$27,860
TOTAL 12-MONTH UPDATE COST		\$113,790

NOTE: This budget is provisional

Budget for the 24-Month Update Training

NOTE: The 24-month update will coincide with the third Treatment College. First-year and second-year graduates will spend one week receiving their own update training, and one week tutoring the new Treatment College students.

Description	Cost	Total Cost
Materials		
Design (logo, signage, binders, etc.)	\$2,000	
Printing	\$5,000	
Postage	\$2,500	
Total Materials		\$9,500
Audio Visual		
Projectors, screens, video, audio, technical time	\$5,000	\$5,000
Classroom Rental		
University classrooms	\$2,500	\$2,500
Curriculum Development		
3 faculty @ \$250 per person	\$750	\$750
Honoraria		
(All honoraria: \$200 per day)		
8 faculty for 5 days	\$8,000	\$8,000
Travel		
(Air: one round-trip coach ticket)		
25 students @ \$700 each	\$17,500	
25 students @ \$400 each	\$10,000	
8 faculty @ \$700 each	\$5,600	
2 staff @ 700	\$1,400	
Ground transfers: 60 people @ \$30 each	\$1,800	
Total Travel		\$36,300
Accommodations		
(University dorm rooms: \$30 per day, per person)		
50 students for 14 nights	\$21,000	
8 faculty for 5 nights	\$1,200	
2 staff for 28 nights	\$1,680	
Total Accomodations		\$23,880
Meals		
(\$35 per day per person)		
50 students for 14 days	\$24,500	
8 faculty for 5 days	\$1,400	
2 staff for 28 days	\$1,960	
Total Meals		\$27,860
TOTAL 24-MONTH UPDATE COST		\$113,790

NOTE: This budget is provisional



May 28, 1998

Phill Wilson
Director, AIDS Social Policy Archive
University of Southern California
3780 Tracy Street
Los Angeles, CA 90027-4649

Dear Mr. Wilson:

I enthusiastically endorse your proposal for an African American AIDS Treatment Team and strongly encourage funding organizations to give serious consideration to supporting this important project.

African Americans account for nearly half of all new AIDS cases in our country. Even here in San Francisco, with the model prevention and care programs of which we are so proud, African Americans are diagnosed with AIDS at a rate twice that of our proportion of the population. Due to a multitude of internal and external barriers, African Americans are less likely to avail ourselves of testing and, if necessary, treatment. As a result, African Americans with HIV and AIDS and generally receive inferior healthcare, and often die sooner than other population groups.

Your strategy for bringing African Americans with HIV and AIDS into higher-quality care is a very positive step in addressing the growing racial disparity in this disease. Treatment education in the community, using trained peer advocates, is absolutely essential in order for many African Americans to benefit from the promising new medical therapies.

I commend you and your colleagues for taking the leadership on this complex issue and for developing a program that has the potential for saving many lives.

Please let me know how I can be of assistance to your project and keep me informed on your progress.

Sincerely,

A handwritten signature in black ink, appearing to read "Willie L. Brown, Jr.", written in a cursive style.

WILLIE L. BROWN, Jr.
Mayor

■ 3780 TRACY ST., LOS ANGELES, CA 90027-4649

PHILL WILSON

Todd,

Here is Another copy of the
Affinity Analysis Document
[Drafting I spoke to you
about. Can you review it and
get back to me. Also, is it possible to
get a letter of endorsement from
SAVVY. Take care] PHILL

FAX COVER SHEET

Centers for Disease Control and Prevention

**Division of HIV/AIDS Prevention -
Intervention Research and Support
1600 Clifton Road, N.E. (Mailstop E-35)
Atlanta, Georgia 30333**

Pages: 18 (*excludes this cover*)

Date: 2-17-99

To: SUMMERS, TODD (fax: 202-456-2438)
VON ZINGERNAGEL, DEBORAH (fax: 202-690-6584)
SHRIVER, MICHAEL (fax: 415-597-9125)

From: **David R. Holtgrave, Ph.D.**
Director
Division of HIV/AIDS Prevention -IRS
Tel: 404-639-5200 Fax: 639-0897

Subject: PERSONAL COPY FROM DAVID HOLTGRAVE.....

Comments:

"PERSONAL COPY FROM DAVID HOLTGRAVE --- PUBLISHED IN FEDERAL

REGISTER 2/17/99"

Please phone 404-639-5200 if retransmission may be necessary.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL AND PREVENTION

Human Immunodeficiency Virus (HIV) Prevention Activities for
African American Populations

AGENCY: Centers for Disease Control and Prevention (CDC),

Department of Health and Human Services (HHS)

ACTION: Notice and Request for Comments.

SUMMARY: The Fiscal Year 1999 appropriation for CDC includes an increase in funds to support Human Immunodeficiency Virus (HIV) prevention activities predominantly for African American populations. CDC is proposing to award approximately \$15.5 million to fund three cooperative programs to address the needs of these populations: community-based organizations (CBO) program, minority organization technical assistance (MOTA) program, and community coalitions demonstration program to develop linkages among HIV, STD (sexually transmitted diseases), TB (tuberculosis), and substance abuse services. On the basis of demonstrated need and available funds, other disproportionately affected racial and ethnic minority populations may be considered for funding.

Under separate announcements, an additional \$500,000 will be awarded to CBOs in the Virgin Islands to provide HIV prevention services, and \$300,000 to Divinity Schools affiliated with Historically Black Colleges and Universities to develop HIV

prevention training and curricula.

The purpose of this notice is to request comments on these proposed programs. After consideration of comments submitted, CDC will publish program announcements to solicit applications. A more complete description of the goals of these programs, the target applicants, availability of funds, program requirements, and evaluation criteria follows.

DATES: The public is invited to submit comments by (insert 14 days after date of publication in the Federal Register).

ADDRESS: Submit comments to:

Technical Information and Communication Branch
National Center for HIV, STD and TB Prevention
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE., Mailstop E-49
Atlanta, GA 30333.

FOR FURTHER INFORMATION CONTACT:

Technical Information and Communications Branch
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention
1600 Clifton Road, NE., Mail Stop E-49
Atlanta, GA 30333
Fax (404) 639-2007
E-mail address: hivmail@cdc.gov
Telephone (404) 639-2072

SUPPLEMENTARY INFORMATION:

CBO Program: The purpose of this program is to support the development and implementation of effective community-based HIV prevention programs, including programs provided by faith-based CBOs, that serve African American communities.

1. Goals (CBO)

- A. Provide financial and technical assistance to indigenous CBOs to provide HIV prevention services to primarily African American populations for which gaps in services are demonstrated. For this program, indigenous organizations are defined as organizations that evolved from and are located within the communities they serve.
- B. Support HIV prevention programs that reflect national program goals and are consistent with the HIV prevention priorities outlined in the jurisdiction's comprehensive HIV prevention plan.
- C. Promote the collaboration and coordination of HIV prevention efforts among CBOs and other local, State, and federally funded programs.

2. Eligible Applicants (CBO)

Eligible applicants are minority CBOs, including faith-based organizations, that meet the following criteria:

- A. An IRS-determined 501(c) tax-exempt status
- B. A governing board composed of more than 50 percent

of the racial or ethnic population to be served. This body must also include, or demonstrate the ability to obtain meaningful input and representation from, members of the target populations, for example, men who have sex with men, youth, women at risk, transgender populations, substance abusers.

C. Located and providing services in any of the following:

- (1) the 20 metropolitan statistical areas (MSAs) with more than 1000 AIDS cases in African American populations in 1997. These MSAs are: Atlanta, GA; Baltimore, MD; Boston, MA; Chicago, IL; Dallas, TX; Detroit, MI; Ft. Lauderdale, FL; Houston, TX; Jacksonville, FL; Los Angeles-Long Beach, CA; Miami, FL; Newark, NJ; New Haven, CT; New Orleans, LA; New York, NY; Oakland, CA; Philadelphia, PA; San Francisco, CA; West Palm Beach, FL; and Washington, D.C.; or
- (2) the counties and independent city with the most syphilis cases in 1997 but not included in the list of MSAs above. The counties are: Cumberland, NC; Cuyahoga, OH; Davidson, TN; Forsyth, NC; Franklin, OH; Fresno, CA; Guilford, NC; Hinds, MS; Jefferson, AL; Jefferson, KY; Maricopa, AZ; Marion, IN;

Milwaukee, WI; Oklahoma, OK; Prince Georges, MD; Shelby, TN; and Tuscaloosa, AL. The independent city is St. Louis, MO.

D. Minority CBOs currently funded under program announcement 704 that are located and provide services in the areas specified in B and C are eligible to apply for funding under this program announcement. However, awards to currently funded minority CBOs will not exceed \$100,000.

E. Faith-Based Organizations: For the purpose of this program announcement, a faith-based community organization is a non-profit organization which (1) has a religious, faith, spiritual focus or constituency, and (2) has access to local religious, faith, and spiritual leaders.

Eligible organizations include

- (1) individual church, mosque, or temple or network of same, or
- (2) a community-based organization whose primary constituency is faith, spiritual, or religious communities, organizations, or leaders thereof.

3. Availability of Funds (CBO)

Approximately \$9,600,000 is available for funding approximately 45 minority CBOs, including faith-based community organizations. Approximately \$600,000 of

this total will be awarded to faith-based organizations;

- A. Approximately \$7,000,000 will be awarded to CBOs in the 20 MSAs with more than 1000 AIDS cases in African American populations in 1997. Awards for new organizations will range from \$150,000 to \$300,000 and the average award will be approximately \$200,000. Applications for more than \$300,000 will be deemed ineligible.
- B. Approximately \$1,600,000 will be awarded to CBOs located and providing services in the counties and independent city with the most syphilis cases in 1997 not included in the top 20 MSAs. These awards will average \$200,000 and will range from \$150,000 to \$250,000. Applications for more than \$250,000 will be deemed ineligible.
- C. Approximately \$1,000,000 may be awarded to minority CBOs currently funded under Program Announcement 704 that are located and provide services in the MSAs, counties, and independent city listed above. Supplemental awards for currently funded minority CBOs will not exceed \$100,000. Applications for more than \$100,000 will be deemed ineligible. Funds awarded to currently funded CBOs must be used to enhance or expand existing activities.
- D. **Funding Priorities:** In making funding decisions,

efforts will be made to ensure a national geographic distribution of funded CBOs, based on AIDS morbidity, and to ensure a national distribution of funded CBOs in terms of targeted risk behaviors, based on AIDS morbidity.

4. Program Requirements (CBO)

- A. Conduct HIV counseling, testing, and referral services and health education and risk reduction (HE/RR) interventions for persons at high risk of becoming infected or transmitting HIV to others. Counseling, testing, and referral services as well as the following four HERR interventions will be funded: Individual Level, Group Level, Community Level, and Street and Community Outreach. Each recipient must conduct at least one of these priority interventions. Applicants are encouraged not to apply for more interventions than they can conduct effectively.
- B. Assist high-risk clients in gaining access to HIV antibody counseling, testing, and referral for other needed services.
- C. Assist HIV positive persons in gaining access to appropriate HIV treatment and other medical care, substance abuse prevention services, STD treatment, partner counseling and referral services, and health education and risk reduction services.

- D. Coordinate and collaborate with health departments, community planning groups, and other organizations and agencies involved in HIV prevention activities, especially those serving the same target population.
 - E. Evaluate all major program activities and services.
5. Evaluation Criteria (CBO)
- A. Assessment of Need and Justification for the Proposed Activities (15 points)
 - B. Long-term Goals (5 points)
 - C. Organizational History and Capacity. (20 points)
 - D. Program Plan (30 total points)
 - E. Evaluation Plan (20 points)
 - F. Communications/Dissemination Plan (5 points)
 - G. Plan for Acquiring Additional or Matching Resources (5 points)
 - I. Budget/Staffing Breakdown and Justification (not scored)
 - J. Training and Technical Assistance Plan (not scored)
 - K. Before final award decisions are made, CDC may make site visits to CBOs whose applications are highly ranked or may review the following items with the local or State health department and applicant's board of directors:
 - 1. The organizational and financial capability

of the applicant to implement the proposed program;

2. The application and program plans for priority interventions, compliance with the jurisdiction's HIV prevention priorities as outlined in the comprehensive plan or, if the proposed program varies from the jurisdiction's comprehensive plan, evaluate the rationale for the variance; and
3. The special programmatic conditions and technical assistance requirements of the applicant.

A fiscal Recipient Capability Assessment may be required of applicants prior to the award of funds.

MOTA Program:

1. Goal (MOTA)

Improve the capacity of CBOs, including faith-based organizations, to deliver effective HIV prevention services to African Americans and increase the effectiveness and responsiveness of the HIV prevention community planning process and health department HIV prevention programs to meet the needs of African American communities heavily affected by HIV and other STDs.

2. Eligible Applicants (MOTA)

- A. National, regional, or local minority organizations.
 - B. National, regional, or local minority religious, spiritual, or faith-based organization, which may include churches, mosques, or temples.
3. Availability of Funds (MOTA)

- A. Approximately \$2.4 million will be available.
Approximately \$600,000 of the \$2.4 million will be available for faith-based projects.
- B. Funding priorities will ensure
 - (1) a national geographic distribution of available technical assistance and training services, consistent with AIDS morbidity;
 - (2) availability of technical assistance and training services to organizations predominantly serving African Americans and highly affected subgroups consistent with AIDS morbidity of these subgroups; and
 - (3) an appropriate balance in the types of technical assistance and training services available.

4. Program Requirements (MOTA)

Delivery of technical assistance must be specified according to (1) racial or ethnic population and (2) targeted high-risk group (e.g., men who have sex with men [MSMs], injecting drug users [IDUs] and non-injecting substance users, women at risk,

transgender, high-risk heterosexuals, youth).

Organizations may apply to provide technical assistance in one or more of the following areas. However, applicants need not apply to provide service in all areas and should not attempt to provide technical assistance in areas in which they do not currently have expertise and capacity.

- A. Technical Assistance for HIV Prevention Service Delivery;
 - B. Technical Assistance for Management and Administrative Capacity;
 - C. Technical Assistance to ensure the needs of racial and ethnic minority populations are addressed in Community Planning; or
 - D. Technical Assistance to develop community capacity for leadership in HIV prevention programs and policy making.
5. Evaluation Criteria (MOTA)

Criteria A through G will be scored, but weights have not been assigned. Public comment is encouraged.

- A. Assessment of Need and Justification for Proposed Activities
- B. Long-term Goals
- C. Organizational History and Capacity
- D. Program Proposal
 - (1) Involvement of Target Population

- (2) Appropriateness of Interventions
- (3) Objectives
- (4) Plan of Operations
- (5) Scientific, Theoretical, Conceptual, or
Program Experience Foundation
- (6) Coordination and Collaboration
- (7) Time Line
- E. Evaluation Plan
- F. Communication and Dissemination Plan
- G. Plan for Acquiring Additional or Matching
Resources
- H. Budget/Staffing Breakdown and Justification (not
scored)
- I. Training and Technical Assistance Plan (not
scored)

Community Coalition Demonstration Program: The purpose of this program is to improve the health status of African American community members by increasing access to linked networks of health services including HIV, STD, TB, and substance abuse prevention, treatment, and care.

1. Goals (Community Coalition)

- A. Plan and develop a linked network of HIV, STD, TB, and substance abuse prevention, treatment, and care services for African American and Latino community members,
- B. Strengthen existing linkages among local

prevention, treatment, and care providers to better serve African American and Latino communities heavily affected by HIV, STD, TB, and substance abuse.

2. **Eligible Applicants (Community Coalition)**

A. Local non-profit health, social service, or voluntary service organizations, or CBOs with IRS-determined 501(c) tax-exempt status and a governing or advisory body composed of more than 50 percent of the racial or ethnic minority population to be served.

B. Applications under this announcement will be categorized into one of two mutually exclusive groups:

(1) organizations serving communities located in high HIV prevalence MSAs, or

(2) organizations serving communities located in lower HIV prevalence geographic areas.

3. **Availability of Funds (Community Coalition)**

A. Phase 1 (Year 1): Approximately 20 organizations will be funded in 1999 to plan and design a linked network of services in African American or Latino communities highly affected by HIV, STD, TB, and substance abuse. Approximately \$2,750,000 will be available to fund approximately 15 projects in the high prevalence MSAs listed under CBOs. It is estimated that the average award will be \$180,000.

ranging from \$75,000 to \$300,000. Approximately \$750,000 will be available in FY 1999 to fund approximately 5 projects in lower HIV prevalence geographic areas listed under CBOs. It is estimated that the average award will be \$150,000, ranging from \$50,000 to \$200,000.

- B. Phase 2 (Year 2 - 5): Three to five of the Phase 1 grantees will receive continuation awards for Phase 2. Selection of Phase 2 grantees will be based on the extent and quality of progress in the planning and designing phase. The number of Phase 2 awards will be based on availability of funds. Phase 2 awards will be made for a 12-month budget period within a project period of up to four years.

Applications for more than \$300,000 in high prevalence areas and \$200,000 in low prevalence areas will be deemed ineligible.

- C. Funding Priorities: In making awards for Phase 1, priority will be given to assuring geographic distribution nationally consistent with HIV/AIDS morbidity.

4. Program Requirements (Community Coalition)

- A. Phase 1 The recipient will be responsible for coordinating efforts among collaborating organizations and agencies and will:

- (1) Identify a full-time position with the responsibility, authority, professional training, and experience needed to lead and coordinate program activities of the coalition;
- (2) Convene a work group consisting of representatives from local service providers and affected community members to develop a plan for a linked network of services;
- (3) Identify key community leaders and engage them as part of the coalition;
- (4) Establish linkages with local HIV prevention community planning groups;
- (5) Conduct a community needs assessment, as appropriate;
- (6) Develop an inventory of existing community resources, as appropriate;
- (7) Use information developed by the community planning groups pertinent to the targeted community;
- (8) Establish linkages with existing local and community-based organizations funded by the federal government to prevent and treat HIV/AIDS, other STDs, TB, and substance abuse including local health departments, neighborhood health clinics, WIC programs and family planning clinics;

(9) Participate in at least one CDC sponsored meeting of funded agencies; and

(10) Begin to implement the plan for a linked network of services.

B. Phase 2: The recipient will:

(1) Fully implement the plan;

(2) Serve as liaison among members of the coalition to provide management oversight, facilitate program implementation and operations, and maintain effective working relationships; and

(3) Conduct an evaluation of the system and of client outcomes.

5. Evaluation Criteria (Community Coalition)

A. Assessment of Need and Justification for Proposed Activities (Total 20 Points)

B. Long-term Goals (Total 5 points)

C. Existing Collaborative Activities and Organizational History and Capacity (25 points)

D. Program Plan (25 points)

E. Program Management and Staffing Plan (10 points)

F. Communication and Dissemination Plan (5 points)

G. Evidence of Support from the Target Community (10 points)

H. Plan for Acquiring Additional or Matching Resources (not scored)

FEB. -17' 99 (WED) 15:59

CDC/DHAP/IRS

TEL:404 639 5260

P. 018

- I. Budget Breakdown and Justification (not scored)
- J. Training and Technical Assistance Plan (not scored)

DATED:

Joseph R. Carter
Acting Associate Director for
Management and Operations
Centers for Disease Control and
Prevention (CDC)



National Center for HIV, STD, & TB Prevention

Office of the Director Office of Communications ***FAX TRANSMITTAL COVER SHEET***

From the desk of

Scott McCoy

Date: 3/3/99

Tel. no.: 404/639-8890

Fax no.: 404/639-8910

Current Mailing Address Below:

11 Corporate Square, Room 1212

Mailstop E-06

Atlanta, Georgia 30329

Pages 11 ***(including cover)***

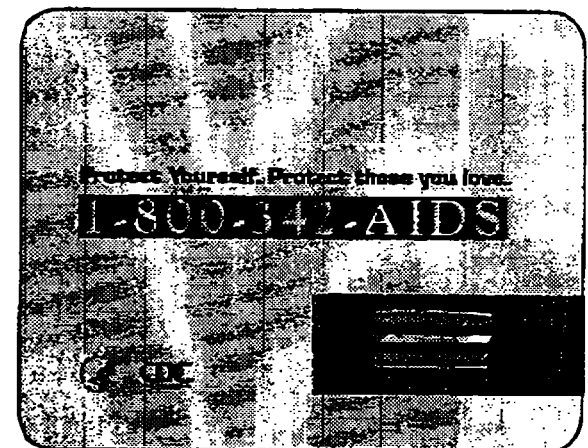
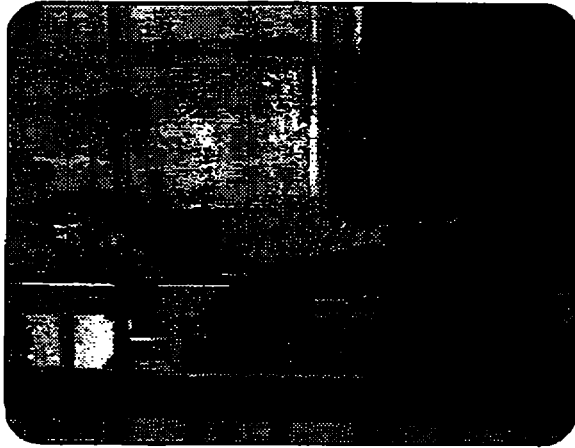
Name: Todd Summers

Tel. No.: _____

Fax No.: 202-456-2438

Comments: Todd, here are the "storyboards" for the African-American PSA's. I will put a clean copy in the mail for you, also. Please call if you have any questions or need anything else - Scott.

Baby :30

**VOICE OVER:**

My man died.

Now they tell me it was AIDS.

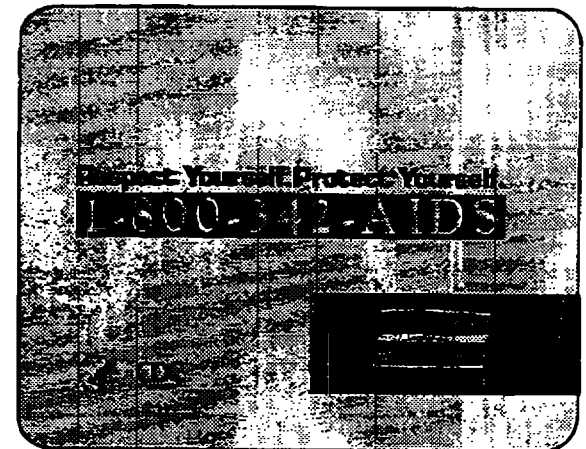
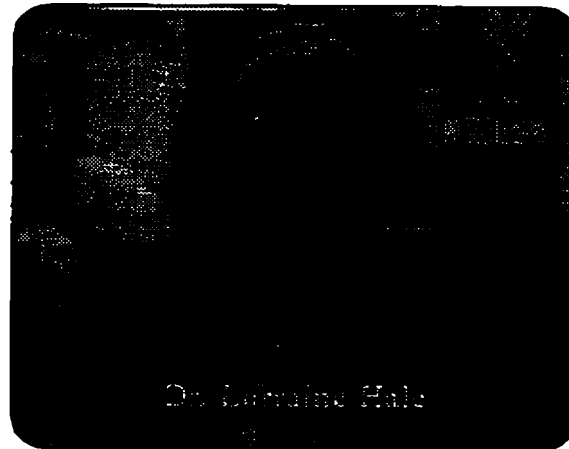
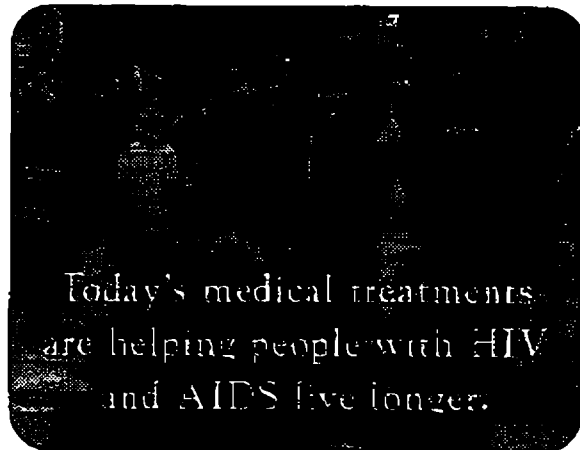
Hey, I didn't know anything about AIDS, and I didn't know he had passed the virus on to me, either...

Not until my baby was born with it.

ANNOUNCER:
(female)

Don't let this happen to you. If you're pregnant, get tested for HIV. There are new medicines that will not only help you, they will also help keep your baby safe. For free information, call 1-800-342-AIDS.

Dr. Hale :30

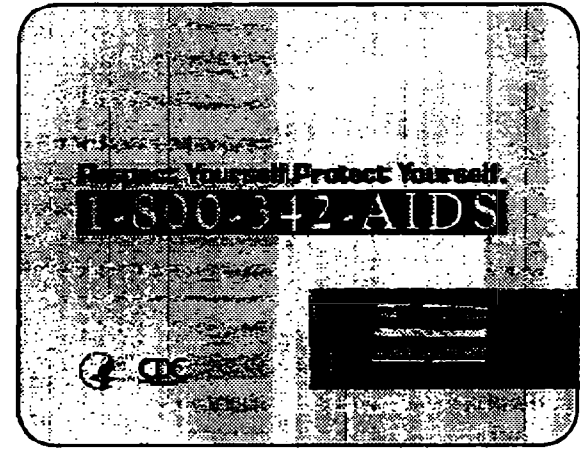


ANNOUNCER: Today's medical treatments are helping people with
(male) HIV and AIDS live longer. But we are still a long way from a cure

DR. HALE: There is no cure for AIDS. That's today.
But it is preventable. It's everyone's job to work at prevention.

ANNOUNCER: To find out more about HIV prevention and
(male) the benefits of early medical treatment, call 1-800-342-AIDS.

Bodybuilder :30

**VOICE OVER:**

I am into feeling good. And I work hard at it.
It's about being as strong and healthy as I can be.
So, I'm going to get tested for HIV, the AIDS virus.
If I do have HIV, I gotta know. Medical treatment
can help me stay healthy. And knowing can help me
prevent passing HIV to others.
Staying healthy...that's what it's all about.

ANNOUNCER:
(male)

Know if you have HIV. Call 1-800-342-AIDS to find
out where you can get a HIV test in your
community.

Motherwit :30

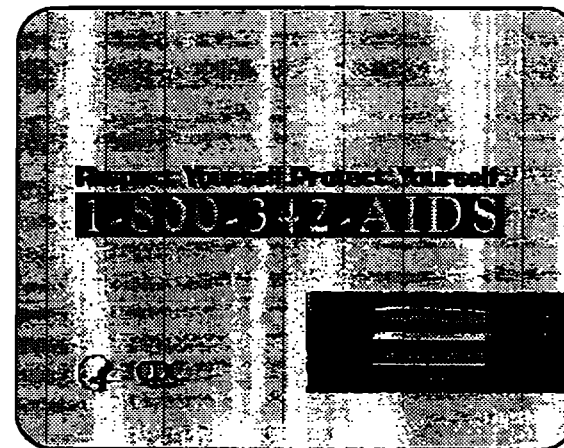
**VOICE OVER:**

I've taught my kids the way my momma taught me. She gave a strong sense of what's right. She called it "motherwit." Even as young as my kids are, they know their way around. And they're well aware I can draw the line if I have to. But with AIDS out there, I'm gonna have to dig a little deeper and talk a little longer about drugs, sex and AIDS.

ANNOUNCER:
(female)

Talking regularly with your children about topics like sex and drugs can keep them safe.
Call 1-800-342-AIDS for a free brochure.

Men Talk About It :30



VOICE OVER:

If I'm gonna have sex, it's gonna be protected. If it's not going to be protected, it's not gonna be sex.

I will talk about sex in a minute.

We have to talk about sex.

It's gonna come up.

If you don't practice safe sex — and I do — then we're not made for each other.

It's not hard to get the words out.

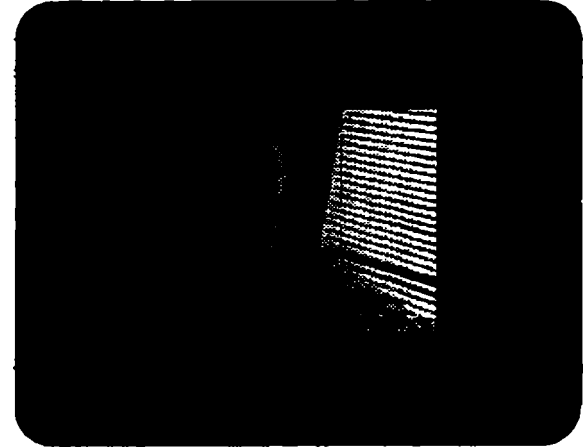
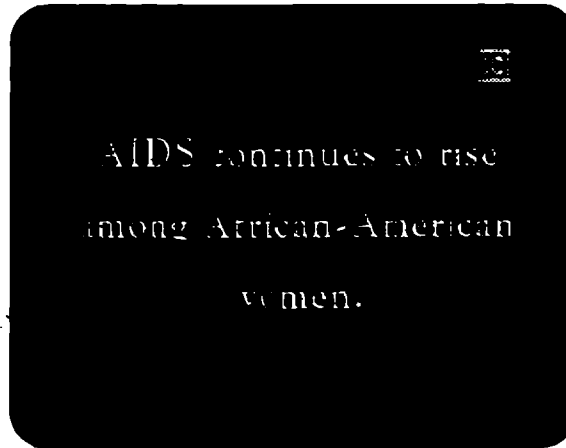
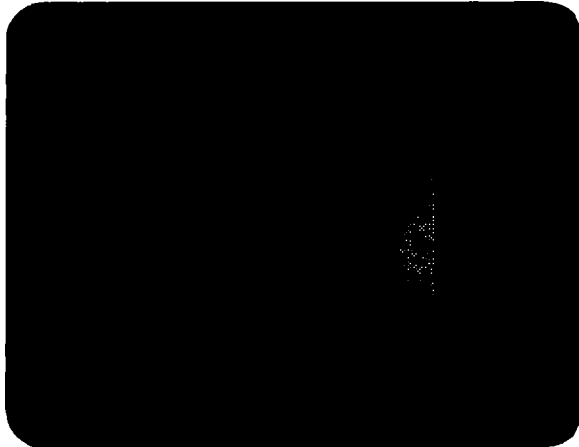
I'm HIV negative and I intend to stay that way.

ANNOUNCER:

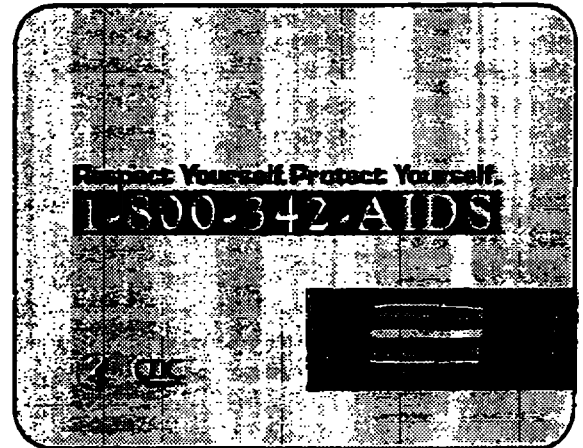
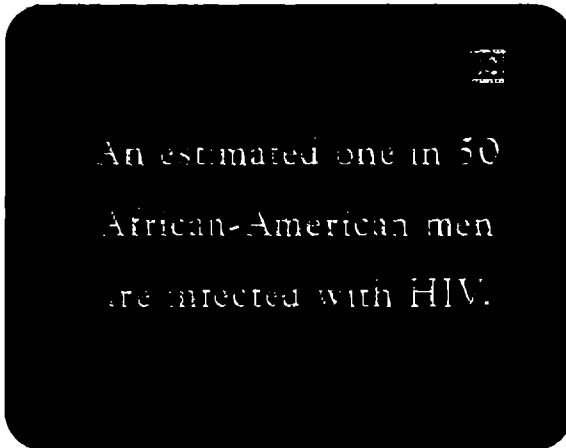
(male)

An estimated one in 50 African American men are infected with HIV. To learn more, call 1-800-342-AIDS.

Gatekeeper :20



Released in 1995. Slides are new
(to focus on African Americans).



VOICE OVER: I could never, never talk to my parents about sex. I mean, that was just like, are you kidding?

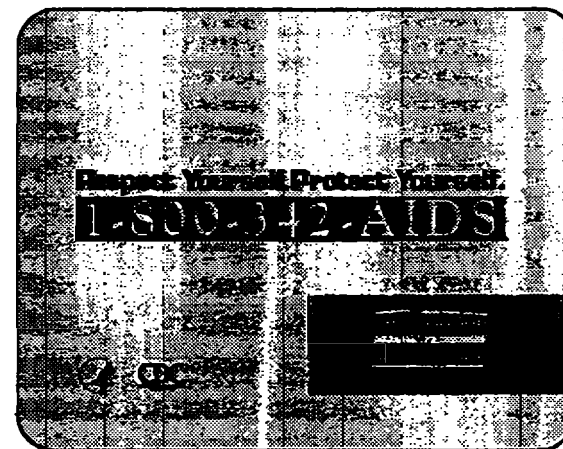
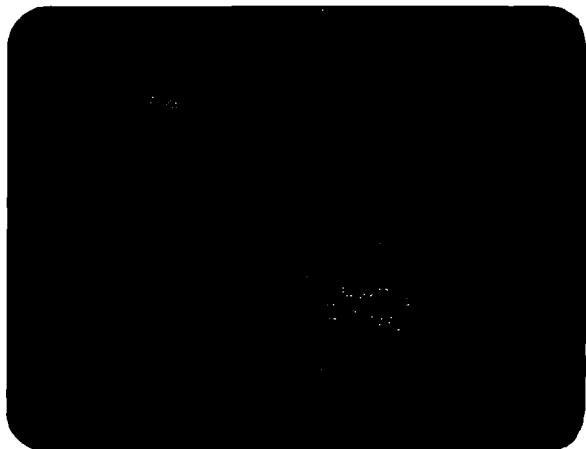
Slide: (no voice over)

VOICE OVER: I mean, I feel really lucky for the fact that I was able to talk to my parents so openly about sex and responsibilities.

Slide: (no voice over)

ANNOUNCER: Don't be afraid to talk to your parents about sex and preventing HIV. Ask questions. Learn more about how to protect yourself.

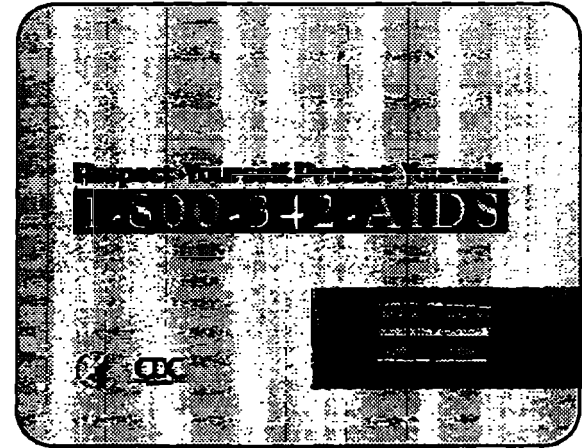
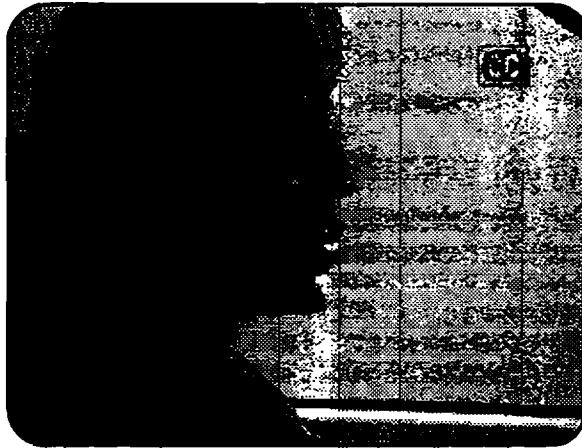
Automatic :30



VOICE OVER:
(male)

It would be nice if latex condoms were automatic.
But since they're not, using them should be.
Simply because a latex condom used consistently
and correctly can prevent the spread of HIV and
other sexually transmitted diseases.

Peer Educator/Condoms :30

**VOICE OVER:**

I'm out here every week talking to people about sex.

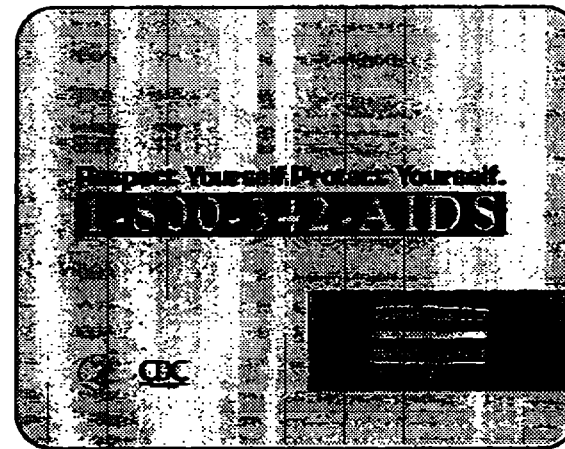
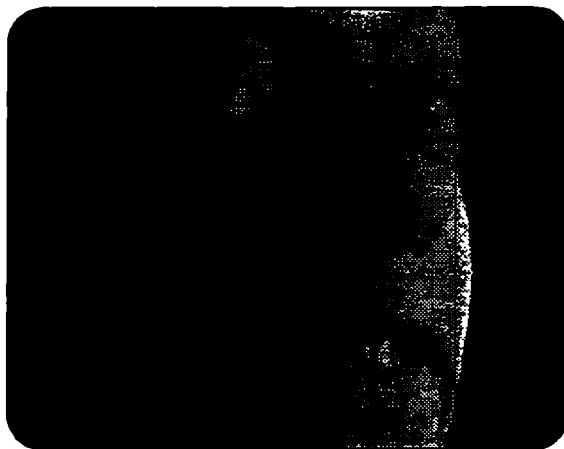
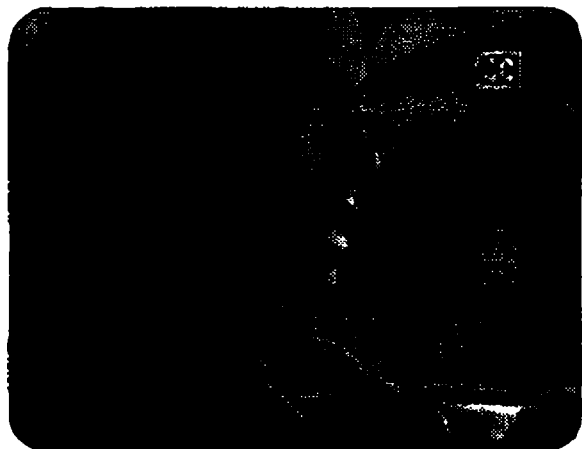
My message is simple.

If you're gonna have sex, a latex condom used consistently and correctly can help prevent the spread of HIV and other STDs.

People out there gotta understand.

That's why I'll go anywhere to talk about latex condoms. Even into your living room.

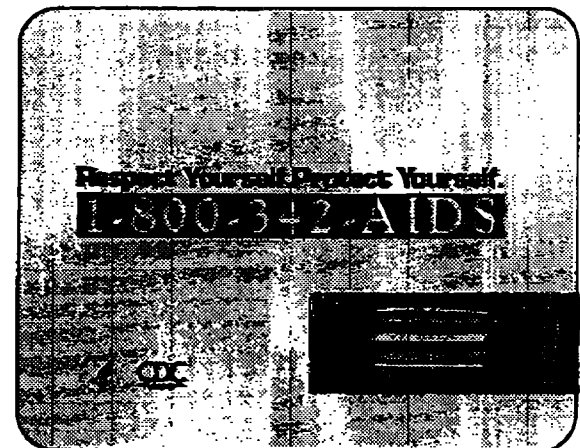
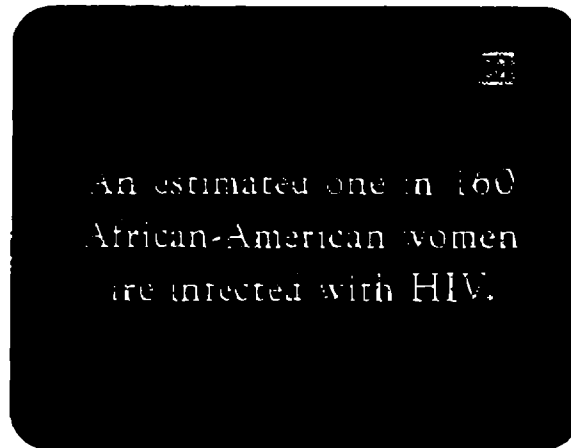
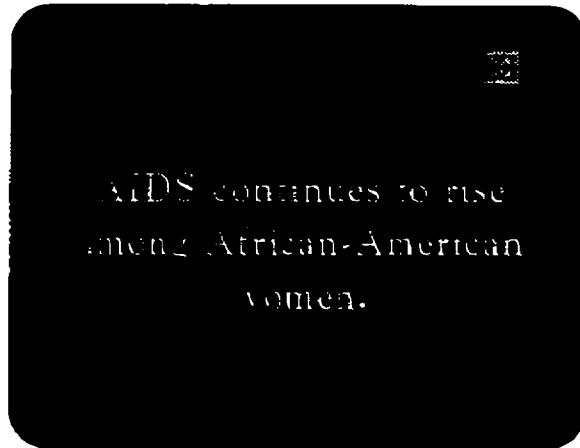
Peer Educator/Delay :30



VOICE OVER:

I see a lot of people my age who aren't ready for sex.
I tell them to put it off until they know more.
Because having sex can cause problems — like
getting HIV.
It's OK to wait. It's a choice you can live with and
feel good about. People out there gotta understand.
That's why I'll go anywhere to talk about preventing
the spread of HIV and other STDs. Even into your
living room.

African American Women :15



VOICE OVER:

AIDS continues to rise among African-American women.

Don't be a statistic. Find out how to protect yourself from HIV, the virus that causes AIDS. Call 1-800-342-AIDS.