FOIA Number: 2018-0758-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Todd Summers

Subseries:

OA/ID Number: 21080

FolderID:

Folder Title:
Issues - Race Initiative

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	3	3

Todd:

Here are the drafts for the Race Initiative.

You have a short version without graphs, charts, and a long version with graphs and charts. The other agency reps. felt the long version was too long and thought we only should make a few points under each issue, "the Oprah test."

We are still working on them, but I wanted to give you an idea of where we were heading.

Matthew.

HIV/AIDS in Racial and Ethnic Minority Populations

Widely circulated reports of a decline in the number of AIDS deaths and in the number of new AIDS cases due to advances in treatment therapies have lead many Americans to believe that we have finally turned the tide on the AIDS epidemic in the U.S. However, what most reports fail to mention is that an estimated 40,000 Americans continue to become **newly** infected with HIV every year, and that more than 600,000 Americans have already been diagnosed with AIDS. Many reports also fail to mention that the epidemic has shifted from hitting hardest in gay white men to now disproportionately affecting racial/ethnic populations.

Throughout his Administration, the President has focused on increasing access to health care for all Americans. The President's Initiative on Race, and its specific goal of identifying and developing "solutions in critical areas such as education, economic opportunity, housing, crime and health care," offer the perfect opportunity for America to discuss AIDS and its impact racial and ethnic communities. This dialogue must focus on the many challenges that AIDS presents, especially in the areas of prevention, services and treatment, including addressing both the disproportionate impact of the disease on racial and ethnic populations and the lack of access to appropriate health care services for these individuals. Clearly, HIV and AIDS is a disease which affects **all** communities in the United States and all communities must be concerned about the epidemic.

Statistics

Through June 1997[1], more than 600,000 individuals in the U.S. had contracted AIDS, of which more than 54% were from racial and ethnic minority communities (Blacks, Hispanics/Latinos, Asians and Pacific Islander, American Indians/Alaska Natives). Since 1992, the percent of AIDS cases in racial/ethnic populations has been greater than the percent of AIDS cases in whites, despite the fact that minority comprise fewer than 25% of the U.S. population.

- 61% of all new AIDS cases reported to CDC were in blacks and Hispanics;
- More than 75% of all women with AIDS are from racial/ethnic populations.
- More than 80% of all pediatric AIDS cases are in racial/ethnic minority populations.
- More than 50% of the 18,000 13 - 24 year old males and more than 75% of the almost 7,000 13- 24 old females with AIDS are from racial and ethnic minority populations.

---

[1] HIV/AIDS Surveillance Report, Centers for Disease Control and Prevention, Midyear Edition, Vol. 9 No. 1, through June 1997.

Barriers to Effective HIV Prevention in Racial and Ethnic Communities

- Prevention messages that are not culturally and linguistically targeted to specific audiences;
- Traditional mistrust of government by minorities given a past history of mistreatment by government (e.g., Tuskegee syphilis experiments, forced sterilization of women, migrating from countries with oppressive governments);
- Denial within racial/ethnic communities that AIDS is a problem for those communities.

Health Care Issues in Racial and Ethnic Communities

- Lack of services provided in a linguistically and culturally appropriate manner
- Lack of insurance or limited insurance;
- Location of services or hours of operation;
- Lack of understanding the health care infrastructure/system; and

Substance Abuse in Racial and Ethnic Communities

- Over 80% of all AIDS cases attributable to injection drug use are in minority men; 78% of all AIDS cases attributable to injection drug use are in minority women;

Barriers to effective substance abuse treatment include:

- lack of culturally and linguistically appropriate programs;
- lack of treatment beds;
- treatment programs which do not address the comprehensive health care needs of an individual

Gay Men and Men Who Have Sex with Men

Gay minority men and men who have sex with other men are heavily impacted by HIV and AIDS.

- Male to male transmission accounts for 68% of all AIDS cases in Asian and Pacific Islanders, 50% in Native Americans, 36% in Hispanics, and 30% in Blacks.

Barriers to Prevention and Services

- Lack of culturally and linguistically appropriate programs;
- Denial within the community that AIDS is a problem due to the stigma associated with homosexuality and drug use based on cultural issues;
- Need to address HIV taking into consideration that gay minorities are dual minorities;
- Lack of organizations which address HIV in this population;
- Lack of funding of programs specifically targeting gay minority men and men who have sex with men.

Women

While the issue of women with AIDS is not new, it has been until recently that specific programs and funding has been at addressing the specific needs of women.

- Since 1991 there has been a 70% increase in AIDS incidence among women--more than any other group or exposure category. The rise is particularly seen in minority women.
- Black women are 17 times more likely to have AIDS than non-minority women and Latinas 6 times more likely than non-minority women.
- While Black and Latina women comprise only 255 of all women in the U.S., they make up 75% of all AIDS cases among women.

Barriers to Prevention and Services

- General belief that the needs of women have been ignored by both the medical communities and organizations providing HIV prevention and services to men;
- Insufficient research specific to HIV in women;

- Cultural norms in minority communities which prevent a female from questioning the actions of her male counterpart.

Youth and Young Adults

Youth and young adults present special concerns related to HIV prevention and health care issues.

- 25% of new HIV infections occur in people under age 22, 50% of new infections occur in people under age 25.
- More than 60% of all new HIV infections are in Black and Latino youth under the age of 25.
- Vulnerable youth are young people of color, gay youth, and young women who have sex with HIV positive men.

Barrier to Prevention and Services

- Lack of programs specifically targeted to youth in a culturally and linguistically appropriate manner;
- Youth are generally without the confidence, knowledge, finances and skills required to negotiate complex medical and social service systems designed for adults;
- Minority youth are often under and unemployed, and thus lack health insurance;
- Youth consider themselves invincible and thus do not heed prevention message; and
- Youth are often dealing with psychological, substance abuse, and housing problems in addition to HIV.

Migrant and Undocumented Workers

The number of migrant farm workers and/or undocumented individuals, by their very nature, is unknown. The number of HIV-positive migrant or undocumented workers or those with AIDS is also unknown.

Barriers to Prevention and Services

- Limited prevention messages which are linguistically and culturally appropriate;
- Rapid movement from one location to another means that prevention, counseling/testing and treatment programs are of the "hit and miss" nature;
- There is often limited or no health care coverage due to low wages or working in a position which does not offer health care coverage;
- For many farm workers, decisions about health care take a lower priority than earning a days wages; and
- Fear of obtaining treatment due to Immigration law and fear of deportation.

Race Initiative Funding

Focusing on HIV prevention and the prevention/treatment of sexually transmitted disease is an important component of an overall HIV prevention and treatment program. The Clinton administration has shown its clear commitment to providing the necessary leadership and requisite funding to address HIV/AIDS in a comprehensive manner.

The President's Race Initiative includes

- $5 million for specific HIV/AIDS prevention related activities which is aimed at reducing new infections in racial and ethnic populations.
- $10 million which will focus on the closely related issue of sexually transmitted diseases.

THE PRESIDENT'S INITIATIVE ON RACE

HIV/AIDS

Office of National AIDS Policy
Sandra L. Thurman, Director

INTRODUCTION

Widely circulated reports of a decline in the number of AIDS deaths and in the number of new AIDS cases due to advances in treatment therapies have lead many Americans to believe that we have finally turned the tide on the AIDS epidemic in the U.S. However, what most reports fail to mention is that an estimated 40,000 Americans continue to become **newly** infected with HIV every year, and that more than 600,000 Americans have already been diagnosed with AIDS. Many reports also fail to mention that the epidemic has shifted from hitting hardest in gay white men to now disproportionately affecting racial/ethnic populations, women, youth and heterosexuals.

Throughout his Administration, the President has focused on increasing access to health care for all Americans. The President's Initiative on Race, and its specific goal of identifying and developing "solutions in critical areas such as education, economic opportunity, housing, crime and health care," offer the perfect opportunity for America to discuss AIDS and its impact on American society. This dialogue must focus on the many challenges that AIDS presents, especially in the areas of prevention, services and treatment, including addressing both the disproportionate impact of the disease on racial and ethnic populations and the lack of access to appropriate health care services for these individuals. Clearly, HIV and AIDS is a disease which affects **all** communities in the United States and all communities must be concerned about the epidemic.

By ensuring that individuals with HIV/AIDS are provided the necessary care and treatment that they need, and that our efforts to prevent new infections work, society as a whole benefits. Healthy, productive contributing members of society are what will continue to make America strong and prosperous.

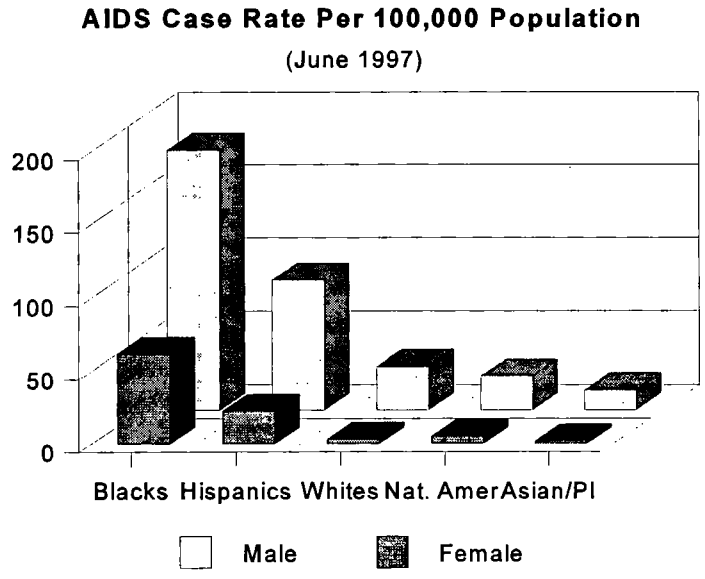
THE STATISTICS

Through June 1997[1], more than 612,000 individuals in the U.S. had contracted AIDS, of which more than 54%, (333,000), were from racial and ethnic communities (Blacks, Hispanics/Latinos, Asians and Pacific Islanders, American Indians/Alaska Natives). Since 1992, the percent of AIDS cases in racial/ethnic populations has been greater than the percent of AIDS cases in Whites, despite the fact that minorities comprise fewer than 25% of the U.S. population.

Data from the Centers for Disease Control and Prevention show the two major modes of transmission are men who have sex with men and intravenous drug use (IDU). The transmission

---

[1] Unless otherwise noted, all statistics are from *HIV/AIDS Surveillance Report, Midyear Edition*, Vol. 9, No. 1, Centers for Disease Control and Prevention. Information is through June 1997.

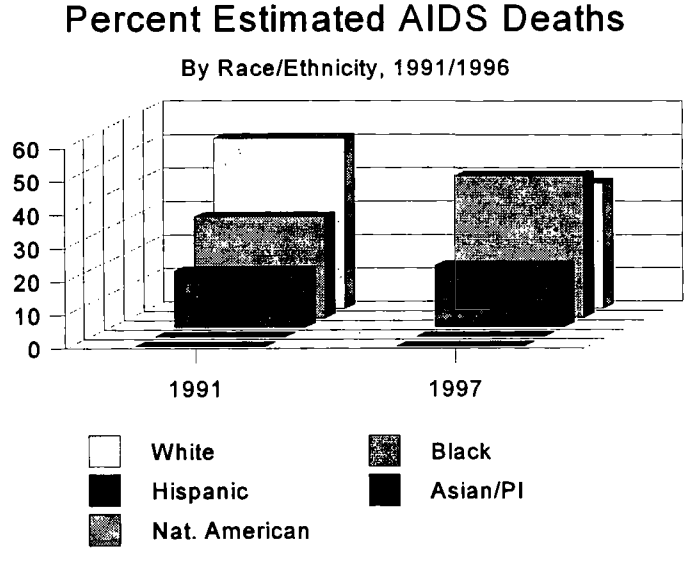


modes for Whites are different; for example, more than 76% of the cases in White males were transmitted by men who have sex with men (MSM), compared to 40% - 50% in minority males.

It is important to note that the epidemic has affected different racial and ethnic communities differently. For example, in blacks, Hispanic and American Indian/Alaska Native males, the main modes of transmission are almost equally divided between MSM and IDU.

In Asian males, however, the main mode of transmission is overwhelmingly MSM (75%) with only 5% of their cases attributed to IDU. In Asian women, however, heterosexual contact accounted for 46% of the cases and IDU for 17% of the cases, while in Black women, IDU accounted for more than 45% of the cases.

The epidemic is also different within the racial and ethnic groups. For example, the main mode of transmission for Hispanics in the Northeast U.S. is IDU, but for Hispanics in the Southwest it is MSM. The difference in epidemic by region is also complicated by the fact there are more than 500 different Federally recognized Indian tribes, more than 50 Asian dialetcs are spoken in the U.S., Hispanics are both U.S. born and come from more than 29 countries, and Blacks are both American born and from overseas.



- New AIDS cases in Blacks and Hispanics accounted for 61% of all AIDS cases reported to CDC through 1996, despite the fact that they comprise less than 25% of the U.S. population.
- More than 75% of all women with AIDS are from recial/ethnic populations.

- More than 80% of all pediatric AIDS cases are in racial/ethnic minorities.
- Eighty percent of injection drug use related cases in males and 78% of injection drug use related cases in females are in racial/ethnic minority populations.
- More than 50 % of the 18,000 13 - 24 year old males and more than 75% of the almost 7,000 13 - 24 year old females with AIDS are from racial or ethnic populations.
- In males, the AIDS case rate per 100,000 population for blacks was 177.6; for Hispanics, 88.9; for American Indians/Alaska Natives, 23.2; and for Asian/Pacific Islanders, 13.8. For Whites, the rate was 29.9/100,000.

PREVENTION IN MINORITY COMMUNITIES

For many individuals from racial/ethnic backgrounds, AIDS is just one of the many issues that they must deal with on a daily basis which affects their lives and which complicates how we respond to the epidemic. Issues such as poverty, homelessness, substance abuse, unemployment, institutionalized racism, homophobia and denial of AIDS as an issue within a community alters how AIDS is viewed and ultimately the success of prevention efforts.

Just as the advertising industry learned that in order to market a product effectively one must target information to specific populations, the same is true with HIV prevention information. Prevention messages must be culturally and linguistically tailored to specific audiences. Complicating the need for targeted messages is the fact that many communities have traditionally mistrusted government given a past history of mistreatment by government (e.g., Tuskegee syphilis experiments, forced sterilization of women, migrating from countries with oppressive governments), many minorities avoid government-sponsored programs.

Barriers To Prevention Efforts

Community Denial	Funding	Lack of Infrastructure	Language Issues
Cultural Issues	Unemployment	Homophobia	Mistrust of Government

Thus, programs must be developed which are community-focused, organized and implemented so that individuals are willing to listen to the messages being conveyed. Despite the statistics, many minority communities still view AIDS as a gay white male disease, often due to denial that those individuals most affected exist within their community. This denial is often based on

religious beliefs or on cultural norms which dictate that matters of sexual activity or drug use are not discussed publicly or openly. This in turn prevents many minority institutions (e.g., churches, sororities, national organizations) from becoming involved in the issue for fear of alienating their constituencies.

The infrastructure necessary to deliver these messages (i.e., community-based organizations), must be supported so that their efforts are successful. Historically, this infrastructure has not been in place, and now minority communities are playing "catch-up" in terms of obtaining funding, developing programs, and doing outreach to their communities.

HEALTH CARE SERVICE ISSUES

There are many issues which act as barriers to accessing health care by members of racial and ethnic communities affected by HIV. These barriers may be social, organizational, and cultural, although they are all interrelated. Social issues may include society's perceptions of and unfamiliarity with a particular racial/ethnic group affected by HIV, which in turn presents obstacles to that group's ability and willingness to seek and obtain health care. Societal sexism, racism, or homophobia may cause members of certain groups to avoid health care. Organizational issues may include a lack of health and support services providers available to that group, lack of transportation, lack of financial resources, geographic location health care facilities and providers, hours of operation of a facility; a group's inability to understand prevention messages due to language barriers, and many others. Cultural issues include characteristics of that group that may affect their ability to access services (e.g., language, poverty, isolation, lack of understanding of the health care system or mistrust of health care providers, cultural attitudes and beliefs, perceptions of illness, or perceptions of member of the group who may be affected by a particular illness, poverty).

The Ryan White CARE Act Program

For many minority individuals, the Federal governments's program to fund health and support services to people infected with HIV/AIDS, the Ryan White CARE Act program, is their only source of medical care. This program provides health care and support services, primarily on an outpatient basis, to people infected with HIV and to people who have developed AIDS. A portion of that program provides training to health care providers and other professionals about HIV and in delivery of services to people with HIV. The Ryan White program recognizes that there are many issues in the delivery of services to racial and ethnic communities, and has implemented many activities to respond to those issues, including researching the issues and developing possible solutions to address them. The Ryan White CARE program very strongly encourages all of its grantees to be as inclusive as possible of racial and ethnic minorities and all

groups affected by HIV in the planning and development of health care programs and systems for people infected with HIV.

Demographic Characteristics of Recipients of Ryan White CARE Act Services

Data on the racial/ethnic characteristics of recipients of services of the largest of the Ryan White CARE Act programs, the Title I programs, which provides grants to metropolitan areas with large numbers of AIDS cases, and the Title II programs, which provides grants to all States and territories, indicate that racial and ethnic communities are being served by these programs (see table below). These programs ensure that services are available to in ways that facilitate access to and use by any individual infected with HIV. However, it is important to note the program only provides services to those who individuals who know their HIV status and make too much money to qualify for Medicaid, but do not make enough to be able to afford their own health insurance. The table below illustrates the demographic characteristics of clients served by Title I and Title II of the Ryan White CARE Act program:

Ryan White CARE Act: Racial/Ethnic Characteristics of Clients Served by the Largest Providers Funded Under the Ryan White CARE Act (1996)

Population Group	Cumulative AIDS Cases Nationally (through June '97)	Percent Clients Served (1996)
White	45.6%	20.7%
Black	33.7%	36.8%
Hispanic	22.8%	37.9%
Asian/Pacific Islander	<1%	1.6%
American Indian	<1%	0.4%
Unknown		2.6%

Source: Health Resources and Services Administration, U.S. Department of Health and Human Services

Ryan White CARE Acting funding in FY 1996 totaled $757,402,000; in Fiscal Year 1997 it totaled $996,252,000; and in FY 1998 it totaled $1,150,200,000.

SUBSTANCE ABUSE

While the overall rate of substance abuse does not differ significantly between minority and non-minority populations, in minority populations, injection drug use or sex with an injection drug user is the most prevalent route of transmission of HIV. Injecting drug use puts individuals at

greatest risk of infection to HIV due to the ease in which HIV is transmitted through the sharing of syringes. Over one-half of new HIV infections are associated with injecting drug use or sex with a person who injects drugs. In minority communities, the risk of infection with HIV is highly correlated with injection drug use. Over 80% of inejction drug use AIDS cases are in racial/ethnic men; 78% of injection AIDS cases are in racial/ethnic women.

Overall Drug Use by Race

- Most current illicit drug users are white. There were an estimated 9.7 million whites (74 percent of all users), 1.8 million blacks (14 percent), and 1.1 million Hispanics (8 percent) that were illicit drug users in 1996.

- The rate of current illicit drug use for blacks (7.5 percent) remained somewhat higher than for whites (6.1 percent) and Hispanics (5.2 percent) in 1996. However, among youths the rate of use are about the same for the three groups.

Injection Drug Use in Racial/Ethnic Women

- 68% of Back women, and 72% of Hispanic women have contracted AIDS through their own IDU and/or sex with an IDU person.

Injection Drug Use in Racial/Ethnic Men

- Black and Hispanic men are the most likely to have contracted HIV through their own injecting drug use. Asian/Pacific Islander men were the least likely to have AIDS from IDU.

- 46% of all individuals who contracted AIDS through IDU were Black, 29% were White, and 25% were Hispanic.

- For Blacks, injecting drug use represents the largest exposure category. For Hispanics, injecting drug use is comparable with non-IDU sexual contact category. For Whites, the IDU category is only 17%.

Substance Abuse Treatment and Primary Substance of Abuse

- Racial/ethnic groups vary widely in the primary substance of abuse reported at admission to substance abuse treatment. While alcohol is the most common primary substance for most racial/ethnic groups, the rates differ widely. Cocaine is the most common primary substance of abuse for blacks, while heroin is the primary substance of abuse for 45% of Puerto Ricans who entered treatment.

The connection between HIV and substance abuse cannot be understated. Of particular concern is ensuring that comprehensive health care services are available for a substance abusers so that they can get into treatment not only for their addition, but for any other disease they may have (e.g., HIV, T.B., hepatitis, STDs). However, the lack of treatment slots due to funding constraints in many communities often means that someone who is ready to go into treatment may have to wait for help until a slot becomes available.

Another issue is that of compliance with HIV treatment regimens for substance abusers. Compliance is essential in order for anti-HIV drugs to work. However, if a drug user is worried about his or her next "fix", the likelihood of them being compliant is low. The need to ensure that comprehensive treatment services (for both HIV and drug addiction) is extremely important.

THE HIV, STD, AND TB CONNECTION

The connection between HIV, sexually transmitted diseases and tuberculosis cannot be understated. The link that exists between HIV and STDs is important to understand because one set of diseases can influence the transmission and severity of the other. Likewise the interaction between HIV and TB is important both to the individual and public health system since it complicates how treatment is provided and may affect the health outcome for the patient.

Individuals who contract an STD have placed themselves at risk for HIV infection by the very actions which allowed infection with the STD in the first place -- unprotected sexual activity.

Also of concern is the relationship between STD and HIV in terms of transmission between partners. STDs, both ulcerative (e.g. herpes, syphilis and chancroid) and non-ulcerative (e.g. chlamydia, gonorrhea and trichomoniasis), can increase the risk of transmission of the AIDS virus three to five fold. Co-infection with STDs increases the likelihood of transmission of the HIV virus from HIV-infected individuals. HIV-infected individuals are more likely to shed HIV virus in their genital secretions and are more likely to shed the virus in greater numbers.

The risk of developing TB in an HIV-positive patients is also of concern Immunosuppression due to HIV is a major risk factor for the development of active tuberculosis. There is a continuing increase in the number of cases of active TB among HIV-infected individuals due to their enhanced susceptibility to the tuberculosis bacillus. In addition, tuberculosis appears to accelerate the course of HIV disease and complicates treatment.

GAY MEN AND MEN WHO HAVE SEX WITH OTHER MEN

Gay minority men and men who have sex with other men are heavily impacted by HIV and AIDS. Men who have sex with men account for more than 63% of all AIDS cases in young men, aged 20 - 24 years old. MSM account for 33% of cases in young men aged 13 - 19 years old.

Overall, the number of AIDS cases in men who have sex with men in the non-minority population is greater than that in racial/ethnic populations. Male to male transmission accounts for 70% of AIDS cases in White men, 68% in Asian and Pacific Islanders, 50% in Native Americans, 36% in Hispanics, and 30% in Blacks. However, given the level of denial and stigma which occurs around homosexuality in minority populations, the accuracy of these statistics must be looked at with caution.

A closely related issue is men who have sex with men but who do not self identify as gay. Often, because of societal and cultural pressures, MSM's may be married and have children yet continue to have sexual relationships with other men. This complicates HIV prevention efforts given that individuals are hard to identify, hard to reach and may not respond to traditional prevention messages aimed at openly gay men. Thus, messages must be specifically targeted to take into account their self-identification as heterosexuals despite their sexual activity with the same gender.

Also of concern are minority youth, who think of themselves as invincible. Special efforts must be undertaken to address issues they experience, such as self-esteem, questioning of their sexual orientation/sexual experimentation, support for those who have chosen to remain abstinent, and other peer pressures such as alcohol and drug use/experimentation/abuse. Another concern are recent reports of that some gay youth believe that it is inevitable that they will become HIV infected, and thus there is no need for them to practice safer sex or not inject drugs.[2]

The issue of substance use/abuse within the gay community must also be taken into account. Impaired decision making related to sexual activity or sharing of needles presents special problems in HIV prevention efforts. In order to be effective, HIV- prevention and treatment programs must take into account the role that alcohol and substance abuse plays in an individual's life.

Men Who Have Sex with Men	Married Men	Denial	Young Adults
Self Esteem	Abstinence	Peer Pressure	Alcohol/Drug Abuse
Targeted Message	Linguistic Appropriateness		Counseling/Testing

[2] Dallas Conference on Gay Men, cite coming.

As discussed elsewhere, the issue of STDs must also play a role in prevention efforts. Individuals who have contracted an STD placed themselves at risk for HIV by the very nature of the behavior which lead to their contracting an STD. Prevention programs must address this connection as a means of impressing upon those individual the consequences of sexual behavior which places them at risk for infection with an STD or HIV.

NEEDS OF WOMEN

Since 1991 there has been a 70% increase in AIDS incidence among women--more than any other group or exposure category. The rise is particularly seen in minority women. Black women are 17 times more likely to have AIDS than non-minority women and Latinas 6 times more likely than non-minority women. While Black and Latina women comprise only 1/4 of all women in the U.S., they make up 3/4 of all AIDS cases among women. In females, the AIDS case rate per 100,000 population was 61.7 for Blacks; 22.7 for Hispanics; 5.4 American Indians/Alaska Natives; and 2.1 for Asian/Pacific Islanders. For whites, it was 3.5/100,000.

Heterosexual transmission is the most rapidly increasing transmission category among women, especially young women. Among women reported with AIDS in 1996, 40% were infected through unprotected heterosexual contact with at-risk partners. Since the principal means of preventing HIV transmission during heterosexual intercourse (the condom), is a male controlled method, the woman is at a disadvantage. Women who are financially dependent on their male partners are often reluctant to insist on condom use for fear of abandonment or physical violence or because of cultural norms which dictate that a women does not questions her partners fidelity by asking him to wear a condom.

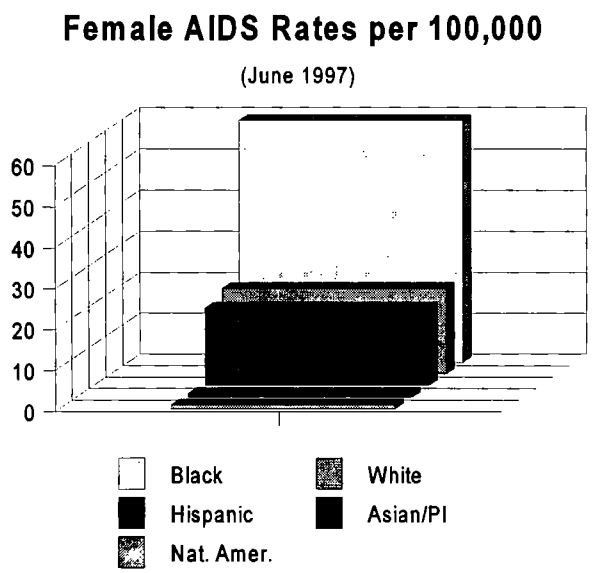
The second leading cause of AIDS among women is injection drug use. In 1996, 34% of women acquired the HIV virus through use of injection drugs. IDU is not the only way drugs are influencing the AIDS epidemic among women.

Young women ages 15 - 24 are disproportionately affected by AIDS for several reasons: they may be more likely to have several partners, they may be more likely to engage in risky behavior, they may be more likely to have partners at higher risk of HIV infection and they may be more biologically susceptible to cervical infections[3]. These findings suggest that adolescent women are becoming infected by older sexual and needle sharing partners and is consistent with the documented age gap between teenaged mothers and their partners. These young women progress from HIV positive to AIDS more rapidly than average, usually within five years of infection.

---

[3] CDC, DSTP,1996; CDC NCHSTP, 1996.

Minority women who are at the highest risk for HIV infection face a multitude of other problems such as poverty, substance abuse, alcoholism, violence, unemployment and unplanned pregnancy. Other factors such as language barriers, poverty, lack of transportation and child care make it difficult for women to access quality health care.



Treatment issues for women must also account for their physical differences from men. As a woman's immune system weakens, she may experience gynecological problems, such as menstrual irregularities, genital ulcers, pelvic inflammatory disease, and premature menopause. Most AIDS treatment research has not taken into account the special needs of women, and concern is often voiced that the medical community does not know whether specific anti-viral drugs work as well in women as in men. Some health care providers question whether the medical community is trained to be able to diagnose AIDS in women to the level which is necessary.

Women also must be concerned about the potential for pregnancy. Studies indicate that an HIV-positive woman has about a 25% change of passing HIV on to her baby. However, with treatment with AZT during pregnancy and childbirth, this risk can be reduced to about 8%. The health risk of pregnancy must also be considered.

YOUTH AND YOUNG ADULTS

More than 60% of all new HIV infections are in Black and Latino youth under the age of 25. Gay and bisexual teenagers comprise more than half of these individuals . Youth and young adults are especially vulnerable given their view on life as that of invincibility. One recent survey of youth found that 87% of 12 - 24 year olds believe that they are not vulnerable to getting HIV.[4] Yet, the statistics indicate differently. Sexual experimentation, drug use/experimentation, peer pressure, lack of role models, fear of rejection, questions about sexual identity, homophobia, lack of assertiveness, all affect a youth's perception of risk and willingness to heed the safer sex/no sex, no drug message.

---

[4] MTV/Yale media survey of 770 people aged 12 - 24, *POZ Magazine*, March 1998, page 44.

Other youth, such as runaways, throwaways, homeless or out-of-school youth, those who often trade sex for money or a space to stay for the night, have unique issues which must be addressed. The first priority for many is money for food or shelter, or to buy drugs. Prevention of HIV is not paramount. For some, given their life situation, HIV infection may be considered a minor nuisance. Thus, these individuals must be given a reason to remain HIV-negative, to use condoms, or to go into drug treatment. Programs which utilize peer counselors have proven to be the most accepted by this population and youth in general.

Adolescents who are infected with HIV, or who are at risk for infection with HIV, present unique challenges with respect to services for and prevention of HIV. The HIV/AIDS statistics concerning youth are alarming and require our immediate attention. A broad overview shows the following:

- 25%of new HIV infections occur in people under age 22, 50% of new infections occur in people under age 25.
- AIDS is the 6th leading cause of death among 15-24 year olds.
- Vulnerable youth are young people of color, gay youth, and young women who have sex with HIV positive men.
- Among youth, HIV transmission is primarily through sexual activity.
- Of cumulative AIDS cases through 6/97, 4.1% were in the 13-24 year age group, and 13.9% were in the 24-29 year age group.

Despite the fact that young people increasingly are affected by the AIDS epidemic, few receive HIV testing, risk counseling, or treatment. One reason is that young people are less likely than adults to seek health care, except in emergency situations. Distrust of adults, concern about confidentiality, lack of health insurance, and lack of transportation are just some of the barriers to obtaining care. In addition, youth generally are without the confidence, knowledge, and skills to negotiate complex medical and social services systems designed for adults.

All too often, young people, those who are gay, homeless, drug users, juvenile offenders, and street -involved, are dealing with psychological, substance abuse, and housing problems in addition to HIV. Too often, programs are seldom designed to offer the comprehensive services required by youth, and often, the information available to providers about designing and implementing successful programs that reach youth is meager.

Providing services to adolescents who are at risk for infection with HIV, or who are already infected with HIV, requires very special consideration of the issues affecting adolescents and development of ways to address them successfully. The Ryan White CARE Act has funded

demonstration projects which address these adolescent care issues, and we have learned much form them. The findings from those projects provide many insights into what those programs aimed at increasing access to care for adolescents should include, and how those services should be provided.

The Ryan White demonstration projects have shown that for care providers to be successful in reaching youth and successfully bringing youth into care, they must:

- apply creative outreach strategies;
- establish trust;
- address the immediate needs of youth;
- address their psychological barriers; and
- make the programs appropriate for youth.

Some examples of the types of things that can be done to implement approaches that increase adolescents' access to prevention and care services are:

- Applying a variety of creative outreach strategies, including traditional strategies (referrals from other providers, distribution of print materials) and non-traditional strategies (visiting bars and clubs that are frequented by gay, lesbian and bisexual youth, contacting homeless and ran-away youth at their hang-outs).

- Establishing trust, which can be a long, labor-intensive process. Strategies include using peer-based models of outreach and counseling, using formerly street-involved adults and street-savvy youth outreach workers, making numerous casual contacts with youth bo build rapport before attempting to link youth with services, , addressing youths' concerns about confidentiality with respect to HIV testing and disclosure of HIV status.

- Addressing immediate needs, since HIV-related concerns are not always a priority for youth. Many HIV-positive youth or at-risk youth have immediate, multiple needs (e.g., shelter, food, clothing, psychological issues,) that must be addressed before HIV-related services can be provided.

Self Esteem Issues Runaways Peer Pressure Alcohol/Drug Use
Sexual Experimentation Lack of Health Insurance Lack of Role Models

---

- Addressing psychological barriers, including poor self image, magical thinking (it won't happen to me), hopelessness and fatalism prevalent among disenfranchised youth.

- Making programs appropriate to youth -- programs should be age, developmentally, and culturally appropriate to youth. For example, many street youth are illiterate or read at no higher than a fourth grade level. Brochures and other outreach materials should accommodate their lower reading skills. Since youth have different risk profiles, no one program may be appropriate for all. Specific programs for gay/bisexual young men, heterosexual young men and women, and youth in recovery from substance abuse may be necessary. Programs should be fun and meaningful for youth, as this helps keep youth involved in the program.

It is important to recognize that adolescents require more care than adults, and that this costs more. Providing high quality health and support services to youth requires more time, and more funds, than services to adults. HIV positive and at risk youth require more intensive case management and much more time than that required by adults (e.g., driving youth to appointments, walking youth through clinics, obtaining housing and employment, addressing issues of homophobia and violence). However, we must look at creative ways to provide these services such as through more active collaboration among service provides, development of linkages across communities, and sharing of information and resources, among other ways, to assist this very vulnerable population.

MIGRANT FARM WORKERS AND UNDOCUMENTED INDIVIDUALS

The number of migrant farm workers and/or undocumented individuals, by their very nature, is unknown. Although the farm worker population is racially and culturally diverse, the majority of migrant and seasonal farm workers are U.S. citizens or legal residents of the U.S.[5] and of Hispanic ancestry. The number of HIV-positive migrant or undocumented workers or those with

AIDS is also unknown. Language and cultural barriers, along with a low perception of risk, hamper patient education efforts in this population.[6]

Several major issues arise when addressing HIV and AIDS in migrant and undocumented communities:

- Rapid movement from one location to another means that prevention, counseling/testing and treatment programs are of the "hit and miss" nature. The need to find work often takes precedence over treatment. Thus, if a person has to leave a location, there are no

---

5 *Facts About America's Migrant Farm workers*, National Center for Farm worker Health, Inc.

6 *Fact Sheet: HIV/AIDS.* National Center for Farm worker Health, Inc.

mechanism in place to ensure follow-up treatment in the next location or to document the treatment which has been received.

- There is often limited or no health care coverage due to low wages or working in a position which does not offer health care coverage. Individuals who not have access to primary care are either not treated or must rely on the emergency room for treatment.[7]

- For many farm workers, decisions about health care take a lower priority than earning a days wages. Their jobs do not offer sick leave or vacation days, and if they do not report to work, they do not get paid and risk losing their position to another individual.

- Protease inhibitors are not a viable option given their high cost, their rigid schedules, inability to take the drugs when in the field, lack of access to the drugs in camp, and the fear of discovery of having HIV by others in camp.

- Immigration law and fear of deportation prevent migrant and undocumented individuals from seeking testing or treatment for HIV-related diseases. Many individuals will not present themselves for fear of being reported to immigration officials. The traditional mistrust of government presents added concerns for undocumented individuals with HIV/AIDS, despite the fact that they may need treatment for a specific symptom or to avoid an opportunistic infection.

Rapid Movement No or Limited Health Care/Treatment Language Barriers
Lack of Educational Materials Fear of Deportation

- Lack of educational material and on-site interpreters are barriers to effective prevention and treatment efforts. Some farm workers may decide to treat themselves with herbal medications, rely on their cultural background which approves of the use of "herbalista" and "curandos," (individuals with no formal Western medicine training but well respected in the community as an individual can treat an illness). Thus, HIV infection may not be diagnosed until much later in the disease stage, once a person has come down with an opportunistic infection and must be hospitalized.

- Community attitudes toward migrant and undocumented workers may prevent services from being offered to these populations despite the public health benefits associated with HIV testing and treatment of HIV, especially with co-morbidities such as TB or STDs.

---

[7] National Advisory Council on Migrant Health. 1993. *Recommendations of the National Advisory Council on Migrant Health.* Rockville, MD: U.S. Department of Health and Human Services, Bureau of Primary Health Care, May 1993.

- In many migrant setting, alcohol and substance abuse is high, thus complicating prevention efforts.

FUNDING ISSUES

The President's FY 1999 HIV/AIDS related budget requests totaled $9.7 billion, including both mandatory (e.g., Medicaid, Medicare and Social Security), and discretionary activities (e.g., NIH and Ryan White), and increase of 8% over FY 1998 and an 85% increase over the FY 1993 level of $5.2 billion. Data on expenditures based on race/ethnicity is not systematically collected or reported by the Federal government.

Funding is an issue of special concern to racial and ethnic populations. Given the historic lack of funding for programs specifically targeting racial/ethnic minority populations, the infrastructure necessary to combat HIV/AIDS at the local level does not exist at the same level as that for the non-minority population. With more recent efforts of directly funding minority-focused, minority-run community-based organizations, and with the provision of technical assistance in the areas of programmatic and organizational management, many community-based organizations are now able to design, implement and evaluate HIV- prevention and service programs. However, it must be noted that many minority community-based organizations are under funded and have limited staff, and thus are having to play "catch-up" with their non-minority organizations.

Race Initiative Funding

The President's Race Initiative includes $5 million for specific HIV/AIDS prevention related activities which is aimed at reducing new infections in racial and ethnic populations. Also contained in the Initiative is $10 million which will focus on the closely related issue of sexually transmitted diseases. Focusing on HIV prevention and the prevention/treatment of sexually transmitted disease is an important component of an overall HIV prevention and treatment program. The Clinton administration has shown its clear commitment to providing the necessary leadership and requisite funding to address HIV/AIDS in a comprehensive manner.

FY 1999 Federal Spending on Selected HIV/AIDS Programs
($ millions)

Program	FY99	+/- over FY98	% over FY98	% over FY93
Ryan White	$1,315.2	+$165	+14%	+241%
ADAP	$385.5	+$100	+35%	n/a
HOPWA (Housing)	$225	+$21	+10%	+125%
NIH AIDS Research	$1,731	+$124	+7.7%	+62%
CDC HIV Prevention	$637	+$4	+0.4%	+28%

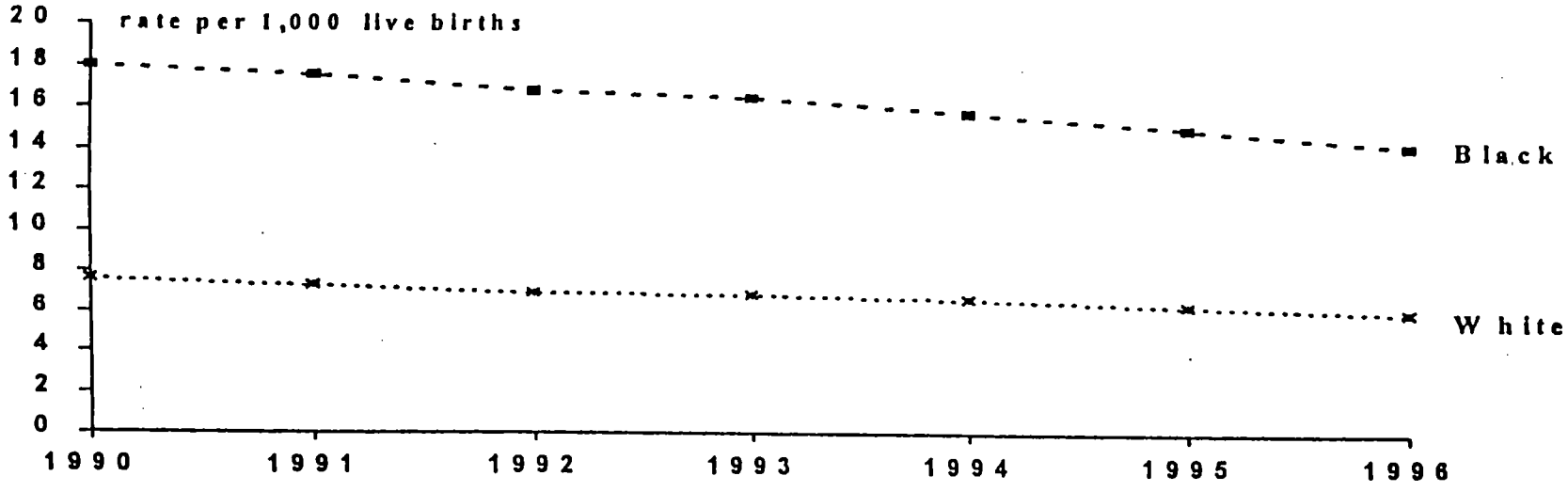
N:\MURGUIA\MONOGRAP\MONO2.WPD

Eliminating Disparities in Health Status Experienced by Racial and Ethnic Minorities:

Special Focus Areas

Infant Mortality

Infant Mortality Rates for the United States, 1990–1996

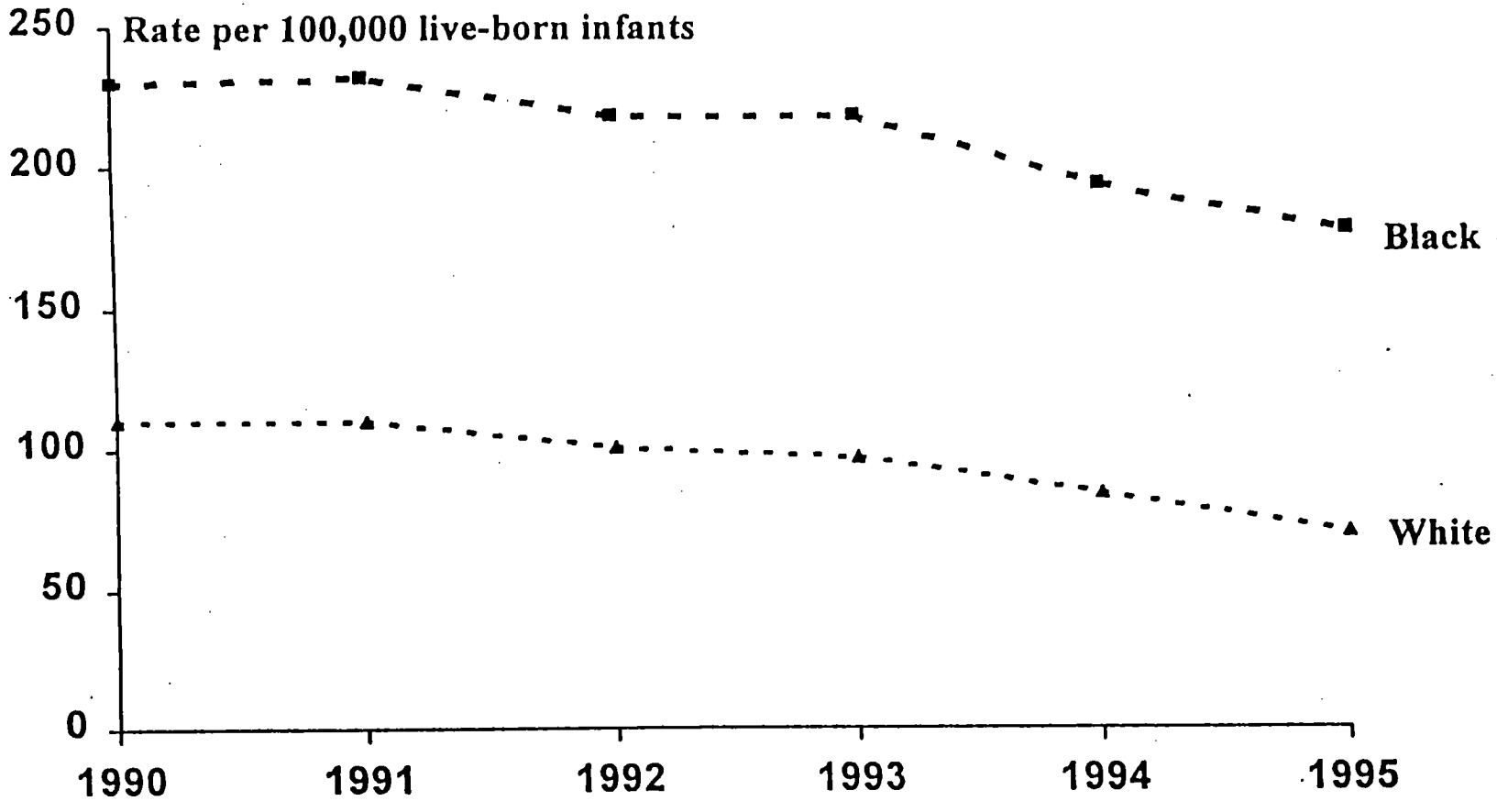


Infant Mortality Rate Baselines:

Total: 7.2 per 1,000 live births (1996 preliminary data)
White: 6.0 per 1,000 live births (1996 preliminary data)
Black: 14.2 per 1,000 live births (1996 preliminary data)
American Indian/Alaska Native: 9.0 per 1,000 live births (1995 linked data)
Native Hawaiian: 6.4 per 1,000 live births (1995 linked data)
Puerto Rican: 8.9 per 1,000 live births (1995 linked data)

Data Source: National Vital Statistics System natality/mortality files, CDC, NCHS

Sudden Infant Death Syndrome (SIDS) Rates for the United States by Race, 1990–1995.



Race for infants who died from SIDS was determined by the race of each infant, and race for all live-born infants was determined by the race of the mother.

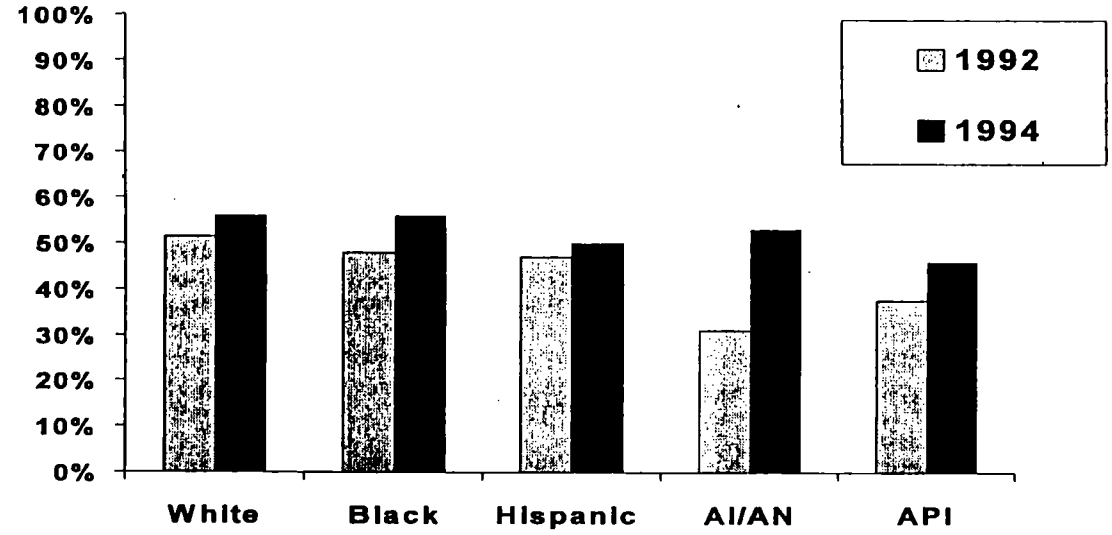
Sudden Infant Death Syndrome Rate Baselines:

Total: 74.2 per 100,000 live-born infants (1996 preliminary data)
White: 71.0 per 100,000 live-born infants (1995)
Black: 178.6 per 100,000 live-born infants (1995)

Data Source: National Vital Statistics System mortality data, CDC, NCHS

Cancer

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, United States, 1992 and 1994.

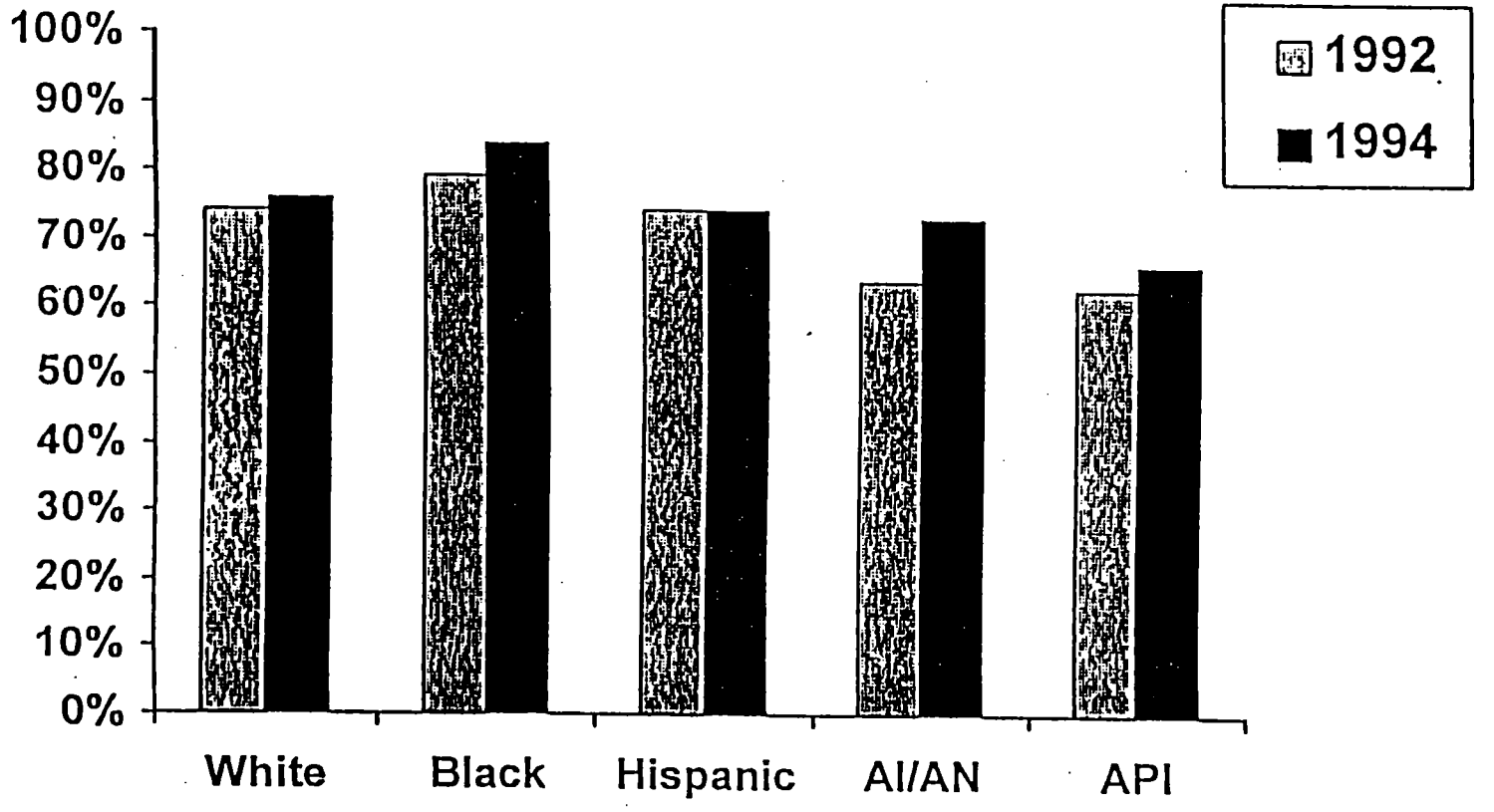


Breast Cancer Screening Rate Baselines for women ≥ 50 years of age:

Total: 56 % **(1994)**
White: 56% **(1994)**
Black: 56% **(1994)**
Hispanic: 50 % **(1994)**
American Indian/Alaska Native (AI/AN): 53% **(1994)**
Asian and Pacific Islanders (API): 46% **(1994)**

Data Source: National Health Interview Survey, CDC, NCHS

Proportion of Women Aged 18 and Older Who Have Received a Pap Test Within the Past 3 Years, United States, 1992 and 1994.



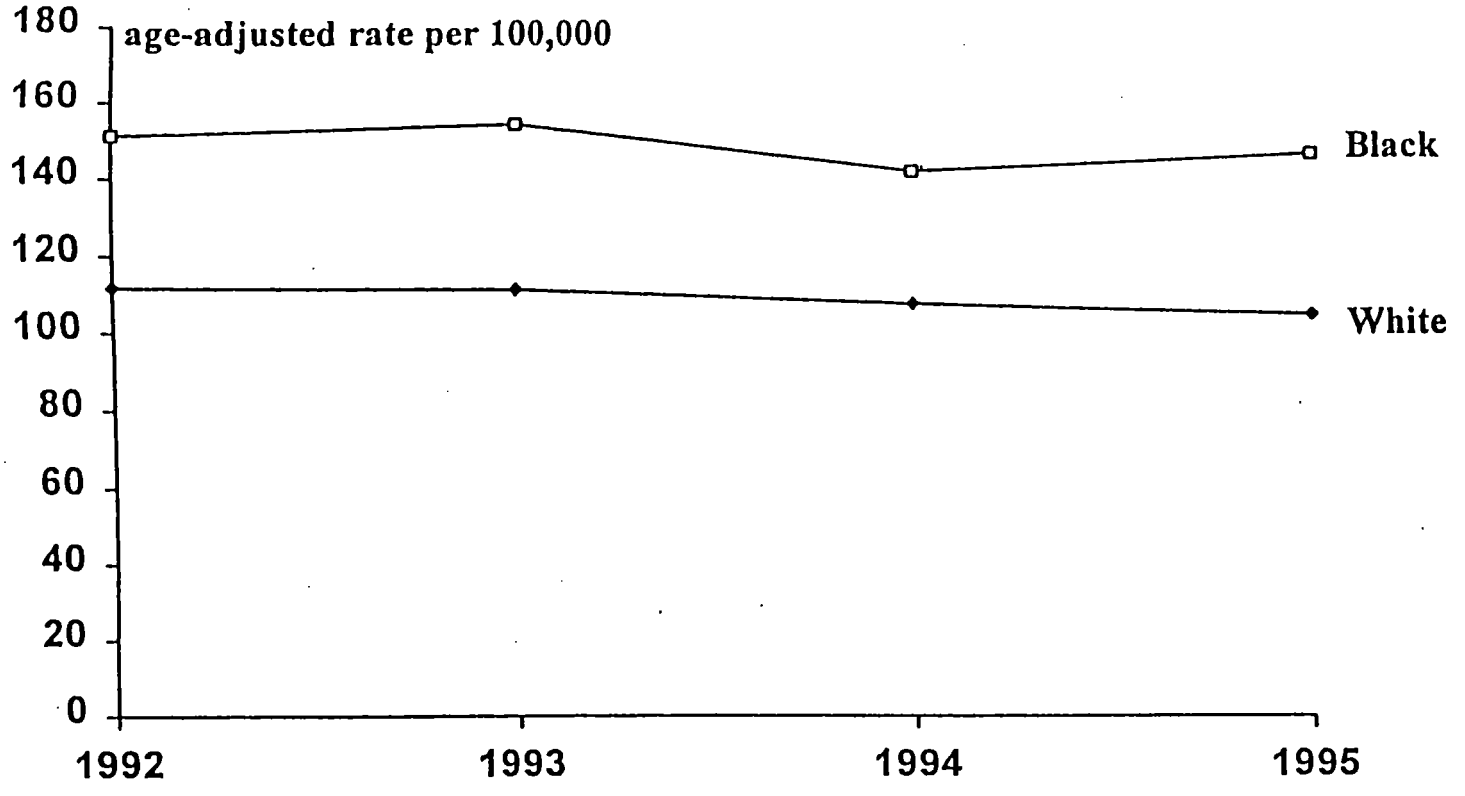
Cervical Cancer Screening Rate Baselines for Women Age ≥ 18 Years:

Total: 77 percent (1994)
White: 76 percent (1994)
Black: 84 percent (1994)
Hispanic: 74 percent (1994)
American Indian/Alaska Native (AI/AN): 73 percent (1994)
Asian and Pacific Islander (API): 66 percent (1994)

Data Source: National Health Interview Survey, CDC, NCHS

Cardiovascular Disease

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1992–1995.

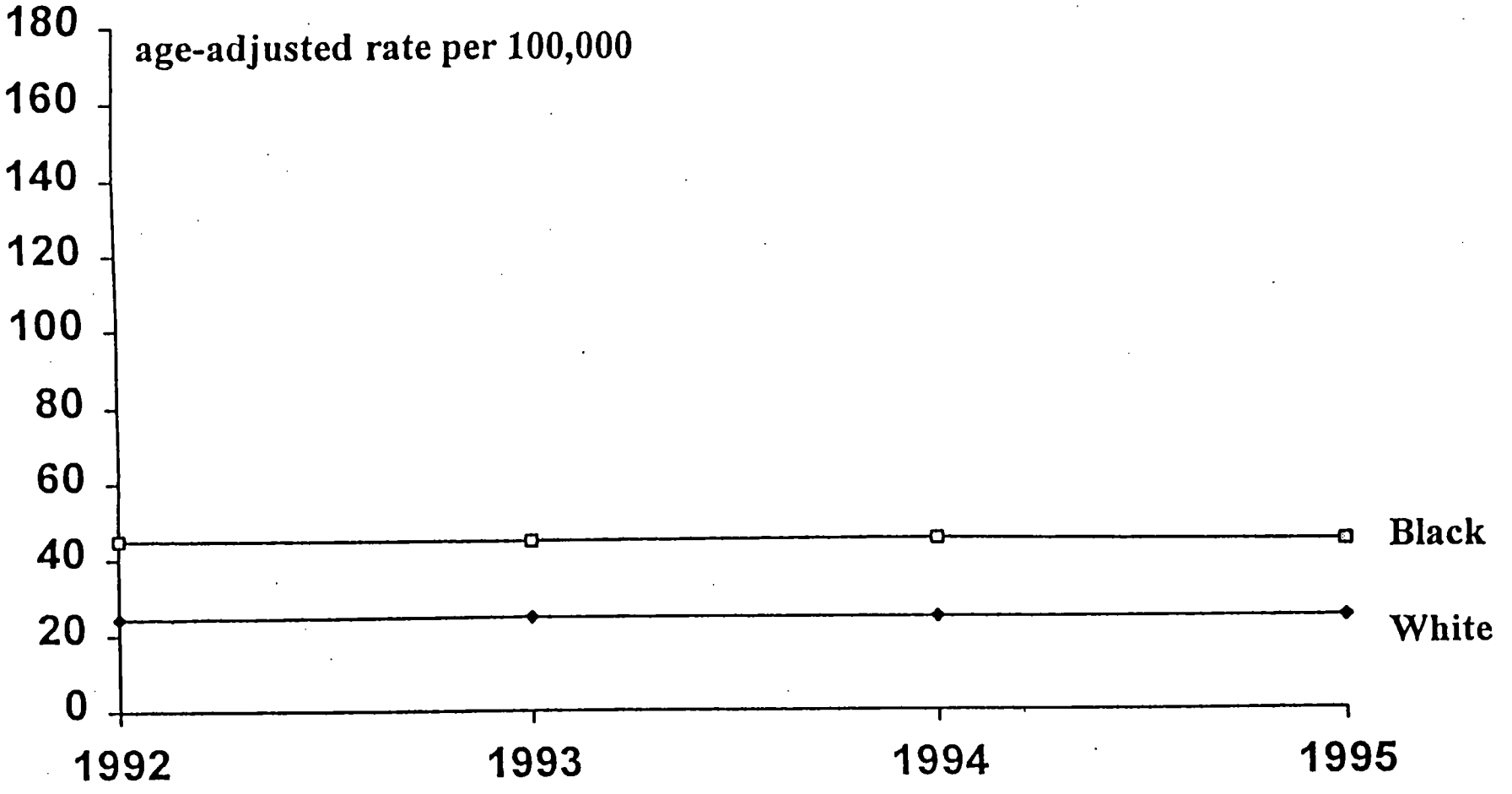


Coronary Heart Disease Mortality Rate Baselines:

Total: 108 per 100,000 persons (age-adjusted) (1995)
White: 105 per 100,000 persons (age-adjusted) (1995)
Black: 147 per 100,000 persons (age-adjusted) (1995)
American Indian/Alaska Native: 76 per 100,000 persons (age-adjusted) (1995)
Asian and /Pacific Islander: 63 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

ıxates of Stroke Death, United States, 1992–1995.



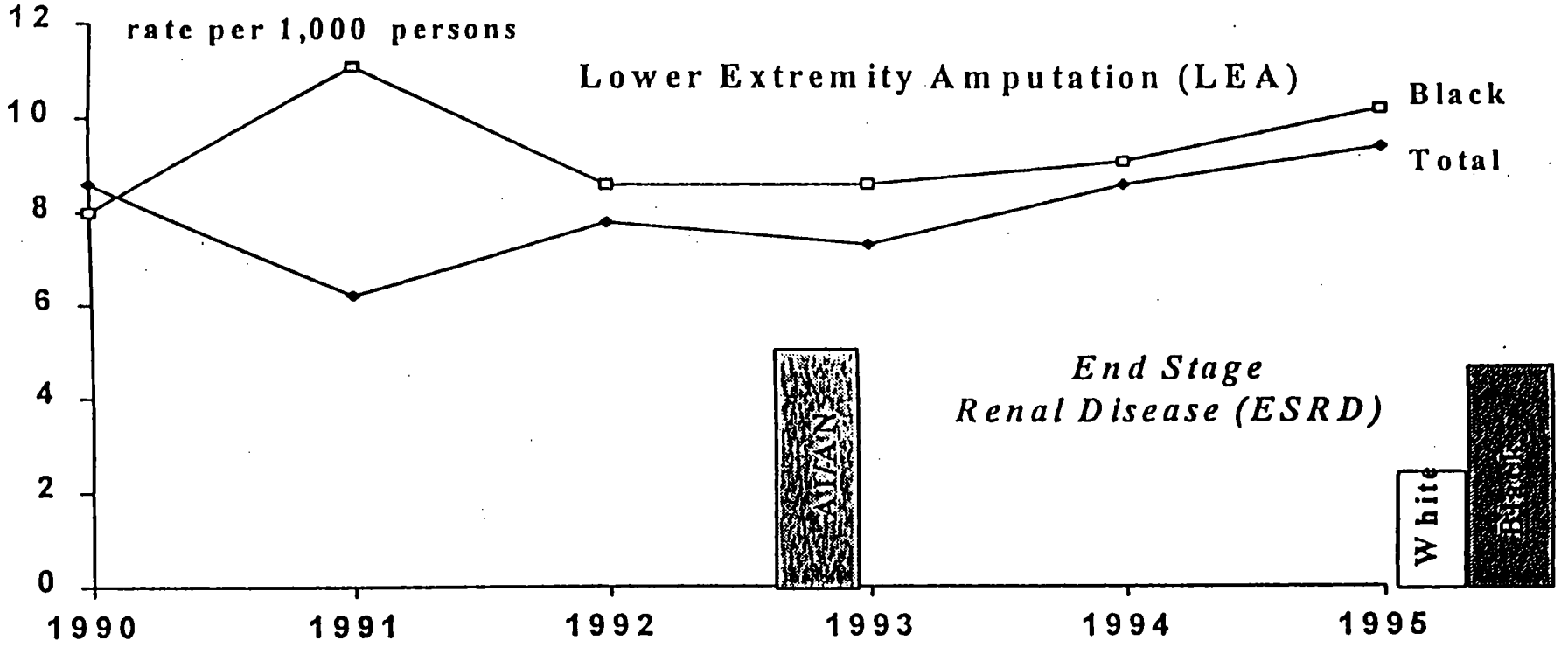
Stroke Mortality Rate Baselines:

Total: 26.7 per 100,000 persons (age-adjusted) (1995)
White: 24.7 per 100,000 persons (age-adjusted) (1995)
Black: 45.0 per 100,000 persons (age-adjusted) (1995)
American Indian/Alaska Native: 21.6 per 100,000 persons (age-adjusted) (1995)
Asian and Pacific Islander: 25.8 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Diabetes

Diabetes-Related Complication Rates for ESRD and Lower Extremity Amputation by Race and Ethnicity, United States, 1990–1995.



Lower Extremity Amputation Rate Baselines:

Total: 9.4 per 1,000 persons with diabetes (1995)
Black: 10.2 per 1,000 person with diabetes (1995)

Data Source: Numerator: National Hospital Discharge Survey, CDC, NCHS
Denominator: National Health Interview Survey, CDC, NCHS

End-Stage Renal Disease Baselines:

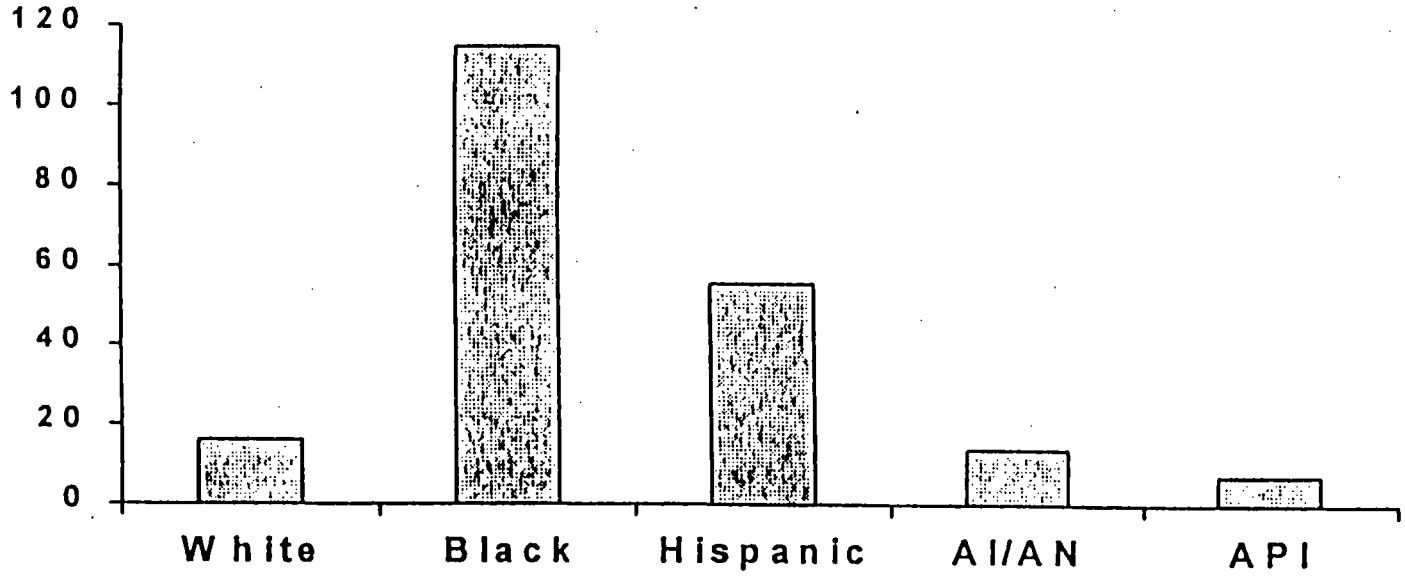
Total: 3.0 per 1,000 persons with diabetes (1992-1995)
White: 2.4 per 1,000 persons with diabetes (1992-1995)
Black: 5.2 per 1,000 person with diabetes (1992-1995)
American Indian/Alaska Native: 5.4 per 1,000 person with diabetes (1992)

Data Source: Bureau of Data M... and Statistics, HCFA Program Statistics

HIV Infection

AIDS Case Rates in Persons >13 Years of Age by Race/Ethnicity, United States, 1996.

Rate per 100,000 persons



Adult (≥ 13 years) AIDS Case Rate Baselines:

Total: 31.4 per 100,000 (1996)
White: 16.2 per 100,000 (1996)
Black: 115.3 per 100,000 (1996)
Hispanic: 55.8 per 100,000 (1996)
American Indian/Alaska Native (AI/AN): 14.1 per 100,000
Asian and Pacific Islander (API): 7.5 per 100,000

Data Source: Adult/Adolescent AIDS Reporting System, CDC

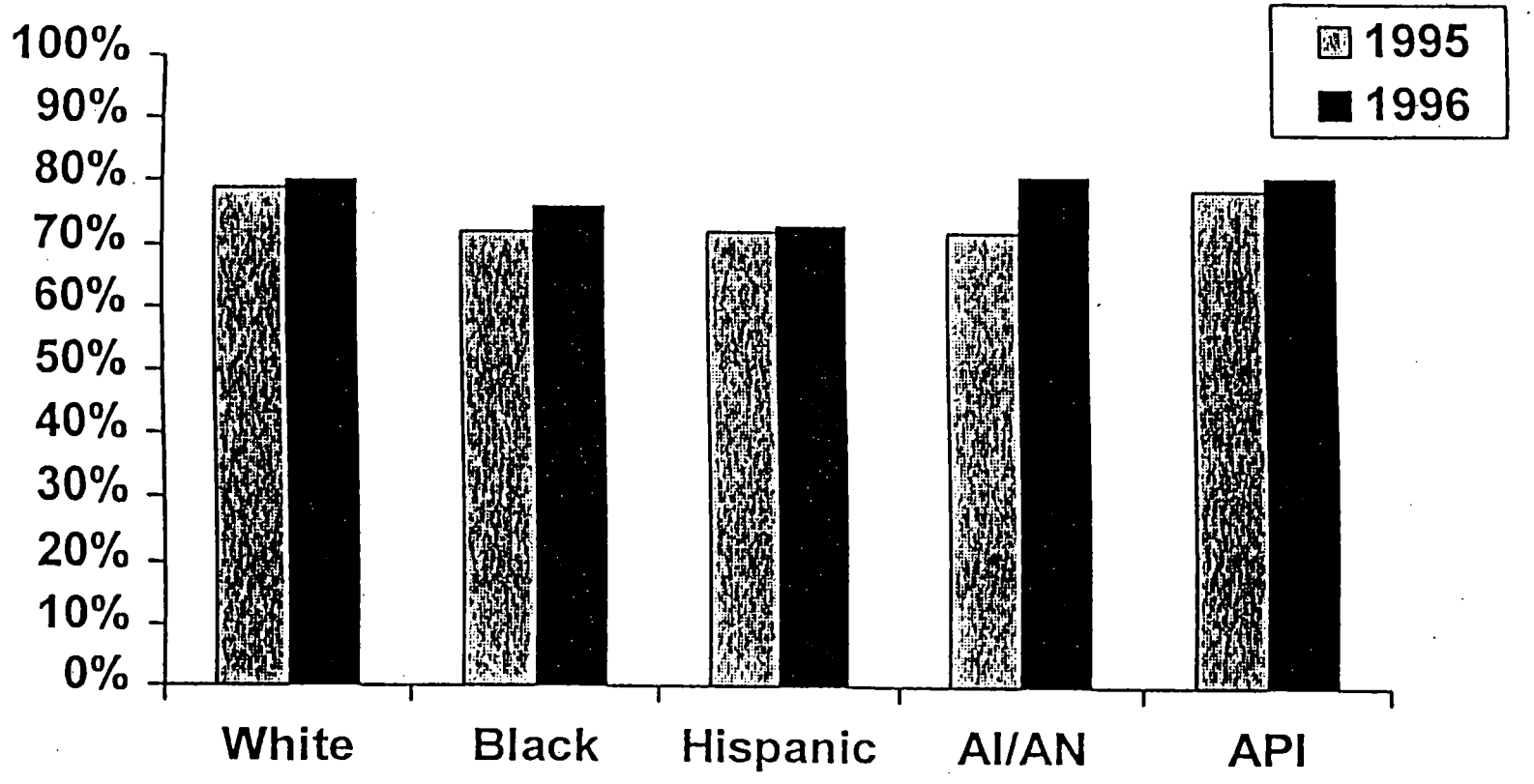
Pediatric (<13 years) AIDS Case Rate Baselines:

Black: 5.7 per 100,000 (1996)
Hispanic: 1.7 per 100,000 (1996)
American Indian/Alaska Native (AI/AN): 0.6 per 100,000
Asian and Pacific Islander (API): 0.0 per 100,000

Data Source: Pediatric AIDS Case Reporting System, CDC

Immunizations

Childhood Immunization Rates* by Race and Ethnicity, United States, 1995–1996.



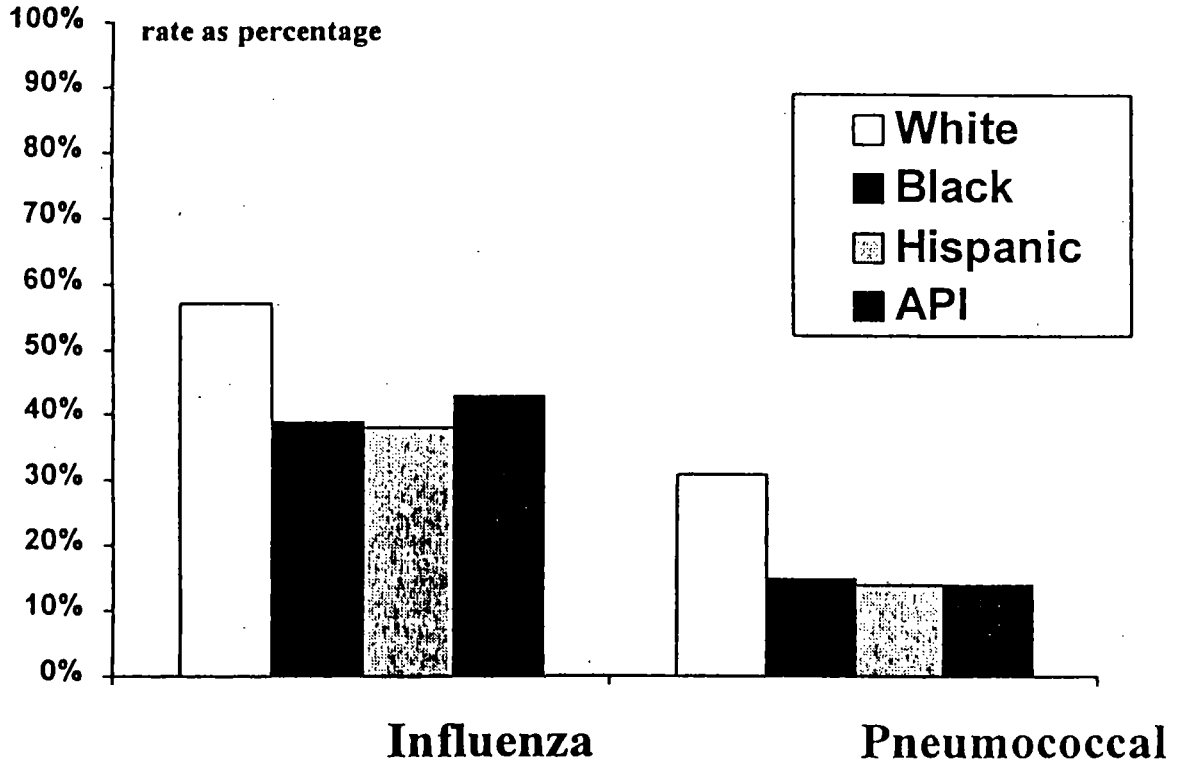
**Immunization rates reflect those children ages 19-35 months of age who have received 4 doses of DTP (diptheria , tetanus, pertussis), 3 Polio, and 1 MMR (measles, mumps, rubella).*

Childhood Immunization Rate Baselines:

Total: 78 percent (1996)
White: 80 percent (1996)
Black: 76 percent (1996)
Hispanic: 73 percent (1996)
American Indian/Alaska Native (AI/AN): 81 percent (1996)
Asian and Pacific Islander (API): 81 percent (1996)

Data Source: National Immunization Survey, CDC, NCHS

Pneumococcal and Influenza Immunization Rates for Persons 65 Years and Older by Race and Ethnicity*, United States, 1994.



*Sample size for American Indian/Alaska Native was too small to quantify

Immunization Rate Baselines for Individuals Age ≥ 65 Years:

Influenza:
- **Total:** 55 percent (1994)
- **White:** 57 percent (1994)
- **Black:** 39 percent (1994)
- **Hispanic:** 38 percent (1994)
- **Asian/Pacific Islander:** 43 percent (1994)

Pneumococcal:
- **Total:** 30 percent (1994)
- **White:** 31 percent (1994)
- **Black:** 15 percent (1994)
- **Hispanic:** 14 percent (1994)
- **Asian/Pacific Islander:** 14 percent (1994)

Data Source: National Health Interview Survey, CDC, NCHS

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 21, 1998

RADIO ADDRESS BY THE PRESIDENT
TO THE NATION

The Oval Office

10:06 A.M. EST

THE PRESIDENT: Good morning. February is Black History Month, the time when we celebrate the rich heritage of the African American community and rededicate ourselves to the value of equal opportunity for all Americans that is at the heart of the American ideal. Today I want to talk about an important step we're taking to make sure all Americans, no matter what their background, have a better opportunity to live healthier lives.

In the last six years we've worked hard to make quality health care more accessible and affordable and to place more emphasis on prevention. And this approach is working. Since 1993, our nation's health has greatly improved. Infant mortality has reached an all-time low, childhood immunization levels are at an all-time high and AIDS death rates are falling, for the first time in the history of the epidemic. Americans are living longer and are in better health than ever before.

This is good news we should all celebrate. But we must not be blind to the alarming fact that too many Americans do not share in the fruits of our progress, and nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people.

Consider: Infant mortality rates are twice as high for African Americans as for white Americans. African American men suffer from heart disease at nearly twice the rate of whites. African Americans are more likely to die from breast cancer and prostate cancer. Overall, cancer fatalities are disproportionately high among both Latinos and blacks. Vietnamese women are five times as likely to have cervical cancer; Chinese Americans four to five times as likely to have liver cancer. Hepatitis B is much more prominent among Asian Americans than the rest of the populations. Native Americans suffer higher rates of infant mortality and heart disease. And for diabetes, Hispanic rates are twice the national average, and Native American rates three times the national average.

Research shows that overall, all these groups are less likely to be immunized against disease, less likely to be routinely tested for cancer, less likely to get regular check-ups.

We do not know all the reasons for these disturbing gaps. Perhaps inadequate education, disproportionate poverty, discrimination in the delivery of health services, cultural differences are all contributing factors. But we do know this: No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities.

MORE

This is our national goal: By the year 2010, we must eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS, and immunization.

My balanced budget plan devotes an unprecedented $400 million to spur promising prevention and outreach programs to help us meet this challenge. I'm asking our top public health officials, led by Secretary Donna Shalala, to convene a task force to find new ways of targeting existing federal programs to reduce racial and ethnic disparities. Our new Surgeon General, Dr. David Satcher, will launch a comprehensive campaign to educate the public and work with community leaders and health professionals to reach more Americans.

These steps, along with our drive to give 5 million more children, many of them minorities, health insurance, and our huge increase in overall medical research, will bring us closer to our goal. But to truly eliminate these disparities and ensure better health for all Americans, all Americans must do their part.

I'm pleased to announce that Grant-Makers in Health, a major coalition of over 136 philanthropic foundations across the country, is joining our efforts. Together we'll host a national conference this spring to help solve this national problem, community by community.

Above all, Americans must take more responsibility for our own health and the health of our children, for good health is the greatest gift God can bestow and it is each of our duty to protect it.

America has the best health care system in the world. But we can't take full pride in that system until we know that every American has the best health care in the world. With these steps, I'm confident that we can meet the challenge and go forward as one America into the 21st century -- stronger and healthier than ever before.

Thanks for listening.

END 10:11 A.M. EST

Race + Health

2/15/08

Briefing mtg @ HHS

Clay Simpson	DAS	
Peggy Hamburg	AS	
Bill Corr	CofS	
Ed Sondik	~~DAS~~	Dir, Natl Ctr for Hlth Statistics
Gary Claxton	DAS	

Peggy - Steering Committee @ HHS (Internal)

"Re-prioritize" existing program $ = re-program? & what?

- No FACA "too cumbersome" "infeasible"

- blah, blah, blah

---

don't talk about data driving decision on why 6 chosen
"raise the bar" - how we are going to close disparities

The White House At Work

Tuesday, September 30, 1997

President Clinton and Vice President Gore Meet with the Race Initiative Advisory Board and Announce New Efforts to End Housing Discrimination

Addressing the second meeting of the Advisory Board to the President's Initiative on Race, President Clinton underscored the importance of continuing the dialogue on race. To that end, the President announced a December 2, 1997 town hall meeting. And while the dialogue continues, we must also enforce the laws that are already on the books. Today, the President announced a HUD initiative to step-up efforts to end housing discrimination. Also on today's agenda, the Advisory Board will hear from noted scientists and demographers who will share their research on the changing population patterns and attitudes on race, working toward meeting one of the Initiative on Race's goals of educating the nation about the facts of race in this country.

NEW EFFORTS TO END HOUSING DISCRIMINATION IN AMERICA

At the President's direction, Housing Secretary Andrew Cuomo will announce today that the Department of Housing and Urban Development will double its efforts to fight against housing discrimination.

- **Doubling the Number of Enforcement Actions Taken Against Housing Discrimination** -- Since the President took office, the Administration has investigated 16,325 housing complaints, taken enforcement actions on 1,085 cases, reached out of court settlements on 6,517 cases, and collected $17.8 million in compensation for victims of housing discrimination. In the next four years, HUD will double the number of housing discrimination enforcement actions.

- **Reaching out to States and Local Organization to Step up Efforts to Promote Fair Housing** --
  HUD will issue $15 million in grants to help 67 private, non-profit housing groups reduce housing discrimination. These grants will be used to investigate allegations of discrimination, provide housing counseling and education, and promote fair housing.

- **HUD Will File Civil Charges of Housing Discrimination in Four Separate Cases** -- These cases show that housing discrimination is not a thing of our past, but an outrage that still exists today. Action by HUD on these cases illustrates three principles: people who break the law must be held accountable; sends a clear message that these kinds of actions will not be tolerated any time, anywhere; and puts a human face on discrimination.

Five Goals of the President's Initiative on Race

- To articulate the President's vision of a just, unified America;
- To educate the nation about the facts of race in this country;
- To promote constructive dialogue to work through the issues of race;
- To encourage leadership at the federal, state, local community and individua to bridge racial divides and;
- To identify and develop solutions in critical areas such as education, econo opportunity, housing, crime and health care.

October 31, 1997

Note to Todd

From Matthew

Re: President's Race Initiative

The latest version of Goal 5 of DHHS's response to the President's Race Initiative focuses on access to care and reducing health disparities but is not specific to prevention, services or research. Ideally, our response should support efforts which will enhance the linguistic and cultural appropriateness of prevention efforts (including building the capacity of minority organizations to develop, implement and evaluate programs), services (including representation on planning councils and the provision of technical assistance to enable minority ASO to develop, implement and evaluation culturally appropriate service delivery models), and research (including ensuring that racial/ethnic populations fully participate in clinical trials including HIV prevention vaccine efforts). In addition, the need to ensure the inclusion of racial/ethnic individuals in the decision making process cannot be understated.

Please note that many of the ideas are enhancements of current efforts which if done better, would go a long way to reducing disparities.

Suggestions

1) Support the OHAP concept paper for a pilot project to provide a comprehensive prevention/service intervention strategy in a hard-hit city with a high number of cases and limited infrastructure. ($5 million);

2) Addressing the disparities in AIDS death rates attributed to protease inhibitors, a national campaign to educate health professionals (doctors, case managers, etc.) and racial/ethnic communities about PI's and their value could be useful. ($2 - $3 million)

   This project would include:

   -- a national education campaign to enhance the HRSA AIDS Education Training Centers' efforts;

   -- working with the American Medical Association, the National Medical Association, National Student Medical Association, the Interamerican College of Physicians and Surgeons and other minority-focused medical associations, support the addition of a continuing medical education (CME) course on HIV infection and treatment;

-- a national campaign to educate case managers and other care providers about the benefits of PI's, adherence issues, ADAP and other sources of funding for PI's. This would be accomplished through a series of regional/local conferences.

(Note: the National Minority AIDS Council has proposed this to DHHS's Office of Minority Health, but OMH has not had funding available to support this effort.)

3) Given the large proportion of individuals from racial/ethnic populations which rely on the ADAP program for treatment, enhanced funding for the ADAP program is necessary. ($ unlimited)

4) Given that only about 40% of individuals return for HIV test results, additional efforts must be made to increase the return-rate. Specific efforts should be undertaken to enhance the quality of pre-test counseling which is conducted as means to encourage individuals to return for their test, especially in anonymous test sites. ($20 million nationwide in "bonus money" to states/localities which show the greatest increases in return rates.) This of course means that the infrastructure to serve newly diagnosed individuals will have to be available.

5) To address HIV prevention efforts, enhanced efforts aimed at minority community-based organizations could be supported. In particular, enhanced direct funding of minority CBOs (not as pass-through from the states), with comprehensive technical assistance to minority community-based organizations would be useful. ($10 million)

6) Given that a large number of racial/ethnic minorities receive their "primary care" at hospital emergency rooms, and that in some areas up to half of racial/ethnic minorities receive their AIDS-diagnosis in the emergency room, the need to ensure that adequate care and treatment is being provided is important. Evaluating the level of care and treatment provided, as well as ensuring that adequate referral systems to case management is in place, is important. ($500,000 for an evaluation project)

7) Increased efforts must be undertaken to educate already infected individuals about safer-sex practices. Specific efforts must be taken to provide comprehensive education to HIV+ individuals so that they do not infect others. Post-test counseling sessions seldom provide this information in detail. This would also include psycho-social counseling as a means to behavior change. ($10 million in grants to fund social workers/counselors at ASO's, CBOs, local health departments, etc.)

8) Given the high infection rate in the homeless population in some communities, additional efforts must be undertaken to educate this population. Specific grants to shelters and others serving this population could be increased ($2 - $3 million)

10) Through SAMHSA, increase the number of substance abuse treatment slots available for HIV infected individuals. ($20 million)

11) Enhance evaluation activities to develop "best practices" for prevention and service delivery, based on the target population. Most organizations rely on anecdotal information or prior experience on which to base their service delivery models and or prevention activities. However, given the large number of HIV infected individuals who do not receive services under Ryan White (those "outside" of the system), efforts should be undertaken which determine why these individuals do not access available services.

(1) A discussion of the disparity rates as outlined by you and Melissa at our last meeting (the current rates, how much we have improved, and what is lagging.

HIV disease is quickly becoming a disease of racial/ethic minority populations.

-- Approximately 65% of all AIDS cases reported between July 1996 and July 1997 were in racial and ethnic populations despite the fact that they account for only 25% of the U.S. population. This is up from 50% two years ago.

-- More than 75% of women with AIDS are racial and ethnic minorities.

-- More than 75% of adolescents with AIDS are racial/ethnic minority minorities.

-- While the main mode of transmission in racial/ethnic populations continues to be MSM, IDU and heterosexual transmission is increasing rapidly, especially for minority women.

-- IDU transmission varies by region of the United States, with IDU transmission in the NE much higher than in the SW or West Coast. The same is true for MSM transmission.

-- AIDS case rates per 100,000 for Black are nearly five times that of Whites, and Hispanics are nearly double that of Whites.

2) Our goal for minimizing disparities for the year 2000, 2010.

This is related to the specific goals that HHS has developed to address the race initiative. In the latest draft I read, Goal 5 deals with HIV and focuses on ensuring access to care and reducing disparities.

Healthy People 2000 goals focusing on reducing rates per 100,000; increase number of HIV-infected individuals who know their HIV status; lower the rate of adolescents who engage in sexual intercourse; increase condom use at last episode of intercourse; increasing the number of drug users in treatment; increasing the number of schools which offer HIV and STD education curricula; and others.

3) Three specific actions in each area in the FY 1998 budget and the time of each initiative

I offer the attached.

4) **Proposed initiatives and budget allocations in the FY 1999 Budget. It would be helpful to note the amounts that you proposed in the original HHS budget submission as well as the amount Congress is likely to allocate for FY 1998.**

This is an internal HHS question. I do not know what they will be proposing or current dollar levels.