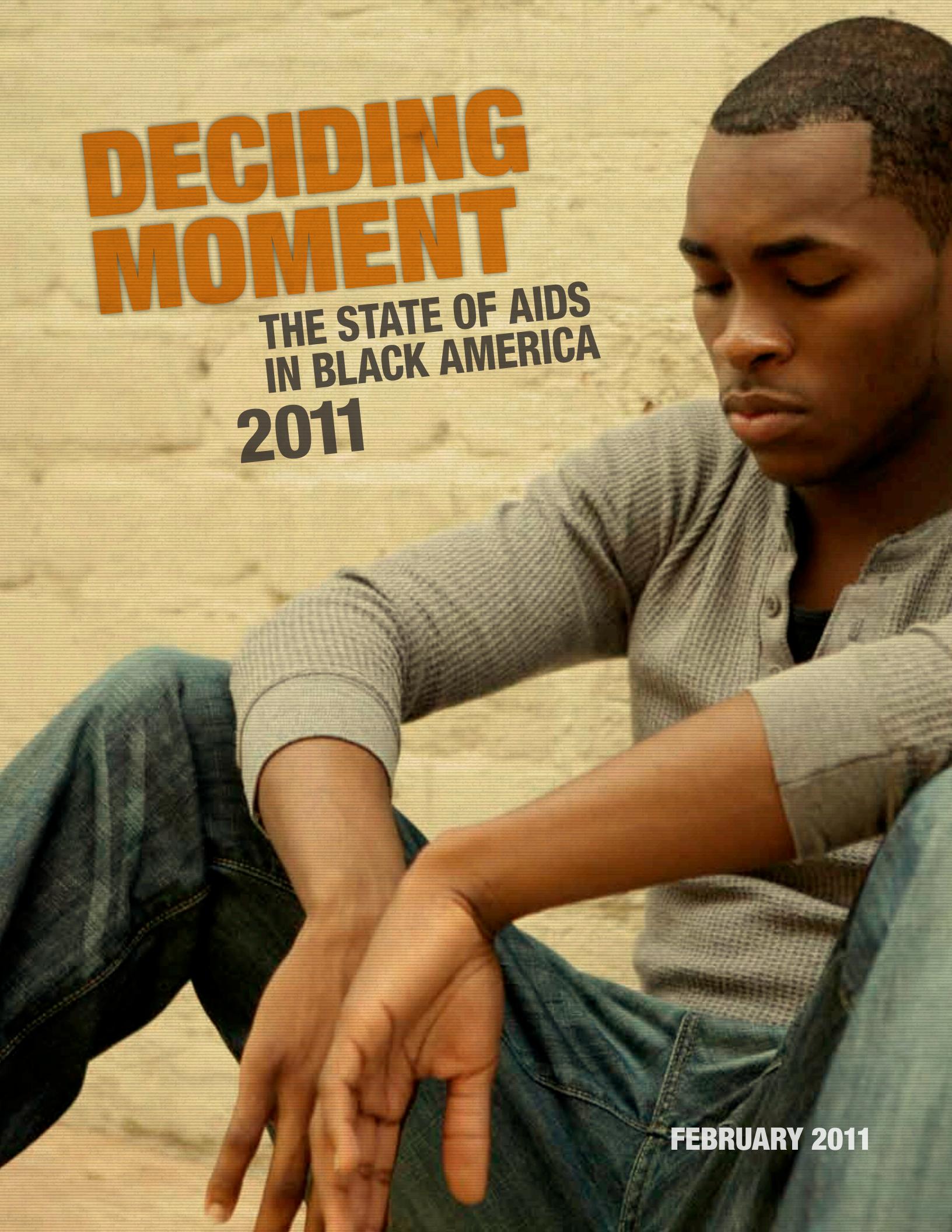


DECIDING MOMENT

THE STATE OF AIDS
IN BLACK AMERICA

2011



FEBRUARY 2011



Deciding Moment: The State of AIDS in Black America, 2011 is a publication of the Black AIDS Institute, 1833 West Eighth Street, Los Angeles, California 90057-4257, 213-353-3610, 213-989-0181 fax, info@BlackAIDS.org, www.BlackAIDS.org.

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This report was made possible, in part, by the generous support of ViiV Healthcare. Other Institute funders include the Arcus Foundation, Broadway Cares Equity Fights AIDS, the Elton John Foundation, the Ford Foundation, the MAC AIDS Fund, Northrup Grumman Corporation and the John M. Lloyd Foundation.



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FROM THE CEO

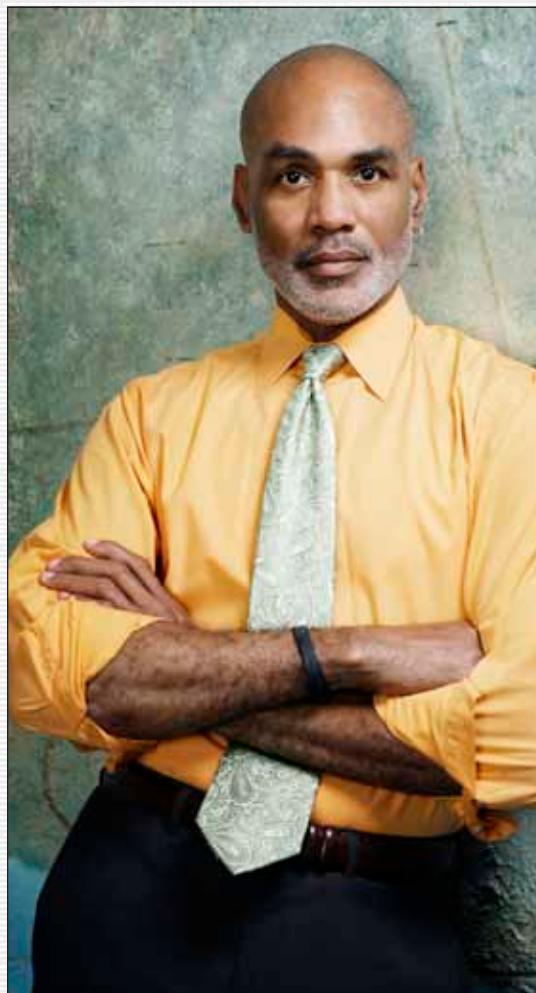
Deciding Moment

Every day, in ways both large and small, each of us has deciding moments. Moments when we decide to do good, bad or nothing. Today we are at a collective deciding moment. When it comes to HIV/AIDS, there is no difference between doing bad and doing nothing. Edmund Burke said, "All that is necessary for the triumph of evil is that good men do nothing." That is especially so in Black America.

The year 2011 represents a landmark in the AIDS epidemic. It marks 30 years since initial recognition of the disease, and 25 years since the number of new HIV infections among Blacks in the U.S. surpassed those among whites.

2011 also marks 15 years since regulatory approval of a new class of drugs, protease inhibitors, which made combination antiretroviral therapy possible. Antiretroviral therapy revolutionized medical management of HIV infection, resulting in a sharp reduction in HIV-related illness and death.

I'm one of the hundreds of thousands of Americans—and millions of people worldwide—who are alive today because of this medical breakthrough. These are certainly



Phill Wilson



reasons for celebrations.

But every day, I'm conscious of our failure to reach everyone in need with the fruits of modern medicine. Everyday I'm reminded that people who look like me continue to get infected with HIV at alarming rates. Our disease progresses and we die faster and more often than anyone else. Globally, only about one in three people, who need these medicines, are receiving them. And here in the U.S.—the richest and most powerful country on earth—only about one in four people living with HIV are in care and have suppressed virus. We have the tools to end the AIDS epidemic. This is a deciding moment.

I'm also conscious of our failure to stop this preventable disease from spreading. Every year, 56,000 Americans become infected with HIV. Nearly one out of two newly infected people are Black.

Fortunately, 2010 was one of those years that helped those of us who work in the AIDS field to find a new burst of energy and

new wells of hope and optimism, because 2010 was one of the most remarkable years in the epidemic's history.

For the first time ever, our country now has in place a comprehensive, results-driven national strategy to fight AIDS here at home. Making this strategy—for all Americans, but especially for Black America—has become a central goal for the Black AIDS Institute.

At long last, the U.S. enacted comprehensive health reform. As a result of this bold step, more than 30 million Americans who currently have no health coverage will have access to quality medical care. This momentous achievement—which brings America into line with other industrialized countries—will especially benefit Black America and people living with HIV.

Last year, we also saw the emergence of new breakthrough technologies for preventing HIV infection. We now have the tools to halt the epidemic—here in the U.S., but also globally.

And in 2010, our country finally rid itself

of some of the most shameful and counter-productive policies ever put in place in our three-decade-long struggle with AIDS. The discriminatory immigration ban on entry to the U.S. by people living with HIV was removed, as were the unconscionable restriction on federal funding for life-saving needle and syringe exchange programs.

But we face enormous obstacles in moving forward. As a country, we are still digging our way out of the worst economic and financial calamity since the Great Depression. The new buzzword in Washington is “cut,” and we know that programs that affect the least powerful and the most vulnerable will be on the chopping block. As this report goes to press, the House of Representatives has already passed legislation to repeal health care reform, and lower courts have split on the constitutionality of the bill. Implementing health care reform is a matter of life and death for many Black Americans living with HIV/AIDS. This is a deciding moment.

Although our mind is on 2011 and the challenges we face, it’s worth taking a look back at the remarkable year of 2010. It reminds of what is possible if we stick together, make our case, and speak to our fellow Americans about the life-and-death consequences of our fight against AIDS.

The report is the latest annual update on the State of AIDS in Black America. We at the Institute hope you, too, find inspiration in revisiting the enormous advances we experienced in 2010.

The report also looks ahead. It offers recommendations for action to preserve and build on last year’s successes. And it also takes a peek at 2012, when the International AIDS Conference returns to the U.S. for the first time in more than two decades, offering a unique opportunity to focus attention on the AIDS crisis in Black America.

From its beginnings, the AIDS movement has been about the joy, beauty and sanctity of life. But Dr. Martin Luther King Jr. taught us that life involves more than merely a beating heart or a functioning

brain. According to Dr. King, “Our lives begin to end the day we become silent about things that matter.”

Unfortunately, the AIDS pandemic has been about leadership, or the lack thereof, and particularly how individual and collective indecision allowed an arguable controllable epidemic to grow into a global pandemic. As we compare the achievements of 2010 with the challenges we face in 2011, let us refuse to remain silent. The lives of our friends and loved ones, the health of our communities, our belief in a healthy and productive future—these things matter, and they demand speech, action, solidarity and determination.

AIDS continues to devastate our communities, but it need not. The tools—technological, communal and spiritual—that we need to reverse AIDS are at our disposal. Let’s use them.

Do not allow evil to triumph. Do not sit by and do nothing. This is our deciding moment!

Yours in the Struggle,



Phill Wilson
CEO
Black AIDS Institute

DECIDING MOMENT: “LOVING MY SON AND HELPING HIM LIVE WITH HIV.”



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EXECUTIVE SUMMARY

Deciding Moment

2010 turned out to be one of the most remarkable years in the 30-year history of the HIV/AIDS epidemic. The first comprehensive strategic framework for the U.S. AIDS response was launched, and major new scientific developments added an array of new tools to the HIV prevention continuum.

A Look Back at 2010

AIDS news in 2010 included the good, the bad and the ugly.

In addition to the release of the national AIDS strategy and momentous scientific advances, good news included the Obama administration's formal end of the long-standing and discriminatory U.S. immigration ban on the entry of people living with HIV. Congress also lifted the 20-year-old ban on federal funding of syringe exchange programs, improving the nation's ability to contain the epidemic among injection drug users and their sexual partners.

Perhaps the most groundbreaking advance in 2010 was passage of national health care reform legislation—a long-sought domestic advance that had eluded Presidents and health advocates for decades. The legislation will extend health coverage to an estimated 32 million people who are currently uninsured, requiring all Americans

to purchase health coverage, prohibiting discriminatory practices of the insurance industry (including exclusion of coverage for pre-existing conditions), and expanding Medicaid and Medicare. As a community that has suffered among the most from America's historically porous health care safety net, Black people living with HIV have much to gain from this extraordinary achievement.

For the first time in the epidemic's history, a variety of media and public-health organizations are carrying out aggressive HIV/AIDS social marketing campaigns specifically focusing on Black America. For example, the Greater Than AIDS initiative, created by the Black AIDS Institute and the Kaiser Family Foundation, launched its "Deciding Moments" campaign, offering real people the opportunity to share simple choices they'd made to reduce both stigma and the spread of the disease.

Unfortunately, several developments in

2010 could not in any way qualify as good. First and foremost, the enduring economic and financial downturn continued to wreak havoc on American families and communities and imperiled essential funding for life-saving AIDS programs. New CDC data on the health effects of poverty underscored the reality of two Americas. And many conservatives do not share the excitement of health advocates and people living with HIV in the country's newly expanded health care safety net, vowing to repeal the law or to starve it of funds needed for implementation.

A horrifying 7.0 earthquake devastated Haiti, destroying much of the country's health infrastructure and imperiling its notable progress in reducing HIV infections. Although the U.S agreed to pony up an additional \$25 million, numerous states confronted severe funding shortfalls for the AIDS Drug Assistance Program, leaving 5,000 people on waiting lists for the drugs they need to survive.

The midterm elections shifted America's political landscape, delivering a wake-up call to the AIDS movement. Republicans won more than 60 races, retaking the House of Representatives for the first time since 2006, diminishing the political clout of several longtime AIDS champions, and sweeping into Washington with pledges to slash spending on non-security programs.

A New National AIDS Strategy

In July 2010, the U.S unveiled a much-anticipated national strategy to address the domestic AIDS epidemic, the first comprehensive AIDS strategy for this country. The strategy has three primary goals—reducing the number of people who become infected with HIV, increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

Black America has the greatest stake in the success of this new strategy. Representing

only 12 percent of the national population, Black people account for 45 percent of all new HIV infections and for 45 percent of all people living with HIV. In short, if the country's AIDS strategy does not work for Black people, it will not work at all.

Reducing New Infections

Acknowledging that little progress has been made over the last two decades in reducing the annual number of new HIV infections, the strategy pledges to intensify HIV prevention efforts in the communities where HIV is most heavily concentrated. This action step is especially critical for Black Americans, who are seven times more likely than white people to become infected. In a number of U.S. cities with significant Black HIV epidemics, levels of infection approach those reported in many African settings.

The national AIDS strategy also calls for steps to expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches. HIV prevention efforts to date have largely sought to encourage individuals to avoid risky behaviors. Yet evidence indicates that Black people do not as a whole engage in higher levels of risk behavior than other parts of the U.S. population, and there is little reason to believe that incremental reductions in risk behavior will achieve the progress required to break the epidemic's back in Black America. Instead, increased focus is needed on programs that address the makeup of sexual networks, disproportionate rates of sexually transmitted infections among Black people, and social and structural factors that increase risk and vulnerability.

The strategy also calls for intensified efforts to educate all Americans about the threat of HIV and how to prevent it. Black Americans are on average more aware of HIV than other racial or ethnic groups, but the share of Black people who report having heard a lot about AIDS fell by almost half between 2006 and 2009, underscoring the need for broad-based efforts to increase the visibility of the AIDS fight. With an epidemic that is more generalized than for America as



President Barack Obama greets people after speaking about the new National HIV/AIDS Strategy (NHAS) in the East Room of the White House, July 13, 2010, in Washington, D.C.

a whole, Black America needs to ensure that every person is aware of the disease and how to avoid becoming infected.

Improving Health Outcomes for People Living with HIV

Despite the extraordinary promise of HIV treatment, the fruits of recent medical advances are not equitably shared by all. Due to gaps in HIV testing, health care access, and treatment adherence, federal officials estimate that only about one in four (26 percent) people living with HIV in the U.S. are currently in care and have effectively suppressed virus. These gaps are especially pronounced in Black America, as Black people are significantly more likely than other Americans to lack health insurance.

The national strategy calls for efforts to establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV. The national strategy aims to

increase the percentage of newly diagnosed individuals who are linked to care within three months of their positive HIV test from 65 percent to 85 percent by 2015.

The strategy also provides for deliberate steps to increase the number and diversity of available providers of clinical care and related services to people living with HIV. The unfortunate reality is that while the face of AIDS in America is Black, relatively few Black physicians are available to care for people living with HIV.

Ensuring quality care for HIV-positive Black people requires federal investments in medical education and training to prepare new cadres of health workers who look like the patients they serve and who understand their needs and values. Because it is impossible overnight to alter the demographic makeup of the healthcare workforce, increased investments are needed in programs to build the cultural competence of HIV clinical personnel.

Under the strategy, steps are required to address co-occurring health conditions and basic needs of people living with HIV, such as housing. This component of the strategy is of particular relevance to Black America. One nationally representative study of people receiving HIV care found that Black patients were more likely to postpone medical care because they lack transportation, were too sick to make their appointments, or had other needs to address. Nationally, Black people are most likely to have inadequate housing.

Reducing Health Disparities

Alleviating the epidemic's disproportionate impact on Black America requires focused efforts that prioritize health promotion in Black communities. The strategy's first action step to minimize health disparities is to reduce HIV-related mortality in communities at high risk of HIV. In this regard, national health care reform offers major new opportunities to close the gaps in health care access that make fighting AIDS in Black America so difficult. Expanded health coverage is likely to increase testing rates in Black America and improve timely access to essential medicines and diagnostic tests.

The strategy also calls for increased focus on community-level strategies to improve health. One potentially promising prevention strategy is to lower community-level viral load (i.e., the amount of circulating virus) through more intensive and successful treatment coverage. In San Francisco, a 40 percent reduction in community-level viral load was accompanied by a 45 percent drop in the number of new HIV infections. To achieve the community-level effects of antiretroviral therapy, substantially greater success is needed in diagnosing HIV in a timely manner, linking people who test positive to care, and helping patients adhere to HIV treatment regimens.

The strategy also pledges to reduce stigma and discrimination against people living with HIV. The national strategy identifies a number of useful approaches and interventions for reducing HIV stigma and discrimination, including engaging communities to

affirm their support for people living with HIV and promoting the leadership and visibility of HIV-positive people.

Improving Coordination of the Response

The strategy calls for increased coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal and local governments. Funding silos and the fragmentation of the federal AIDS response among multiple agencies and bureaus make coordination of AIDS efforts a challenge. Given the multiplicity of needs among Black Americans living with HIV, having a seamless continuum of services in place is a necessity for long-term success in the AIDS fight.

The strategy provides for improved monitoring and reporting on progress to achieve results. To succeed, the national strategy must improve outcomes for Black Americans affected by HIV. One strategic target—to increase by 2015 the proportion of HIV-diagnosed Blacks with undetectable viral load by 20 percent—is specific to Black America. The remaining targets—which focus on such priorities as reducing new infections, increasing knowledge of HIV status, and improving health care utilization—are generic targets for the country as a whole. The Black AIDS Institute has strongly encouraged the White House Office of National AIDS Policy to ensure that performance data are disaggregated by race/ethnicity in order to ensure that the national strategy is working for Black America.

To succeed, the national strategy must be more than a guidebook for the federal government. It must also affect approaches by state and local governments, by affected communities, and by the private sector. The nature of the national strategy underscores the importance of broad ownership and engagement in the implementation and monitoring of this results-based framework. If the national strategy is to work for Black America, then Black America will need to contribute by holding itself accountable for results.

Major New Prevention Developments in 2010

The year 2010 saw major strides toward development of key building blocks for a combination approach to HIV prevention. Although some of these developments are preliminary, they indicate that investments in HIV prevention research are now bearing fruit.

Study results presented at the International AIDS Conference in Vienna indicated that HIV-negative women who received a vaginal gel containing the antiretroviral tenofovir were 39 percent less likely to become infected during vaginal intercourse than uninfected women who received a placebo. The trial, conducted in South Africa, is the first to find that a microbicide is effective in reducing the risk of sexual transmission. Additional studies are underway to confirm these trial findings, to test other vaginal microbicide candidates, and to assess the safety and efficacy of similar products to be used during anal intercourse.

Long-awaited trial results were also presented in late 2010 for the first trial of the use of antiretrovirals prior to sexual intercourse to reduce the risk of sexual transmission. In a study involving gay men in the U.S. and other countries, men who took a daily combination of the antiretrovirals emtricitabine and tenofovir were 44 percent less likely to become infected than those who received a placebo. Among men who carefully adhered to the daily regimen, the reduction in the risk of infection exceeded 90 percent.

In 2010, there was growing interest in the possibility that antiretroviral treatment, which has dramatically lowered AIDS deaths in the U.S., could also help prevent new HIV infections. As the amount of virus in an HIV-infected person's body directly affects the likelihood that he or she will transmit the virus to others, it is believed that the virus-suppressing attributes of therapy could help lower HIV infection rates. The National Institutes of Health is currently supporting a

five-year trial involving 1,750 discordant couples (i.e., one partner is infected, the other uninfected) to clarify the overall prevention potential of antiretroviral treatment and to obtain answers to key questions.

After three trials in sub-Saharan Africa found that adult male circumcision reduced the odds of female-to-male transmission by roughly 60 percent, observers began asking whether circumcision might help slow the spread of HIV in the U.S. Black men in the U.S. are less likely than white men to be circumcised, although they are more likely to be circumcised than Mexican-Americans. Evidence to date on the possible prevention benefits of circumcision in the U.S. has been mixed, with a recent meta-analysis of available data finding no statistically significant difference in HIV infection risk between circumcised and uncircumcised men.

Although no major vaccine trial results were released in 2010, important progress was nevertheless reported in the search for a safe and effective preventive vaccine. In particular, a series of antibodies were discovered that appear to neutralize HIV. It will take years to convert these and other lab advances into products suitable for testing. But these signs of progress have significantly increased optimism that it will be possible to generate broad immunity against HIV in the foreseeable future.

In another development on the prevention front, the results of two World Bank studies of cash transfers to young people were released at the International AIDS Conference. In each of the studies, which were conducted in Africa, young people who received cash payments conditioned on particular behaviors (such as staying in school or avoiding unsafe sex) were significantly less likely to become infected with HIV or another sexually transmitted disease. Although these African study results may not be directly applicable to the U.S., they nevertheless indicate that focused cash payments to low-income young people who are living in vulnerable situations may nevertheless have important prevention benefits.

Each of these prevention advances re-

ported in 2010 remains preliminary. In the case of pre-exposure prophylaxis, the federal government is already taking steps to develop formal guidance for its integration in the prevention continuum. Together, however, these developments suggest that we may be living through a golden age of HIV prevention research.

2012 International AIDS Conference in Washington, D.C.

The XIX International AIDS Conference will be held July 22-27 in Washington, D.C. It will be the first International AIDS Conference held in the U.S. since 1990, when the conference took place in San Francisco. With a conference venue in a city with one of the heaviest AIDS burdens among Black people outside sub-Saharan Africa, the 2012 meeting offers a historic opportunity to bring global attention to the fight against AIDS in Black America. The meeting will also occur in the midst of a presidential campaign, which will likely pivot on such critical issues as the future of health care reform legislation and federal support for essential safety-net programs.

The International AIDS Society, sponsor of the conference, had opted not to hold the conference the U.S. due to longstanding immigration law provisions barring the entry of HIV-positive people into this country. Nearly all high-income countries had either never had such rules or repealed them over the years. The U.S. immigration restrictions were lifted by the Obama administration, allowing the international conference to be held in the United States for the first time in more than two decades.

The Black AIDS Institute has been designated as one of six local partners for the 2012 Washington conference. In this role, the Institute is helping plan the conference and ensuring broad-based community participation. As a key player in the preparation of the

conference, the Institute is working to ensure that the AIDS fight in Black America is a centerpiece of conference proceedings and related media coverage.

Recommendations

To ensure that we seize the opportunities that will present themselves in 2011 and that we successfully overcome key challenges, the Institute respectfully offers the following priority recommendations and urges their immediate implementation:

- **The country must implement and scale up health care reform.**
- **Steps should be taken to improve the evidence base for action to promote health care access for people living with HIV.**
- **Federal and state lawmakers should make wise and robust investments in life-saving, cost-effective AIDS programs.**
- **CDC should carefully monitor and report on HIV prevention spending.**
- **Federal officials and key stakeholders should collaborate to ensure the success of the CDC's new "12 cities" initiative.**
- **Steps should be taken to ensure that new biomedical prevention tools are rapidly assessed, and if effective, expeditiously implemented.**
- **Black communities throughout the U.S. should mobilize to support a strong and sustained AIDS response and to ensure the success of the national AIDS strategy.**



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MOMENT:
“SUPPORTING
OTHER WOMEN
WHO ARE
POSITIVE.”**

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2010 Year in Review

The Good, the Bad and the Ugly

2010 turned out to be one of the most remarkable years in the 30-year history of the HIV/AIDS epidemic. For the first time in its history, the federal government released a national AIDS strategy, and several remarkable scientific advances took place, making clearer than ever that a world without AIDS is possible. Here is a look back at the best and the worst (and a few things in between) of the year that was 2010.

The Good

End of the Travel Ban

The Obama administration kicked off the year by aligning with the rest of the developed world by ending 20 years of discrimination against people with HIV who want to travel or immigrate to the United States (Technically, the travel ban was lifted at the end of 2009, but the implementation of the new policy did not really begin until 2010). Imposed in 1987, the ban was implemented on the erroneous grounds that those with HIV represented a “dangerous and contagious” risk and that HIV was being imported into the U.S. by HIV-positive visitors of immigrants. The overwhelming conclusion of medical and public health experts—both at the time the immigration ban was implemented, as well as subsequently—was that

restricting entry to the U.S. based solely on a traveler’s HIV status was without any rational basis.

End of the Ban on Needle Exchange

This year, Congress lifted the 20-year-old ban on federal funding of syringe exchange programs, improving the nation’s ability to contain the epidemic among injection drug users and their sexual partners. Among Black people some 40 percent of men and 47 percent of women have contracted HIV through their own or their partner’s injection-drug use. The change in the law will allow harm reduction programs, such as syringe exchanges, to expand efforts to reduce the use of contaminated needles, get dirty needles off the streets, and link people suffering from chemical dependence with drug treatment.

You Say PrEP, I Say PEP

PrEP is merely the latest in a growing array of uses of antiretroviral compounds for HIV prevention. These include use of antiretrovirals to prevent mother-to-child transmission, antiretroviral-based topical microbicides, and antiretroviral therapy to reduce the viral load and associated infectivity of people living with HIV.

Another prevention method with which PrEP might easily be confused is post-exposure prophylaxis. Originally developed for health care workers who may have been exposed to HIV while performing an invasive medical procedure, post-exposure prophylaxis (PEP), the approach has subsequently been extended to sexual and other non-occupational exposures. Administration of PEP is the recommended approach for victims of sexual assault that involves a significant possible exposure to HIV. It is recommended that PEP be initiated within 72 hours of exposure and continue for 28 days. The degree of protection afforded by PEP following a sexual exposure is unclear, although it is less than 100 percent.

PrEP, by contrast, is taken before sex occurs. As noted in the accompanying article, evidence suggests that PrEP is most effective when taken daily, as prescribed.

Health Insurance Reform

The passage of the Access to Care Act represented perhaps the most significant HIV-related legislative achievement in the history of the epidemic. For 30 years people with HIV/AIDS (PLWHA) have experienced sometimes insurmountable barriers to health care access due to their inability to afford or obtain health insurance. The new law:

- Requires all Americans to have health insurance, expanding the risk pool and driving insurance premiums down. The federal

government will subsidize those who are unable to afford coverage.

- Ensures coverage for 32 million of the more than 40 million uninsured Americans.

- Bans insurance companies from making coverage decisions based on “pre-existing conditions,” making it illegal for insurers to refuse coverage or terminate coverage for PLWHA and other significant health issues.

- Prohibits lifetime caps on the dollar amount of coverage a health insurance plan will provide in an insured person’s lifetime. Given the potential enormous cost of life-saving HIV treatments over one’s lifetime—antiretroviral drugs alone can cost \$12,000—\$14,000 a year—“guaranteed availability and renewability of coverage” provides a key victory for people with AIDS.

National HIV/AIDS Strategy

In July, President Obama fulfilled his campaign promise to develop a National HIV/AIDS Strategy (NHAS). Its launch marks the first time in the history of the HIV/AIDS pandemic the U.S. has a plan for a coordinated response to hold decision-makers accountable for results. But while the administration has set out clear and concise goals and objectives so that we finally have a picture of where our nation is heading, the “devil” lies in details like determining how we get there, who holds the roadmap, how we protect the most vulnerable and how it addresses the unique challenges facing Black America.

Scientific Breakthroughs

Three major scientific breakthroughs took place during 2010:

- In what *Time* magazine called the year’s number one medical advance, a study involving gay and bisexual men found that daily pre-exposure prophylaxis (PrEP) prevented high-risk HIV-negative people from becoming infected with the virus. (For more in-depth information on the study, see the chapter “Preventing New Infections.”)

- South African researchers Salim and Quarraisha Abdool Karim announced that



Members of the Presidential Advisory Council on HIV/AIDS, which was established to provide policy recommendations on the U.S. Government's response to the AIDS epidemic.

a study they conducted found that a vaginal microbicide containing a one-percent solution of antiretroviral tenofovir significantly reduced women's risk of sexual transmission. Interestingly, the rate of new genital herpes infections also dropped by 51 percent. (The chapter "Preventing New Infections" provides additional information on the study.)

■ Scientists discovered at least eight antibodies able to prevent a wide range of HIV strains from infecting human cells in a laboratory. It was found that a 60-year-old Black man, now known as Donor 45, carries antibodies that protect against 91 percent of viral strains, making him one of science's most powerful secret weapons in the quest for an HIV vaccine.

HIV Prevention Public Health Campaigns

For the first time in the epidemic's history, a variety of media and public-health organizations are carrying out aggressive HIV/AIDS social marketing campaigns specifically focusing on Black America. For example,

the Greater Than AIDS initiative, created by the Black AIDS Institute and the Kaiser Family Foundation, launched its "Deciding Moments" campaign, offering real people the opportunity to share simple choices they'd made to reduce both stigma and the spread of the disease. Additionally, several major corporate sponsors—including Clear Channel, Walgreens, NBC, CBS, Essence communications, Johnson Publishing, The National Newspaper Publishers Association, American Urban Radio Networks and the National Basketball Association—increased their commitment to spreading health messages.

Outreach also expanded to include explicit messages for gay and bisexual Black men, women, faith leaders and PLWHA. For example, New York City's Department of Health and Mental Hygiene rolled out its "I Love My Boo" campaign, originally developed by Gay Men's Health Crisis and featuring gay and bisexual men of color embracing their significant other. Here Media also announced it will launch a new web portal featuring Greater Than AIDS messages.

GOP 'Pledge to America' Bodes Poorly for HIV/AIDS

As part of their "Pledge to America," which they embraced during their successful campaign in 2010 to retake the House of Representatives, House Republicans proposed to reduce non-security-related government spending to amounts appropriated in Fiscal Year 2008. Altogether, this approach, if enacted into law, would result in \$100 million in spending cuts.

What might this mean for the fight against AIDS? To assess the impact of the spending proposal of the new House majority, amfAR (formerly the American Foundation for AIDS Research) looked at the effects of cutting each AIDS program of the federal budget back to FY08 levels.

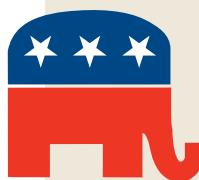
According to the amfAR analysis, the proposed spending cuts would reduce funding for HIV prevention services by 8.3 percent¹—a hefty reduction, indeed, considering that prevention accounts for only 3 percent of all federal AIDS spending.

More than 4,300 people might lose access to life-preserving medications under the AIDS Drug Assistance Program if such cuts are enacted.¹ Severe cuts in federally-funded AIDS research would be needed, and the President's Emergency Plan for AIDS Relief (PEPFAR) would have to cap or slow the expansion of urgently needed prevention, treatment, and care and support programs in developing countries.²

Notes

1. amfAR (2010). *Rolling Back Funding to FY 2008 Levels: Impact on the Domestic and Global AIDS Epidemic*. Accessed on January 25, 2011 at http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Funding%20Rollback%20Issue%20Brief%20Nov%202010.pdf.

2. Henry J. Kaiser Family Foundation (2010). *U.S. Funding for HIV/AIDS: The President's FY2011 Budget Request*. Accessed on January 26, 2011 at <http://www.kff.org/hivaids/upload/7029-06.pdf>.



The Bad

Economy

More than any other force, the ongoing global economic meltdown and the housing market debacle framed many of the most important policy debates and decisions affecting AIDS, both in the United States and worldwide. From funding cuts to AIDS Drug Assistance Programs (ADAP) and AIDS service organizations (ASOs), to budget reductions for mental health and other essential forms of care, federal, state and local governments reduced resources allotted to critical AIDS programs and initiatives. Even though the economy appears to have turned the corner, concerns about jobs, revenues and budget gaps are causing many state and local legislators to agree that they must slash spending and avoid tax increases. Future cuts to education, health care and social services programs appear likely.

Poverty vs. Race

In July Centers for Disease Control and Prevention (CDC) released results of a federal study examining the intersection of race, poverty and HIV among heterosexuals in 23 poor inner-city neighborhoods. Researchers learned that when other racial and ethnic groups experience the same social determinants faced by Black Americans, their risk for HIV rises. "There were no significant differences in HIV prevalence by race or ethnicity in these low-income urban areas: prevalence was 2.1 percent among Blacks, 2.1 percent among Hispanics, and 1.7 percent among whites," reported the CDC statement. Unfortunately, some media organizations erroneously interpreted this data to mean that race is not a driving factor in HIV transmission, igniting an absurd debate over whether race or poverty is the key driver of HIV in Black communities. But the fact of the matter is: both race *and* poverty propel the epidemic in the United States. Poor people are more likely to get

AIDS, and Black people are more likely than others to be poor.

Midterm Elections

The midterm elections shifted America's political landscape, delivering a wake-up call to the AIDS movement. Republicans won more than 60 races, retaking the House of Representatives for the first time since 2006. Many of the strongest Congressional AIDS champions no longer occupy key leadership positions, including House Speaker Nancy Pelosi, who has been replaced by Rep. John Boehner of Ohio. Many new members of the Republican majority promised to reduce federal spending on discretionary programs, such as the Ryan White CARE Act, the CDC's HIV prevention program and substance abuse and mental health services for people living with HIV.

The Ugly

Haiti Earthquake

The devastating 7.0 earthquake that leveled much of Port-au-Prince and its surrounding areas decimated Haiti's public health and AIDS treatment infrastructure, potentially setting the country back after years of progress in reducing HIV prevalence. (By 2008, Haiti had reduced its HIV prevalence rate among adults to 2.2 percent, down from almost 10 percent in 1993.)

Immediately following the quake, the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO), widely believed to be the oldest AIDS organization in the world, continued to provide antiretrovirals to thousands. But many other AIDS clinics were destroyed and key staff members killed, including at SEROvie, Haiti's largest AIDS organization serving gay and transgender people.

Since then, some organizations have resumed treating PLWHA, but tent-camp life potentially fuels the spread of HIV, with unprotected sex, prostitution and even

rape—facts of life—while health care and HIV prevention services remain virtually nonexistent.

ADAP Funding Cuts

One of the most devastating consequences of the Great Recession has been funding cuts to ADAP. While in 2010 the federal government provided a \$25 million boost, and several drug manufacturers offered discounts to states and free drugs to needy PLWHA, most people on ADAP require help for years, if not a lifetime. According to the National Alliance of State and Territorial AIDS Directors (NASTAD), as of January 2011 over 5000 people in 10 states remained on waiting lists for antiretroviral drugs. Nineteen states had instituted other cost containment measures, including capping enrollment, reducing drug formularies and narrowing income eligibility requirements. By the end of March 2011, 10 states are slated to implement additional cost controls.

Challenges to Health Care Reform

In 2011, health care reform will face numerous challenges, at the very same time that the Obama administration and states will be taking steps to implement it. Chief among these challenges: Many freshman members of the 112th Congress pledged to kill health care reform and cut the federal deficit. While it is highly unlikely that they will repeal the new law—surveys show that public opposition to its provisions has waned significantly—they might conceivably succeed in starving critical measures by depriving them of funding, delaying and/or complicating their implementation. What's more, new measures can't scale up without additional resources.



NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES

JULY 2010



A National HIV/AIDS Strategy

What It Means for Black America

In July 2010, the Obama administration unveiled a much-anticipated national strategy to address the domestic AIDS epidemic, the first comprehensive AIDS strategy for this country.¹ The strategy has three primary goals—reducing the number of people who become infected with HIV, increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

The Black AIDS Institute(BAI) and other community leaders played an important role in the development of the national strategy. The Institute was an early supporter of the Coalition for a National AIDS Strategy, which spearheaded advocacy efforts to encourage the executive branch to identify clear goals and priority action steps for the AIDS fight. As members of the Presidential Advisory Council on HIV/AIDS, Phill Wilson, BAI's President and Chief Executive Officer, and A. Cornelius Baker, chair of BAI's board of directors, provided feedback on early drafts of the strategy and will play a continuing role in monitoring its implementation.

AIDS affects people from all walks of life in the U.S., but Black America has the greatest stake in the success of this new strategy. Representing only 12 percent of the national population, Black people account for 45 percent of all new HIV infections² and for 45 percent of all people living with HIV.³ In short, if the country's AIDS strategy does not work for Black people, it will not work at all.

This chapter examines the goals and strategies outlined in the new AIDS strategy. It describes how the different components of the national strategy apply to Black America and why Black communities need to be engaged in efforts to ensure that the goals in the strategy are achieved.

Reducing New HIV Infections

An estimated 56,000 people in the U.S. become newly infected with HIV each year.⁴ No meaningful reduction in the annual number of new infections has occurred in this country over the last two decades.⁵

The national strategy aims to reduce the number of new infections by 25 percent by the year 2015. The strategy calls for three action steps to achieve the first reduction in national HIV incidence since the 1980s.

■ Step 1: Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.

Black America is more heavily affected by HIV than any other racial or ethnic group. Black people are seven times more likely to become infected than whites and roughly three times more likely to contract HIV than Latinos.⁶ Among the subpopulations of high-risk groups most likely to become infected, Black America accounts for the three most vulnerable groups—Black female injection drug users (2,735 infections per 100,000 people), Black male injection drug users (1,881 per 100,000), and Black men who have sex with men (1,710 per 100,000).⁷

The national strategy calls for funding for HIV prevention to follow the epidemic, with resources allocated in accordance with epidemiological evidence. Unfortunately, this has not always occurred. Gay and bisexual men—who account for 57 percent of all new HIV infections⁸, with Black gay men most at risk of infection⁹—are notably underserved by current prevention efforts. According to a recent analysis by CDC, only 41 percent of extramural HIV prevention funding from the federal government targeted gay and bisexual men in 2009—significantly below their actual share of the national epidemic. These funding inequities increase the likelihood that programs are often not available to address the exceptionally high risk of infection confronted by Black gay men.

The national strategy notes that Black Americans generally have been historically underserved by HIV prevention programs, although some strides have been made in aligning allocations with epidemiological evidence. According to CDC, 50 percent of all extramural HIV prevention resources supported services for Black people in Fiscal Year 2009.

Certain cities and states are especially affected by HIV and require federal prevention support to address their disproportionate

disease burdens. Indeed, in a number of U.S. cities with significant Black HIV epidemics, levels of infection approach those reported in many African settings.¹⁰ In the quest to eliminate syphilis, the federal government focuses resources on the counties that account for the lion's share of infections.¹¹ A similar approach is warranted for HIV, with high-burden communities receiving extra financing to mount emergency responses to lower rates of new infections.

The strategy calls for improved program accountability to hold recipients of public funds accountable for results. As the most affected group in the U.S., Black America has a particular stake in making sure that prevention programs set and reach specific goals and targets. As the provider of most HIV prevention funding in the U.S., the federal government has a natural role to play in promoting accountability for results. But local Black communities may also play a watchdog role to ensure that state and local health departments use limited prevention funds to address the most pressing prevention needs.

■ Step 2: Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

Since the U.S. Centers for Disease Control and Prevention began funding community-based HIV prevention programs, these efforts have primarily sought to encourage individuals to reduce their number of partners and to use condoms during sexual intercourse.¹² Most HIV prevention programs target individuals rather than social groups or communities, and relatively few have focused on people living with HIV.¹³ In general, these individual-focused programs have been primarily targeted to individuals that belong to so-called “high-risk” groups.

According to available evidence, there are several reasons why an approach focused almost exclusively on individual behavior is unlikely on its own to significantly reduce the number of new infections in Black

NHAS Targets 12 Cities with High HIV

A key component of the implementation of the National HIV/AIDS Strategy is an initiative designed to enhance HIV prevention in 12 areas with high HIV burden.

These cities are:

Atlanta, Georgia
Baltimore, Maryland
Chicago, Illinois
Dallas, Texas
Houston, Texas
Los Angeles, California
Miami, Florida
New York, New York
Philadelphia, Pennsylvania
San Francisco, California
San Juan, Puerto Rico
Washington, D.C.

Nearly all of these cities are home to large numbers of Black people living with HIV. In both Atlanta and Washington, Black people make up more than 80 percent of new HIV cases. And in Baltimore and the Manhattan borough of New York City, roughly one out of seven middle-aged Black men are HIV-infected.

The new "12 city" initiative seeks not only to funnel new resources to heavily affected parts of the U.S., but to promote new, innovative ways of tackling the AIDS

problem. Each of the cities is provided with enhanced funding to undertake evidence-based planning and strategy development.

What started as a CDC funded announcement has evolved to become a signature demonstration program for the national AIDS strategy, with agencies all across the Department of Health and Human Services (HHS) agreeing to participate. The initiative has the potential to usher in new ways of doing business in the AIDS field, breaking down bureaucratic silos, reducing the fragmentation of local responses, and permitting high-prevalence cities to implement integrated efforts that link prevention and treatment programs.

While the initiative has enormous potential, there are a number of questions and potential obstacles. First-year funding has been secured, but follow-up funding is less certain. High-level support for the initiative will be needed to ensure that the promises of cooperation from diverse HHS agencies are translated into active engagement. Above all, local planning exercises will require extensive support to think outside the box, base strategies on the best available evidence, and transition from process outcomes to actual health results for people.

America. First, incremental changes in sexual behavior are likely to be inadequate in communities and geographic settings where any single sexual encounter carries very high odds of HIV exposure. In a CDC-sponsored study of gay and bisexual men in five cities, nearly half of all Black gay men were HIV-infected.¹⁴

Moreover, despite their disproportionate vulnerability to HIV, Black Americans as a whole do not engage in higher levels of risk behavior than other groups. This is vividly reflected with respect to Black gay men. Although Black gay men are significantly more likely to become infected than white gay men, they do not engage in greater levels of risk behavior.¹⁵ Indeed, some stud-

ies suggest that Black gay men are *less* likely than white gay men to take sexual risks, even though they are several times more likely to become infected.¹⁶ Instead, factors other than risk behavior are likely to play an important role in the continued spread of HIV, including but not limited to high rates of sexually transmitted infections in Black communities, the makeup of sexual networks, and the effects of disproportionate rates of incarceration among Black people.

If behavior alone cannot account for the epidemic's extraordinary burden in Black America, it stands to reason that behavioral interventions alone will fail to turn the tide against HIV in Black communities. More than any other single group, Black Ameri-

Three Questions: Gregorio Millett

Gregorio Millett, Senior Policy Adviser, Office of National AIDS Policy, answers three questions:



What inspired you to take up the cause of HIV/AIDS?

I grew up in New York City in the 1980s and 1990s. People everywhere were visibly sick. I watched Black men, whom I admired deeply—like Craig Harris, Donald Woods, Essex Hemphill—pass away. I decided that I needed to do my part. I started attending ACT UP meetings and volunteered to lead workshops for GMHC [Gay Men's Health Crisis], teaching Black and Latino men who have sex with men [MSMs] about HIV prevention.

What personally motivates your HIV work?

I have always hated gross generalization to explain complex problems. I used to bristle at the stigmatization of Black gay men—that HIV prevalence was likely higher in our community because of promiscuous sex and rampant drug abuse. It compelled me to

conduct a series of research studies while at the Centers for Disease Control and Prevention that proved that Black men who have sex with men, and African Americans generally, do not engage in higher-risk behaviors that place us at greater risk for HIV infection. In fact, I found that existing community prevalence, density of sexual networks and less access to care likely explained the racial disparities in infection rates.

Why is a national AIDS strategy important to the well-being of Black people?

African Americans make up 12 percent of the population but 46 percent of new HIV infections each year in the United States. We also make up about half of the more than one million people living with HIV in the U.S. We are more likely to be HIV-positive and not be aware of our diagnosis than other communities, more likely to be diagnosed with AIDS rather than HIV, less likely to access HIV care after being diagnosed and more likely to die from HIV, even in the era post antiretroviral therapy.

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cans urgently need a *combination* approach that employs multiple strategies to protect against HIV transmission, combining individual-focused strategies with biomedical interventions that reduce the likelihood of transmission, community-level strategies that address social norms, and structural interventions that alleviate social factors that impede risk reduction.

One key approach is to implement programs that focus not just on individuals but on the makeup and norms of sexual networks. Studies have consistently found that high rates of partner change and sexual concurrency (i.e., having two steady sex partners at the same time) increase the likelihood of the rapid spread of HIV within sexual networks.¹⁷ Although Black Americans as a

whole do not engage in higher levels of risk behavior than whites, they are notably more likely than whites to be having sex with more than one partner at the same time, often for extended periods of time.¹⁸ Prevention programs are urgently needed in Black communities that warn of the risks of sexual concurrency.

In the case of Black gay men, there is evidence that the structure of social networks is often determined not just by personal preference but also by negative stereotypes, underscoring the need for anti-racism campaigns in gay communities. In a large multi-ethnic survey of gay men in San Francisco, Black gay men were the least preferred sexual partners, were less likely than other gay men to be considered friends, were less welcome in

gay venues, and were regarded as higher risks for HIV.¹⁹ According to the researchers who conducted the survey, “The racial disparity in HIV observed for more than a decade will not disappear until the challenges posed by a legacy of racism towards Blacks in the U.S. are addressed.”²⁰

In recent years, CDC has emphasized the need to complement traditional prevention strategies, which have largely focused on HIV-uninfected individuals, with programs specifically geared to people living with HIV.²¹ However, most HIV-positive individuals have yet to be reached by prevention efforts. Among HIV-positive people in care, only 18 percent say they have had at least one prevention-related conversation with an outreach worker or prevention counselor.²²

In addition to individual and community-level prevention strategies, greater efforts are needed to increase access to biomedical prevention strategies that reduce the likelihood that any single act of risk behavior will result in transmission. One such strategy is prompt diagnosis and treatment of sexually transmitted infections. A meta-analysis of published studies by a CDC research team found that disproportionate infection risks among Black gay men could also partially be explained by above-average rates of untreated sexually transmitted infections, which significantly increase the risk of HIV transmission and acquisition.²³ This finding underscores the need to complement behavior change programs with substantially stronger STI prevention and treatment services in Black communities.

Other biomedical approaches include pre-exposure antiretroviral viral prophylaxis, which is addressed in the chapter on new prevention developments in 2010. In addition, continued research is warranted regarding the possible prevention benefits of male circumcision, as well as vaginal and rectal microbicides, for Black Americans.

In working to increase access to tools that reduce the biological likelihood of transmission, particular focus is needed on the riskiest behaviors. According to CDC, for example, receptive anal intercourse has

a 10-times higher per-act risk of transmission than receptive vaginal intercourse and a nearly 8-times higher risk than insertive anal intercourse.

In short, no population in the U.S. has a more urgent need for a combination approach to HIV prevention than Black America than Black men who have sex with men who engage in receptive anal intercourse. In addition to traditional behavior change initiatives, prevention efforts in Black communities need to include greater emphasis on community-level strategies, prevention interventions for people living with HIV, public awareness campaigns that combat racism and other social factors that increase HIV vulnerability, and enhanced STI services.

■ Step 3: Educate all Americans about the threat of HIV and how to prevent it.

Black people are significantly more likely than whites or Latinos to know someone with HIV or who has died of AIDS.²⁴ They are also significantly more likely to consider HIV one of the country’s most serious health problems, rating AIDS as second in severity only to cancer. Finally, Blacks are also more likely than Americans as a whole to fear contracting HIV, and 80 percent of Black parents of children 21 or younger worry that their child may become infected.

However, awareness about AIDS is declining. The percentage of Black Americans who report having heard a lot about HIV declined from 62 percent in 2006 to 33 percent in 2009.²⁵

There are some efforts underway to address these issues. The federal government’s Act Against AIDS Leadership Initiative, which provides capacity-building support to leading national Black political and cultural organizations, is working to increase AIDS awareness, reaching more than 100 million people with media messages in its first year of operation (April 2009—March 2010).²⁶ The Black AIDS Institute and the Henry J. Kaiser Family Foundation launched Greater Than

AIDS, a national media and community outreach campaign that seeks to increase public awareness of the epidemic's devastating impact in Black communities and to reduce the stigma associated with the disease.²⁷

The need for broad-based awareness of HIV is especially pronounced in Black America. Unlike other segments of the American population, in which AIDS is concentrated in discrete groups (such as gay men and drug users), the epidemic is more generalized in Black America, affecting Black people from many walks of life.²⁸ For example, Black women are 15 times more likely than white women to become infected with HIV.²⁹

Making sure that every Black American knows his or her HIV status is especially critical to progress in the fight against AIDS. A positive HIV test is not only the gateway to life-preserving HIV treatment, but people who test HIV-positive are also significantly more likely to take steps to prevent others from being exposed to the virus. According to CDC, people who are HIV-infected but don't know it are 3.5 times more likely to transmit the virus to others than individuals who know their HIV-positive status.³⁰

Black people are significantly more likely than other Americans to get tested for HIV.³¹ However, given that Black Americans are several times more likely to be infected than other groups, much higher testing rates are needed. Nationally, one in three Black people who test HIV-positive are only diagnosed late in the course of infection³²—when HIV treatment regimens may be less effective, and following years during which many people may unknowingly have been exposed to infection. According to a recent CDC-sponsored 21-city survey of gay and bisexual men, Black men were more than twice as likely to have unrecognized HIV infection as white men.³³

In addition to ensuring the *availability* of HIV testing services, these services need to be effectively *marketed*. The Black AIDS Institute is seeking to do its part to promote HIV testing in Black communities nationwide. Through its Test 1 Million campaign, and now the Greater than AIDS campaign,

BAI mobilizes celebrities and other key opinion leaders to participate in statewide testing tours, and is working to galvanize and train local testing coalitions in cities with a high burden of HIV among Black people.

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

The emergence of effective combination antiretroviral therapy in the mid-1990s revolutionized the fight against AIDS, offering for the first time the prospects of effective treatment for people living with HIV. Today, treatments have improved to such a degree that a newly infected person can expect to potentially live a normal life expectancy with proper medical care.³⁴

Yet despite the extraordinary promise of HIV treatment, the fruits of recent medical advances are not equitably shared by all. Due to gaps in HIV testing, health care access, and treatment adherence, federal officials estimate that only about one in four (26 percent) people living with HIV in the U.S. are currently in care and have effectively suppressed virus.³⁵

These gaps are especially pronounced in Black America, resulting in significantly poorer health outcomes. Black people living with HIV are more likely to die than HIV-positive individuals from other racial or ethnic groups,³⁶ and their survival time is shorter following an AIDS diagnosis.³⁷

Black America has an overriding interest in improving health outcomes for people living with HIV. The national strategy outlines three priority action steps to achieve this aim.

■ Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

Assessments in a number of cities in the U.S. suggest that the percentage of people with diagnosed HIV infection who are not in regular HIV primary care approaches 40 percent.^{38 39} In many cases, people with a new diagnosis of HIV are not effectively linked to care. In New York City, Black people newly diagnosed with HIV are less likely to enter care within three months of diagnosis than whites.⁴⁰ The national strategy aims to increase the percentage of newly diagnosed individuals who are linked to care within three months of their positive HIV test from 65 percent to 85 percent by 2015.

Black Americans confront numerous obstacles to quality medical care. Black people are more likely than any other racial or ethnic group, and more than twice as likely as whites, to be living in poverty.⁴¹ Black Americans are more than 50 percent more likely than whites to lack health coverage of any kind.⁴² In part, this low rate of health coverage for Black people is tied to economic conditions, as private employment remains the principal source of health coverage in the U.S. In December 2010, the unemployment rate among Black Americans was 15.8 percent—nearly twice the rate for whites.⁴³

There is evidence that many HIV-positive Black patients may not be receiving quality care. In one large study of people living with HIV, Black patients were more than twice as likely as whites to experience treatment failure.⁴⁴ Some studies have found that African Americans are less likely than other groups of people living with HIV to receive antiretroviral therapy.^{45 46} However, a more recent study found that Black patients were less likely to receive inappropriate antiretroviral regimens than whites.⁴⁷ These possibly contradictory studies highlight the need for greater analysis of the causes and impact of health access disparities on the spread

of HIV and HIV health outcomes in Black communities.

Being linked to care is only the first step in a long-term process to ensure favorable medical outcomes for Black Americans living with HIV. It is also important that people remain engaged in the care, as studies show that patients who drop out of HIV care are more likely to die as those who continue to see their doctor. The national strategy establishes a target of ensuring that at least 80 percent of people living with HIV who are served by the federal Ryan White care program have at least two medical visits with their HIV provider each year.

■ Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services to people living with HIV.

Quality medical care depends on a relationship of openness, communication and trust between the patient and the health care provider. In particular, studies show that patients are more likely to adhere to HIV treatment regimens if they have a strong relationship with their doctor.^{48 49}

For HIV-positive Black patients, development of a strong patient-provider partnership is frequently hindered by racial and cultural differences. A survey of 33 urban clinics is revealing. While 45 percent of clinic patients were Black, only 25 percent of physicians were Black.⁵⁰ According to the National Institutes of Health, Black gay men are less likely than other gay men to have access to a private clinic, less likely to feel comfortable talking openly with their health care provider, and more likely to experience homophobia in the health care setting. These issues are exacerbated by the lack of access to primary care physicians in Black communities. A disproportionately high percentage of Black patients receive their primary health care in emergency room settings, thus denying them the

ability to develop a strong patient-provider partnership.

Ensuring quality care for HIV-positive Black people requires federal investments in medical education and training to prepare new cadres of health workers who look like the patients they serve and who understand their needs and values. Because it is impossible overnight to alter the demographic makeup of the health care workforce, increased investments are needed in programs to build the cultural competence of HIV clinical personnel and peer health educators.

The strategy also calls for intensified efforts to educate health care providers on the need for routine, voluntary HIV screening. A recent study in New York City found that only about one in three internal medicine residents were aware that the CDC had recommended routine screening in health care settings.⁵¹

■ Step 3: Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

HIV treatment has enormous benefits, but it isn't necessarily easy. Antiretroviral therapy requires individuals to take their medications each day—exactly as prescribed. And while it is possible to live well with HIV, it isn't possible to forget about the disease, as patients need to visit their doctor regularly and have their bodies monitored periodically.

Many Americans have difficulty taking their medications as prescribed or visiting their doctor regularly. For HIV disease, however, especially rigorous adherence is necessary to prevent treatment failure.⁵²

However, many Black Americans living with HIV struggle to adhere to demanding HIV treatment regimens as a result of other health conditions or personal challenges associated with poverty. One nationally representative study of people receiving HIV care found that Black patients were more likely to postpone medical care because they

lack transportation, were too sick to make their appointments, or had other needs to address.⁵³

Many Black people living with HIV struggle with chemical dependence, which has been shown to lower treatment adherence.⁵⁴ Nationally, Black people account for 55 percent of all injection drug users living with HIV or AIDS.⁵⁵

Homelessness or housing instability also increases personal stress and hardship, which may make it difficult for patients to adhere to treatment. Nationally, Black people are most likely to have inadequate housing.⁵⁶

To thrive on HIV medications, Black Americans, as with anyone else with the disease, need a range of medical and social services that extend beyond HIV-specific care. Black America's stake in a holistic, comprehensive approach to HIV care and treatment is clear.

Reducing HIV-Related Disparities and Health Inequities

As previously noted, Black Americans are several times more likely than other Americans to become infected with HIV. And once infected, they are notably more likely to die.

Reducing these disparities requires focused efforts that prioritize health promotion in Black communities. The national strategy identifies three priority steps, which together aim to increase by 20 percent the number of HIV-diagnosed Black people with an undetectable viral load.

■ Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection.

Available treatments for HIV are powerfully effective, but individuals need access to quality HIV care in order to benefit from treatment. The national strategy calls for

concerted efforts to increase access to regular monitoring tests for viral load and CD4 tests. These tests confirm that the prescribed treatment is having the intended effect, and they also alert clinicians regarding the need to switch regimens.

National health care reform in the United States, through the Patient Protection Affordable Care Act (ACA), enacted in 2010, offers major new opportunities to close the gaps in health care access that make fighting AIDS in Black America so difficult. The new law, which is being phased in through 2014, includes an individual mandate for health insurance coverage, offers subsidies to low-income people to purchase insurance, bars insurers from refusing to cover pre-existing conditions, and expands Medicaid to cover those who can't afford private insurance. Once fully enacted, it is projected by the Congressional Budget Office that the law will provide health insurance coverage to 32 million Americans who are currently uninsured.⁵⁷

By expanding insurance coverage, the new health care bill will help increase HIV testing, as people who are uninsured are less likely to get tested.⁵⁸ Expanded health coverage will also improve access to HIV medications and diagnostic tests for people who currently struggle to obtain them. Full and timely implementation of health care reform is an important strategy for closing HIV-related health disparities.

■ Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities.

As previously noted, individual-focused prevention strategies are unlikely to be adequate in populations with high background prevalence of HIV, such as Black America. The national strategy calls for increased attention to community-level issues that contribute to the spread of HIV.

One potentially promising prevention strategy is to lower community-level viral

load through more intensive and successful treatment coverage. As the risk of HIV transmission is directly linked to the HIV-positive partner's viral load,⁵⁹ it is believed that broader, more effective treatment coverage would help slow the rate of new infections by reducing the overall level of virus circulating within the community. In San Francisco, a 40 percent reduction in community-level viral load was accompanied by a 45 percent drop in the number of new HIV infections.⁶⁰

Capturing the prevention potential of antiretroviral treatment requires a much better job in delivering therapies to those who need it. Only about one in four people living with HIV have fully suppressed virus,⁶¹ and Black people living with HIV are significantly more likely than other HIV-positive patients to experience viral rebound after starting therapy.⁶² To achieve the community-level effects of antiretroviral therapy, substantially greater success is needed in diagnosing HIV in a timely manner, linking people who test positive to care, and helping patients adhere to HIV treatment regimens.

■ Step 3: Reduce stigma and discrimination against people living with HIV.

In recent years, Black America has mobilized like never before to address the AIDS crisis. In 2011, 14 national Black political and cultural organizations have developed and begun implementing strategic AIDS action plans to contribute to the AIDS response in Black America. Black celebrities, political leaders, activists and ordinary citizens have joined together to increase HIV awareness and urge a stronger collective response.

These efforts are bearing fruit. Yet stigma and discrimination continue to hinder the AIDS fight in Black America. Numerous studies confirm that many Black people living with HIV experience discrimination and social disapproval in their daily lives and in their efforts to access needed services.^{63 64} According to these studies, the stigma associated with HIV inhibits open discussion of the

AIDS challenges, discourages people living with HIV from disclosing their HIV status, and deters individuals from getting tested or from accessing HIV-related services.

Misconceptions and lack of information help perpetuate HIV-related stigma and discrimination. Black Americans are notably more likely than whites or Latinos to believe that AIDS can be cured or that a vaccine to prevent HIV currently exists.⁶⁵ More than four in 10 Black people are not aware that drugs exist to reduce the risk that an HIV-positive pregnant woman will pass the virus along to her newborn.⁶⁶

The national strategy identifies a number of useful approaches and interventions for reducing HIV stigma and discrimination, including engaging communities to affirm their support for people living with HIV and promoting the leadership and visibility of HIV-positive people. On World AIDS Day 2010, the Congressional Black Caucus Foundation did its part to put some of these strategies into practice, joining a coalition of activists in Washington, D.C. for a day-long session to examine the harmful effects of HIV stigma and to explore strategies for alleviating it.⁶⁷ Other national traditional Black institutions are engaging in similar efforts to confront HIV/AIDS in Black communities.

Studies indicate that the harmful effects of stigma are mitigated when people living with HIV have a strong social support network. A majority of African Americans (58 percent) report knowing someone living with HIV—a far larger percentage than any other racial or ethnic group.⁶⁸ That means that individual Black Americans have a potentially powerful role to play in combating the stigma—by supporting those they know who are living with HIV—including encouraging them to enter and stay in treatment, speaking openly to peers about the need for compassion and tolerance, and emphasizing through words and actions that all of Black America must unite to address the AIDS crisis.

Achieving a More Coordinated National Response to the HIV Epidemic

The national strategy calls for a more coordinated, business-like, outcome-driven approach to AIDS. As the population most heavily affected by the epidemic, Black America has an overriding interest in an effective and coherent national response.

■ Step 1: Increase the coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal and local governments.

Effective coordination of federal efforts on AIDS is both a challenge and a necessity. While achievement of treatment aims depends on effectively linking people who test HIV-positive to quality medical care, ensuring this linkage is often bureaucratically challenging, as different agencies are separately responsible for HIV testing (CDC) and the delivery of HIV medical services (Health Resources and Services Administration, and the Centers for Medicare & Medicaid Services). Holistic care is vital to maximizing medical outcomes, but different arms of the federal government take the primary role of supporting general HIV clinical services (HRSA and CMS), substance abuse and mental health services (Substance Abuse and Mental Health Services Administration), housing services (U.S. Department of Housing and Urban Development), and financial entitlements.

Although most funding for AIDS in the U.S. is supplied by the federal government, planning takes place at state and local levels. Enforcement of federal mandates can be challenging in a complicated federalist system such as ours, where states and localities take the lead on implementing public health

initiatives. And many states and localities do not link their prevention and care planning processes.

Given the multiplicity of needs among Black Americans living with HIV, having a seamless continuum of services in place is a necessity for long-term success in the AIDS fight. Black America has a stake in ensuring the success of the national strategy's aims of improving the coordination of program administration, ensuring an equitable allocation of resources based on actual need, and strengthening data collection. A number of national Black organizations can be instrumental in advocating better coordination, including the Congressional Black Caucus (CBC), the National Organization of Black County Officials (NOBCO), and the National Black Caucus of State Legislatures (NBCSL), and the National Conference of Black Mayors (NCBM).

■ Step 2: Develop improved mechanisms to monitor and report on progress toward achieving national goals.

Although the U.S. has achieved enormous gains in the AIDS fight, especially in reducing AIDS deaths, no systematic mechanism has been in place to hold decision-makers and program implementers accountable for results. Only in 2008 did the U.S. develop its first-ever estimate of new HIV infections based on a direct measure of incident HIV, finding that the country had made little if any progress in reducing the rate of new infections over the last two decades.⁶⁹

The implementation plan for the national strategy includes clear, measurable targets in the national AIDS response, including a 25 percent reduction in new HIV infections by 2015 and quantifiable improvements in linkage to care and continuity of care for people living with HIV.⁷⁰ Data sources are specified in the implementation plan, with annual progress reporting planned.

To succeed, the national strategy must improve outcomes for Black Americans

affected by HIV. One strategic target—to increase by 2015 the proportion of HIV-diagnosed Blacks with undetectable viral load by 20 percent—is specific to Black America. The remaining targets—which focus on such priorities as reducing new infections, increasing knowledge of HIV status, and improving health care utilization—are generic targets for the country as a whole. The Black AIDS Institute has strongly encouraged the White House Office of National AIDS Policy to ensure that performance data are disaggregated by race/ethnicity in order to ensure that the national strategy is working for Black America.

As this report goes to press, federal agencies are developing National HIV/AIDS Strategy operational plans. These plans need to explicitly utilize mechanisms to include Black America. The national targets for the new strategy are specifically laid out in a *federal* implementation plan. The new strategy, however, is a *national* strategy, not one for the federal government alone. Indeed, thousands of individuals in communities throughout the U.S. attended town hall meetings to provide input into the new national strategy.

The nature of the national strategy underscores the importance of broad ownership and engagement in the implementation and monitoring of this results-based framework. If the national strategy is to work for Black America, then Black America will need to contribute by holding itself accountable for results.

“This national strategy—the first-ever since the beginning of the epidemic—provides a framework for success,” said Phill Wilson, the Black AIDS Institute’s President and CEO. “All of us—from the senior reaches of the federal government to individuals at the grassroots—need to roll up our sleeves to make sure we reach our agreed national targets. Those of us who have been working in AIDS since the beginning of the epidemic have been waiting a long time for this kind of national leadership. Now is the time to make a difference in the lives of our communities.”

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Preventing New Infections

Major Developments in 2010

An array of proven biomedical technologies and strategies is available to prevent new HIV infections.¹ If brought to scale and used to their utmost, standard approaches could avert a majority of new HIV infections.²

However, like most health prevention tools, available HIV prevention strategies have their limits. For example, while condoms are highly effective in preventing transmission, women typically have to rely on men to use them. Likewise, studies have shown behavior change programs to be effective in encouraging safer sexual behavior,³ but these programs fail to reach most people at risk of HIV infection.⁴

Just as combining different classes of antiretroviral drugs produces a substantially stronger and longer-lasting effect than using one drug alone,⁵ multiple approaches to HIV prevention are needed to achieve maximum impact in reducing new infections. After all, people and groups differ from one another, and individuals themselves have varying needs as they age and as personal circumstances change. An ideal approach to HIV prevention would combine strategies that encourage safer behavior, interventions that reduce the likelihood that any single risky act will result in transmission, and approaches that address broader social or structural factors that increase HIV risk and

vulnerability.

The year 2010 saw major strides toward development of key building blocks for a combination approach to HIV prevention. Although some of these developments are preliminary, they indicate that investments in biomedical HIV prevention research are now bearing fruit. These include:

- Evidence of the efficacy of a vaginal microbicide;
- Evidence that use of an antiretroviral regimen prior to sexual exposure reduces the risk that an HIV-uninfected gay men will contract HIV;
- Growing excitement regarding the prospects that antiretroviral treatment itself can reduce the number of new infections by rendering people living with HIV less infectious;
- Continuing debate about the role of male circumcision for HIV prevention in the U.S.;
- Limited, but important, progress in the search for a preventive vaccine; and
- Emerging evidence that providing cash to low-income people in vulnerable situ-

ations may reduce their risks that they will become HIV-infected.

Microbicides

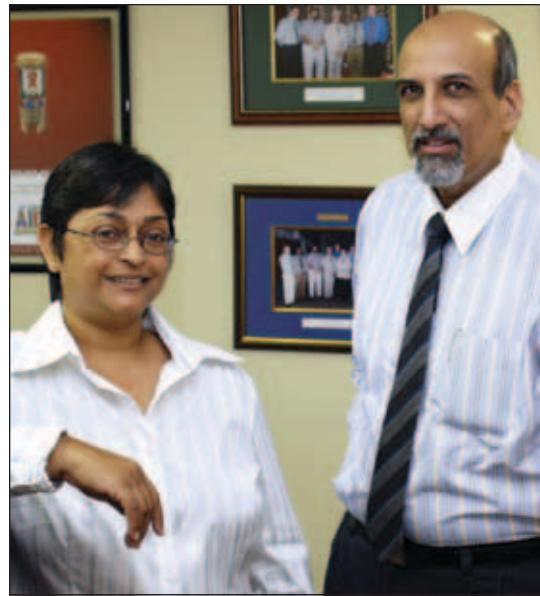
One of the great prevention challenges in AIDS has been the lack of an effective prevention method that women can use on their own. Black women account for 61 percent of new HIV infections among females in the U.S.,⁶ and women represent roughly 60 percent of all people living with HIV in sub-Saharan Africa.⁷ Globally, nearly 17 million women are living with HIV.⁸

Microbicides—products variously formulated as gels, films or sponges, or in vaginal rings, which may be topically applied to reduce their risk of HIV transmission—have long offered great promise as an HIV prevention tool. Yet several clinical trials yielded disappointing results, leading some to question whether a safe and effective microbicide would ever be developed.

Such doubts were definitively swept away at the Vienna International AIDS Conference in July 2010, when a team of researchers from South Africa presented results of a trial evaluating a vaginal gel containing the antiretroviral tenofovir. The study found that women who received the microbicide were 39 percent less likely to become infected than trial participants who received a placebo.⁹ The trial—led by the husband-wife team of Salim and Quarraisha Abdool Karim—found that microbicide recipients who adhered most carefully to the product directions (which required users to apply the microbicide 12 hours before and 12 hours after sex) were 54 percent less likely to become infected.

Ongoing studies are now underway to confirm the results from the South Africa trial.¹⁰ If ongoing trials confirm the results, it is projected that the product could be approved and marketed as early as 2014.¹¹ In the meantime, studies of other experimental microbicides are also being conducted.¹²

As a first-generation microbicide is likely to confer only partial protection against



Quarraisha and Salim Abdool Karim

infection—a conclusion underscored by the South Africa results—it will be necessary to use microbicides as one of several methods for sexual risk reduction. It will also be critical to accompany product roll-out with intensified education to prevent the good news from leading individuals from relaxing their guard against HIV and increasing overall sexual risk-taking. Nevertheless, the microbicide news from Vienna has rightly been received as a bolt of lightning by the AIDS field, significantly brightening future prospects for preventing new infections among women and increasing the decision-making autonomy of women with respect to their own sexuality.

At the same time, evidence that a product is effective as a vaginal microbicide does not mean it will prevent HIV transmission during anal intercourse. The anus is considerably different in structure and makeup from the vagina, and the risk of transmission during anal intercourse is significantly greater than during vaginal intercourse.

Research efforts to develop a rectal microbicide are underway, although they are at an earlier stage than the vaginal microbicide field. At publication time, data analysis was ongoing from an early-stage trial of a tenofovir gel for rectal application. An additional

Who's Working on Developing HIV Vaccines

Federal Vaccine Research Leaders

National Institutes of Health (NIH)
National Institute of Allergy and Infectious Diseases (NIAID)
Division of AIDS (DAIDS)
www3.niaid.nih.gov/about/organization/daids
Director: Carl W. Dieffenbach, Ph.D.
carl.dieffenbach@nih.gov
301-496-9112

Dale and Betty Bumpers Vaccine Research Center (VRC)
www.niaid.nih.gov/about/organization/vrc/Pages/default.aspx
Director: Gary J. Nabel, M.D., Ph.D.
gary.nabel@nih.gov
301-496-1852

U.S. Military HIV Research Program (USMHRP)
www.hivresearch.org
Director: Colonel Nelson Michael, M.D., Ph.D.
301-251-5000

Non-Governmental Vaccine Research and Advocacy Leaders

International AIDS Vaccine Initiative (IAVI)
www.iavi.org
Chief Executive Officer: Seth Berkley, M.D.
info@iavi.org
212-847-1111

HIV Vaccine Trials Network (HVTN)
www.hvtn.org
Principal Investigator: Larry Corey, M.D.
ask@hvtn.org
206-667-6712

AIDS Vaccine Advocacy Coalition (AVAC)
www.avac.org
Executive Director: Mitchell Warren
avac@ava.org
212-367-1279

HVTN's Legacy Project
www.hvtn.org/legacy
Director: Steven Wakefield
legacy@hvtn.org
206-667-2300

NIAID HIV Vaccine Research Education Initiative (NHVREI)
bethegeneration.nih.gov
bethegeneration@nih.gov

Phase I trial of a rectal microbicide was being planned as of December 2010.

Pre-Exposure Prophylaxis

Because antiretrovirals have proven effective in reducing the odds of transmission in other contexts—such as during pregnancy of delivery, as a result of breastfeeding, or following a blood exposure in health care settings—experts have long believed that taking the drugs before sexual intercourse might help lower the risk of sexual transmission.

Long-awaited trial results for the first pre-exposure prophylaxis (PrEP) candidate were released in late 2010, transfixing the AIDS field and the broader scientific community in much the way the microbicide research results did in Vienna. The study, involving HIV-negative men who have sex with men in the U.S. and other countries, evaluated a daily combination of the antiretrovirals emtricitabine and tenofovir. Study participants who took the drug combination were 44 percent less likely to become infected than trial participants who received a placebo.¹³ Blood tests were used to detect the presence of the drug combination among participants in the intervention arm, and study participants whose blood demonstrated a high level of adherence to the daily regimen were 92 percent less likely to become infected. The study also found that the regimen was safe and generally well tolerated.

The study results astonished the AIDS field and received front-page coverage in leading newspapers. The 92 percent efficacy documented in individuals who rigorously adhered to the study protocol approaches the level of efficacy desired in a preventive vaccine. Clearly, the emergence of PrEP represents extraordinarily good news in the fight against AIDS.

However, the study results also come with a number of questions, caveats and challenges. While the results are impressive, the study is only the first of its kind and

needs to be confirmed by other studies that are ongoing. In particular, several trials are underway to test the efficacy of PrEP for the prevention of HIV transmission during vaginal intercourse.¹⁴ Although the higher relative risk of transmission during anal intercourse, as compared to vaginal intercourse, would suggest that PrEP is likely to prove effective during heterosexual sex, this proposition has yet to be proven, which is why the above-noted trials are being conducted.

In addition, there are real questions regarding implementation of PrEP. On a practical level, the daily regimen tested by the first PrEP trial is expensive—an estimated \$14,000 a year, or \$38 a day.¹⁵ Will Medicaid, private insurance companies, or other third-party payers agree to reimburse such an expensive option—especially when coverage for preventive health services generally is so spotty, and when the overriding push is to lower health care costs? Will CDC seek to nudge third-party payers by certifying PrEP as a standard prevention intervention on the basis of this first trial? Such questions remain unanswered, although CDC and other policy-makers are already busy examining them.¹⁶

Without a fair and equitable policy on access to this strikingly effective new prevention method, the fruits of this major advance could be limited to those with the ability to pay. That would run counter to a foundational principle of the AIDS movement—that *everyone*, rich or poor, deserves equal access to life-saving and health-preserving medical interventions.

Another question regarding feasibility has to do with daily adherence. It is well documented that people with HIV or other chronic or life-threatening conditions often have difficulty adhering to treatment regimens. The findings from this first study underscore the importance difference in protection based on the degree of adherence to the prevention regimen. Will healthy, uninfected individuals take these medications on a daily basis? What strategies exist to improve adherence rates for healthy individuals who may not see their doctors on a regular

Finding Our Voices, Claiming Our Power

How does a Black woman ask about something indiscreet in the presence of men, whom she does not know and a media that consistently exploits her likeness and refuses to see beyond Black women's body parts? Might asking dishonor me, my race or my ancestors? Could my honest question be distorted into a shameful, but all-too-common, image: Black woman hyper-sexualized? And what would Jesus—and my ancestors—do?

I pondered those questions as I gathered the courage to ask the obvious at a press conference at the 2010 International AIDS Conference.

On Day Two of the conference a groundbreaking study on microbicide captured my attention. I wondered if women would use it under real-world conditions, in which fear of losing love, jeopardizing their economic stability, placing their children in harm's way, and experiencing verbal, emotional or physical abuse—even death—keeps many from insisting upon practicing safer sex? "What does the gel taste like?" I asked a friend who had attended conference private press briefing earlier. "I don't know," he replied, "I was too chicken to ask."

The 889 Black South African women who had volunteered for the clinical trial hadn't chickened out, but had risked their wellbeing—uncertain whether the drug was safe. I also reflected upon my ancestors, whose bravery had opened doors for me to attend this conference.

Lives lay in the balance. Someone needed to inquire what the gel tasted like. Both the Bible and African proverbs informed my thoughts: *To whom much is given, much will be required.*

But a Black woman can't just walk up to a microphone and say, "How does the microbicide taste?" Or can she?

"Last question—quick question, quick answer," the moderator said. I took a deep breath, the voice in my head recited the Marianne Williamson line "Your playing small doesn't serve the world. There's nothing enlightened about shrinking..."

I asked, "Can you characterize the

nature of the gel for me, please? What does it look like? What does it smell like? What's the touch-feel? How does it taste? Take me through the five senses."

Epidemiologist Dr. Quarraisha Abdool Kareem invited me to see for myself. I squirted a dollop of gel into my hand. Suddenly I found myself amidst a mass of reporters with TV cameras, digital cameras, notepads and pens, a sea of mostly white faces.

Then I witnessed something remarkable: Black women dressed in African attire, followed by several white men, shoved journalists aside to sample the gel. Humbled because their determination implied that they, too, represented communities in need of this answer, I placed a blob into several hands then displayed my microbicide-filled palm to the cameras. I did not taste the gel in front of the media, but it is clear, odorless, the consistency of KY Jelly and has a slightly salty, body-like flavor. A woman could use it without her partner knowing.

Whether overseas or in the United States, publicly or in our bedrooms, the AIDS epidemic requires us to step beyond our comfort zones. We must be braver than we've been; we must find our most powerful voice. Black people, in particular, must express the previously unspeakable and advocate for ourselves and our loved ones.

- Do I know my HIV status and the status of my sexual partner?
- Can we get HIV-tested together and show each other our results?
- Can we always use a condom?
- Father, mother, uncle, auntie, sister, brother: Have you spoken explicitly to your son, daughter, friend, other loved one about the steps they must take to avoid becoming infected—and are you engaging in those behaviors as well?
- Community: What steps are you taking to end HIV/AIDS fear and stigma?
- Leader: What actions are you taking to help end this epidemic?

We must ask the obvious questions.

Hilary Beard is a Philadelphia-based health writer and editor and the editor-in-chief of the Black AIDS Weekly.

BTAN Vists IAVI Vaccine Research Lab

On December 16, 2010, Black HIV/AIDS activists including leaders of the Black Treatment Advocates Network (BTAN), fellows of the African American HIV University (AAHU), and others, toured the International AIDS Vaccine Initiative's (IAVI) Vaccine Design and Development Laboratory in Brooklyn, N.Y. IAVI's Brooklyn lab is the only facility in the world dedicated solely to AIDS vaccine research. The tour was a part of a new partnership between IAVI and the Black AIDS Institute.

The day began with presentations by Seth Berkley, president, CEO and founder of the International AIDS Vaccine Initiative (IAVI), Phill Wilson, President and CEO of the Black AIDS Institute (BAI), and Director of the Office of National AIDS Policy and Senior Advisor on Disability Policy at the White House Jeffrey Crowley, followed by an engaging panel discussion between the three, who were also joined by Black AIDS Institute Board Chair A. Cornelius Baker, and Gay Men of African Descent Executive Director Tokes Osubu. The panel discussed issues such as progress to date in AIDS vaccine research, what communities can do to support such research, and how to "prepare the ground" in Black communities for the day when an effective HIV vaccine exists.

After the panel, the delegation suited

up in lab coats, latex gloves, and goggles, for a private tour of the laboratory. Participants visited the Medicinal Chemistry Lab, Microscopy Room, the lab where new candidate vaccines are evaluated, and the lab where innovative vectors (i.e., mechanisms for the delivery of a vaccine) are developed and assessed. At each point of the tour, the lead scientist for that part of the lab described the work being done and how it advanced the search for a preventive vaccine. Following the tour, participants had a chance to debrief and ask questions about what they had seen.

The IAVI tour was an exceptional experience. It gave BTAN and AAHU leaders a chance to get to know how AIDS vaccine research works and to see how investments in vaccine research are paying off. The tour helped participants truly envision a day when AIDS can be made a thing of the past.

As a result of the tour, the participants are better equipped to help raise HIV vaccine literacy in Black communities, speak to what an AIDS vaccine might look like, and dispel myths about vaccine research. The tour underscored the need for Black leaders, advocates, and community members at large to get more in touch with this type of research and to advocate not just for the research itself, but for other community members to understand how it works, and support its application.

basis? These questions also warrant further investigation.

And, finally, for PrEP, as for other prevention advances, is there a risk that the good news from the research front will encourage individuals to throw away their condoms and to have less concern about how many sex partners they have? As with all new prevention tools, rollout will need to be thoughtful, taking steps needed to prevent an overall increase in risk behavior.

Antiretroviral Treatment as HIV Prevention

In 2010, there was growing interest in the possibility that antiretroviral treatment, which has dramatically lowered AIDS deaths in the U.S., could also help prevent new HIV infections.¹⁷ The interest stems from the fact that HIV treatment, if used effectively, significantly reduces HIV viral load (i.e., the amount of virus in a person's body)

in people receiving the therapy.¹⁸ Because HIV-positive people with high viral loads are more likely to transmit the virus to others,¹⁹ the expectation has been that individuals with treatment-induced viral suppression are significantly less infectious.

In 2010, health officials in San Francisco released research findings that seemed to buttress the hopes that treatment could significantly strengthen prevention efforts. In San Francisco, viral load tests results as well as positive HIV tests are reported to health authorities, enabling health officials to track both overall community viral load and new HIV infections over time. The study found that a 40 percent decline in median viral load in San Francisco between 2002-2003 and 2008 was associated with a 45 percent reduction in new HIV diagnoses.²⁰

Capturing the prevention potential of antiretroviral treatment requires near-universal knowledge of HIV status, timely initiation of therapy, strong treatment adherence, and regular virologic and immunological monitoring to determine when it is time to switch regimens. Health care gaps in the U.S. have prevented the country from maximizing the prevention benefits of treatment. Due to gaps in HIV testing, health care access, and treatment adherence, federal health officials estimate that only one in four people living with HIV in the U.S. has effectively suppressed virus.²¹ As the chapter “A National HIV/AIDS Strategy” describes, Black Americans are most likely to suffer as a result of these important health care gaps.

Although the evidence suggests that treatment, if used properly and made universally available, could help slow the rate of new infections, there are still a number of important unanswered questions. The National Institutes of Health is currently supporting a five-year trial involving 1,750 discordant couples (i.e., one partner is infected, the other uninfected) to clarify the overall prevention potential of antiretroviral treatment and to obtain answers to key questions.

For treatment-as-prevention, as for other emerging prevention advances, care needs to

be taken to avoid unintended consequences. After the Swiss National AIDS Commission proclaimed that the risk of HIV transmission from an HIV-positive with an undetectable viral load was extremely low, studies found an overall reduction in condom use among discordant couples in Switzerland.²² Given that the odds of transmission are significantly higher during anal intercourse than during vaginal intercourse, the dangers that an increase in sexual risk behavior could overwhelm the prevention benefits of treatment are especially concerning for gay and bisexual men. According to one modeling exercise, effective use of treatment might sharply lower transmission rates among heterosexual couples but could well have only a modest effect for gay couples.²³

One question regarding treatment-as-prevention has to do with its possible effects on HIV-related stigma and human rights. On the one hand, expanding use of antiretrovirals beyond people living with HIV could help destigmatize the disease, in that an individual who presented an antiretroviral prescription at a pharmacy could be either HIV-negative or HIV-positive. On the other hand, however, concerns have been expressed in some quarters that a major push for preventive use of antiretrovirals could lead, in extreme cases, to coercive administration of these powerful medicines to people who don’t want to take them.

Male Circumcision

Three trials in sub-Saharan Africa demonstrated that adult male circumcision reduces the risk of HIV transmission from an HIV-positive woman to an HIV-negative man during vaginal intercourse by roughly 60 percent.^{24,25,26} Since the release of these trial findings, urgent efforts have been undertaken in a number of African countries to offer male circumcision as a prevention option.

The emergence of this strikingly effective strategy for slowing heterosexual transmis-

sion inevitably raised questions regarding the applicability of these findings to the U.S.²⁷ In particular, the potential role of circumcision has been of particular interest with regard to the fight against AIDS in Black America. Black males are somewhat less likely than whites (73 percent versus 88 percent) to be circumcised, but significantly more likely to be circumcised than Mexican-American men (only 50 percent of whom are circumcised).²⁸ Black men in the U.S. are far more likely than white men to become infected during heterosexual intercourse, which is also the leading cause of transmission among Black women.²⁹

The research findings on circumcision have also prompted some to speculate about the possible prevention benefits of circumcision for gay and bisexual men. Earlier studies suggested that circumcised gay men were significantly less likely to become infected with HIV than their uncircumcised counterparts.^{30 31} More recently, however, a comprehensive analysis of available data involving 18 studies and more than 53,000 gay and bisexual men found no statistically significant difference in HIV infection risk between circumcised and uncircumcised men.³²

CDC has advised that “individual men may wish to consider circumcision as an additional HIV prevention measure.”³³ To date, however, CDC has issued no formal recommendations on circumcision for HIV prevention in the U.S.

science research to learn as much as possible about ways to stimulate immunity against HIV. One important undertaking was the creation by the International AIDS Vaccine Initiative (IAVI) of a Neutralizing Antibody Consortium (NAC), which seeks to identify so-called “broadly neutralizing” antibodies that are capable of clearing HIV from the body or preventing actual infection from taking hold. In 2008, the NAC launched the first dedicated HIV neutralizing antibody center at the world-renowned Scripps Research Institute.

The Vaccine Research Center (VRC) at the National Institute of Allergy and Infectious Disease continues to focus major funding toward basic and applied research pertaining to AIDS vaccines. The VRC’s strategic plan provides for focused research to build the evidence base for different types of preventive vaccines, including those that generate neutralizing antibodies and those that elicit a cellular immune response.³⁵

In 2009, NAC researchers discovered powerful new HIV antibodies, with commentators suggesting that HIV’s “Achilles heel” may have been discovered. Further advances were reported in 2010, when researchers discovered additional antibodies that appear to neutralize HIV.

It will take years to convert these and other lab advances into products suitable for testing. But these signs of progress have significantly increased optimism that it will be possible to generate broad immunity against HIV in the foreseeable future.

Vaccines

To date, the search for a safe and effective vaccine to prevent HIV infection has been slow. Only three vaccine candidates have advanced to large-scale human efficacy trials, with only one of the three showing modest favorable results.³⁴

With early product development efforts yielding disappointing results, leaders in the vaccine field have gone back to basics over the last several years, investing considerable financial and technical resources in basic

Conditional Cash Payments

Although HIV strikes both rich and poor—both in the U.S. and in Africa,—living in poverty may increase the vulnerability of some individuals to HIV infection. In Africa, for example, the lack of economic opportunity for adolescent girls often increases their dependence on older males, potentially increasing their risk of having sex with men

who are more likely to be HIV-infected.³⁶ In the U.S.—where Black Americans are more likely to be poor, uninsured and poorly housed—conditions of poverty may reduce access to services and contribute to unstable living situations that make people more likely to engage in risky behavior.³⁷

At the 2010 International AIDS Conference, two studies by researchers from the World Bank found that so-called conditional cash transfers—or the periodic payment of cash in exchange for particular behaviors—reduced the risk that young people in Africa would become infected with HIV. In one study, regular cash payments to young women who stayed in school led to a 60 percent decline over two years in the number of new HIV infections.³⁸ In a separate study, cash payments to young men and women to avoid unsafe sex resulted in a 25 percent drop in new sexually transmitted infections.³⁹

Although the studies are not directly applicable to the HIV prevention challenge in Black America, they nonetheless begin to fill a major gap in prevention research. In particular, while it has long been known that certain social and economic factors may increase vulnerability to HIV, it has been less clear how best to intervene to address the broader roots of risk behavior. In the U.S., there is growing interest in investments in housing support as a structural intervention to reduce the risk of HIV infection among low-income, unstably housed individuals.⁴⁰

The prevention advances in 2010 are all different. For each, there remain important unanswered questions and potential challenges. But together, the findings indicate that our ability to slow the spread of HIV has advanced considerably beyond the early “use a condom every time” messages. While work continues to develop a safe and effective preventive vaccine, the growing toolkit for HIV prevention suggests that potentially greater progress in reducing new infections may be achievable in the coming years.

The numerous research advances in 2010

also underscore the urgent need for continued public and private support for HIV prevention sciences and to ensure universal access to proven prevention and care strategies. America’s longstanding investment in scientific research is continuing to revolutionize the AIDS fight, offering hope to millions of people in this country and throughout the world.

However, without sustained philanthropic and government support for HIV prevention, the promising developments of 2010 may not be available to those who need them most. As leaders at the national, state and local levels debate calls for major cuts in government spending, it is critical that we avoid shortchanging programs that help keep America safe, healthy and productive.

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DECIDING MOMENT:

“GETTING TREATED SO HE WOULD
BE BORN HIV NEGATIVE.”



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WE ➤ AIDS





Historic Milestone, Unique Opportunity

2012 International AIDS Conference in Washington, D.C.

The XIX International AIDS Conference (IAC) will be held July 22-27 in Washington, D.C. It will be the first International AIDS Conference held in the U.S. since 1990, when the conference took place in San Francisco. With a conference venue in a city with one of the heaviest AIDS burdens among Black people outside sub-Saharan Africa, the 2012 meeting offers a historic opportunity to bring global attention to the fight against AIDS in Black America. The meeting will also occur in the midst of a presidential campaign, which will likely pivot on such critical issues as the future of health care reform legislation and federal support for essential safety-net programs.

The International AIDS Society, sponsor of the conference, had opted not to hold the conference in the U.S. due to longstanding immigration law provisions barring the entry of HIV-positive people into this country. Nearly all high-income countries had either never had such rules or repealed them over the years. The U.S. immigration restrictions were lifted by the Obama administration in October 2009, allowing the international conference to be held in the United States for the first time in more than two decades.

The Black AIDS Institute (BAI) and the Positive Women's Network (PWN) have been designated as one of six local partners for the 2012 Washington conference. In this role, BAI and PWN are helping plan the conference and ensuring broad-based community participation. Other partners include the White House Office of National AIDS Policy, the National Institutes of Health, the D.C.

Department of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.

As a key player in the preparation of the conference, BAI is working to ensure that the AIDS fight in Black America is a centerpiece of conference proceedings and related media coverage.

A Victory for Non-Discrimination

The return of the international conference to the U.S. "represents a significant victory for public health and human rights," according to the International AIDS Society.¹ Exhaustive study of experience in the U.S. and abroad of restrictive immigration laws and policies has consistently shown

Previous International AIDS Conferences

Year	Location	Participants	Theme
1985	Atlanta, Georgia, USA	2,000	
1986	Paris, France	2,800	
1987	Washington, D.C., USA	6,300	
1988	Stockholm, Sweden	7,500	
1989	Montreal, Canada	12,000	The Scientific and Social Challenge of AIDS
1990	San Francisco, USA	11,000	AIDS in the Nineties: From Science to Policy
1991	Florence, Italy	8,000	Science Challenging AIDS
1992	Amsterdam, Netherlands	8,000	A World United Against AIDS
1993	Berlin, Germany	14,000	Time to Act
1994	Yokohama, Japan	10,000	The Global Challenge of AIDS: Together for the Future
1996	Vancouver, Canada	15,000	One World One Hope
1998	Geneva, Switzerland	15,000	Bridging the Gap
2000	Durban, South Africa	12,000	Breaking the Silence
2002	Barcelona, Spain	18,500	Knowledge and Commitment for Action
2004	Bangkok, Thailand	18,500	Access for All
2006	Toronto, Canada	26,000	Time to Deliver
2008	Mexico City, Mexico	20,000	Universal Action Now
2010	Vienna, Austria	19,000	Rights here, Right Now

such discriminatory practices to have no public health basis and to contribute nothing toward national efforts to bring AIDS under control.²

Instead, travel restrictions based solely on one's HIV status are discriminatory and counterproductive.³ These discriminatory policies separate families and loved ones and interfere with the freedom of movement on which our increasingly globalized economy depends.

Although the number of countries that continue to impose discriminatory travel restrictions is disconcertingly large, there is a clear trend toward repeal of such rules. In addition to the U.S., diverse countries such as China,⁴ Namibia⁵ and South Korea⁶ have removed their HIV-related travel restrictions in the last two years.

A Key Gathering

The International AIDS Conference serves as the single most important meeting for the AIDS field. In 2012, it is estimated that more than 25,000 delegates from nearly 200 countries will gather in Washington to learn about the latest developments, strategize together, and work collectively for a more effective and sustainable AIDS response.

The International AIDS Conference, held every two years, is frequently the venue for some of the most important scientific announcements on AIDS. At the last conference in 2010 in Vienna, researchers from South Africa mesmerized conference-goers and the global media by presenting data from the first clinical trial ever to show that a microbicide gel could lower women's risk of becoming infected during sexual intercourse.⁷

The conference attracts the participa-

tion of some of the world's most influential people. Regular participants in the past have included former U.S. President Bill Clinton, former South African President Nelson Mandela, Microsoft founder Bill Gates, former U.N. Secretary-General Kofi Annan, and rock star and AIDS activist Bono. The conference also provides an unmatched platform to call attention to key issues that have been neglected in the past. At the 2008 conference in Mexico City, the Black AIDS Institute released a report, *Left Behind—Black America: A Neglected Priority in the Global AIDS Epidemic*, which found that if Black America were its own country, it would have the 16th largest number of people living with HIV in the world.⁸ The report was cited by President Clinton in his keynote address to the conference and received high-profile coverage in leading media outlets, including the *New York Times*, *Washington Post*, *Los Angeles Times* and CNN.

A Unique Opportunity in 2012

Previous international AIDS conferences have shed light on the unique AIDS challenges faced by the host country. The 2000 International AIDS Conference in Durban, South Africa—the first ever held in sub-Saharan Africa—played a pivotal role in spurring greater global resolve to make antiretroviral treatments available in developing countries. Likewise, the 2004 conference in Bangkok helped spotlight the difficulties of sustaining effective AIDS responses in Asia.

In 2012, the conference will be held in our nation's capital. It will provide an unparalleled opportunity to train global attention on America's own AIDS epidemic. And it will specifically generate renewed focus on the AIDS fight in Black America.

Washington may be the city in the developed world most heavily affected by AIDS. At least 3 percent of the city's population is living with HIV, with Black Washingtonians accounting for more than 80 percent of all

From the Archives: Times Reports on Move from Boston

AMSTERDAM PICKED FOR AIDS MEETING

By Lawrence K. Altman

BOSTON, Sept. 11, 1991 — The international AIDS meeting originally scheduled for Boston next year has been moved to Amster-

dam in the wake of a

furor over United States restrictions on foreign visitors, sponsors of the meeting said here today.

The Boston site of the meeting was canceled last month because of Bush Administration requirements that short-term visitors to the United States declare whether they are infected with the AIDS virus. Groups representing people with AIDS threatened to disrupt the meeting to protest the policy, under which foreigners infected with the virus can be barred from the United States unless they get a waiver.

Officials of Harvard University, which is co-sponsoring the meeting with the World Health Organization, said they had moved the meeting to a country without travel restrictions for people infected with the AIDS virus because the Bush Administration did not change its policy.

"To save the conference, it had to be moved out of the United States," said Dr. Jonathan Mann, who will head the six-day conference, which is tentatively scheduled to begin July 19. Dr. Mann, a professor at the Harvard School of Public Health, is a former director of the World Health Organization's global AIDS program.

HIV cases.⁹ The epidemic in Washington, capital of the world's richest and most powerful country, is more severe than the epidemic

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February 7, 2011

in Haiti, capital of the poorest country in the Western Hemisphere.¹⁰ According to the former Director of the District of Columbia's HIV/AIDS Administration, HIV rates in Washington are higher than in West Africa and comparable to rates in Uganda and parts of Kenya.¹¹

With Washington serving as the host city for the 2012 conference, the world will better understand the generalized nature of the AIDS crisis in Black America, with infections not only affecting discrete populations, such as gay men and drug users, but also occurring at high levels among heterosexual men and women. Having the conference in Washington will focus attention on the issues that facilitate the spread of HIV and make it so difficult to mount an effective response. These include widespread poverty, lack of health coverage, homelessness and housing instability, women's disproportionate vulnerability to HIV, the combined effects of racism and homophobia, and the impact of large-scale incarceration of Black males.

The conference will also bring global attention to the epidemic's worldwide impact on the Black Diaspora. Although global attention has properly focused on the epidemic's unmatched breadth and severity in sub-Saharan Africa, the reality is that people of African descent are disproportionately affected by HIV wherever they reside in large numbers, including in the Caribbean, in Western Europe, and throughout the Americas.¹²

Attendees at the conference will be able to share perspectives and learn from one another's experiences. As the Black AIDS Institute explained in its landmark report *Left Behind*, the AIDS fight in Black America shares many characteristics with epidemics in sub-Saharan Africa. Too often, however, America has failed to heed the lessons learned in other parts of the world, potentially hindering our ability to mount the most effective response to our own epidemic.

In collaboration with other partners, the Black AIDS Institute is already at work to plan for the 2012 Washington conference, with the aim of maximizing the awareness-

HIV in the District: By the Numbers

Washington, D.C. (2008)

	Total	Black
Population	100% (588,800)	54.4% (320,307)
New HIV Diagnoses	100% (1,037)	77.6% (805)

raising and advocacy potential of the meeting. The Institute plans to produce a major report on AIDS and the Black Diaspora, bring key decision-makers and opinion leaders together to chart future directions, use the conference as a unique opportunity to build AIDS capacity in Black communities nationwide, and undertake other activities to generate extensive media coverage.

Right Place, Right Time

Given the demographics of the AIDS epidemic in the United States, the magnitude of the epidemic in Washington, D.C., and D.C.'s position among cities hardest hit by HIV/AIDS, there is no city in the country more appropriate to host the XIX International AIDS conference. Not only is it the political epicenter of the United States (and to some degree, the World), but the city of about 600,000 also experiences arguably the most dire urban HIV/AIDS emergency in the developed world. In 2009 city officials reported a 3 percent HIV/AIDS prevalence rate for D.C. (An epidemic with prevalence greater than 1 percent is considered generalized and severe.) That's a worse epidemic than Haiti and Rwanda, and just about as bad as Nigeria and the Congo. And while it isn't quite the "Chocolate City" it once was, D.C. is still predominantly a Black city. But as it goes in the USA, Black Washingtonians

bear an even greater HIV/AIDS burden than census numbers would suggest.

While the numbers look grim, there is reason to be hopeful. Over the past few years a renewed energy among the residents and government of the city has elevated combatting the HIV crisis to a top local priority. Important policy changes, such as the end of the ban on federal funds for syringe exchange (which left D.C. unable to invest any public dollars in needle exchange programs which demonstrate efficacy in preventing HIV while not increasing drug use), and updated testing recommendations have opened the door for better surveillance, prevention and treatment. Projects like Sheila Johnson's film "The Other City" and the Black AIDS Institute's 2008 report "Left Behind," have helped to raise the profile of the problem in the District.

There is a national microscope on D.C.'s response to AIDS now, and progress is being made; in 2009, new AIDS cases were down for the first time ever. It will take the continued determination of D.C. residents, organizations like Community Education Group and Us Helping Us, and politicians and community leaders, to take this progress to the finish line. The spotlight shown by the International AIDS Conference in 2012 will hopefully accelerate that progress as well.

For more information on the epidemic in D.C., and the people who are doing something about it, please see the Black AIDS Institute's D.C. City Sheet, available at www.BlackAIDS.org.

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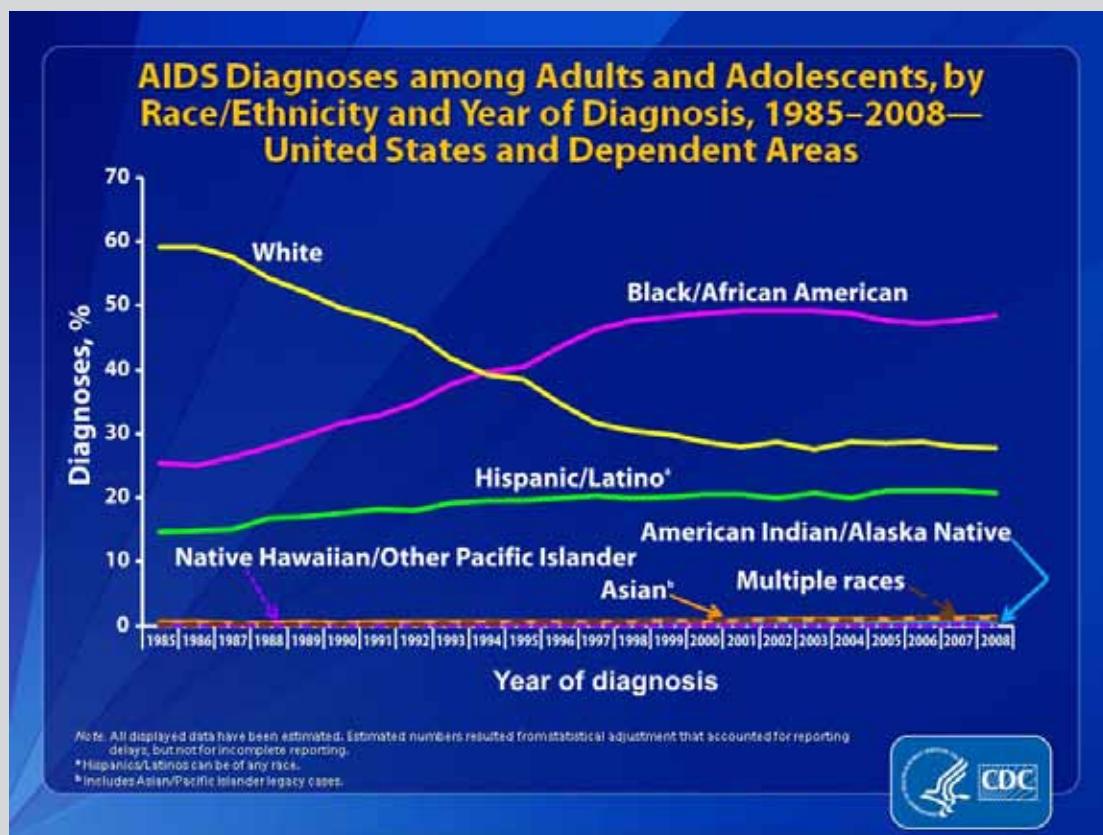
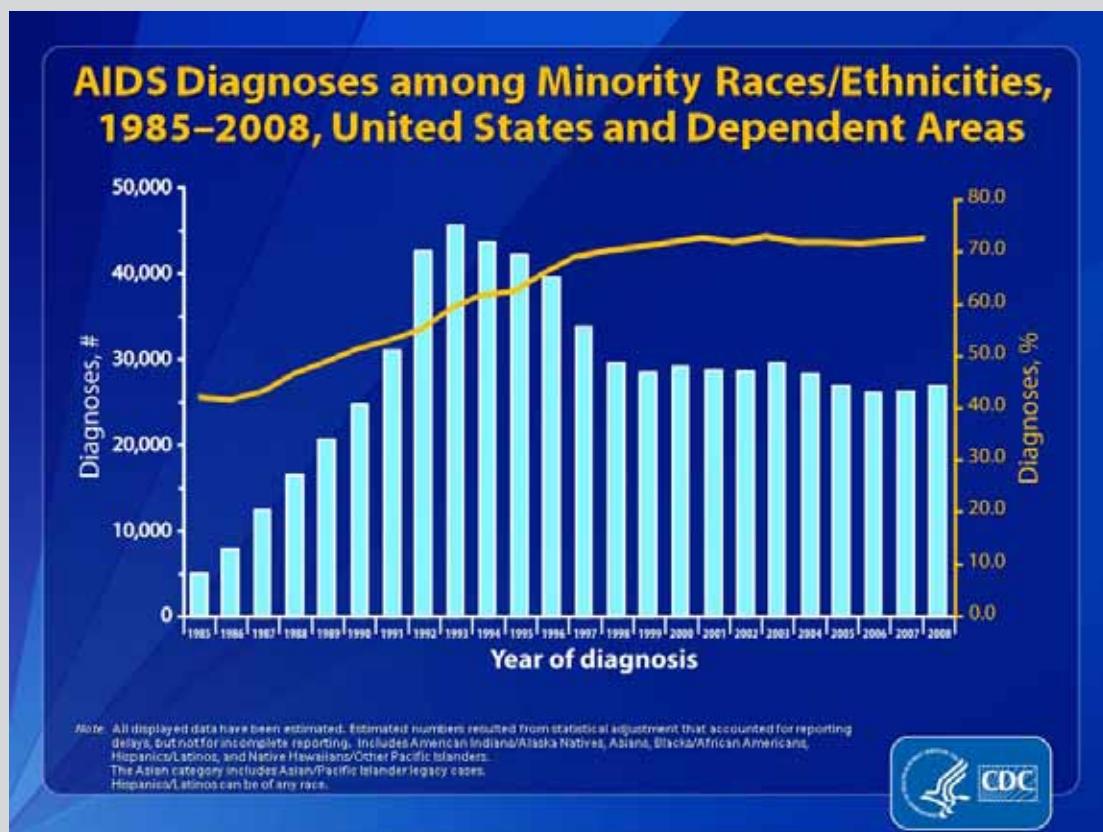
5. Global Network of People Living with HIV (GNP+). Namibia Lifts Travel Restrictions Against

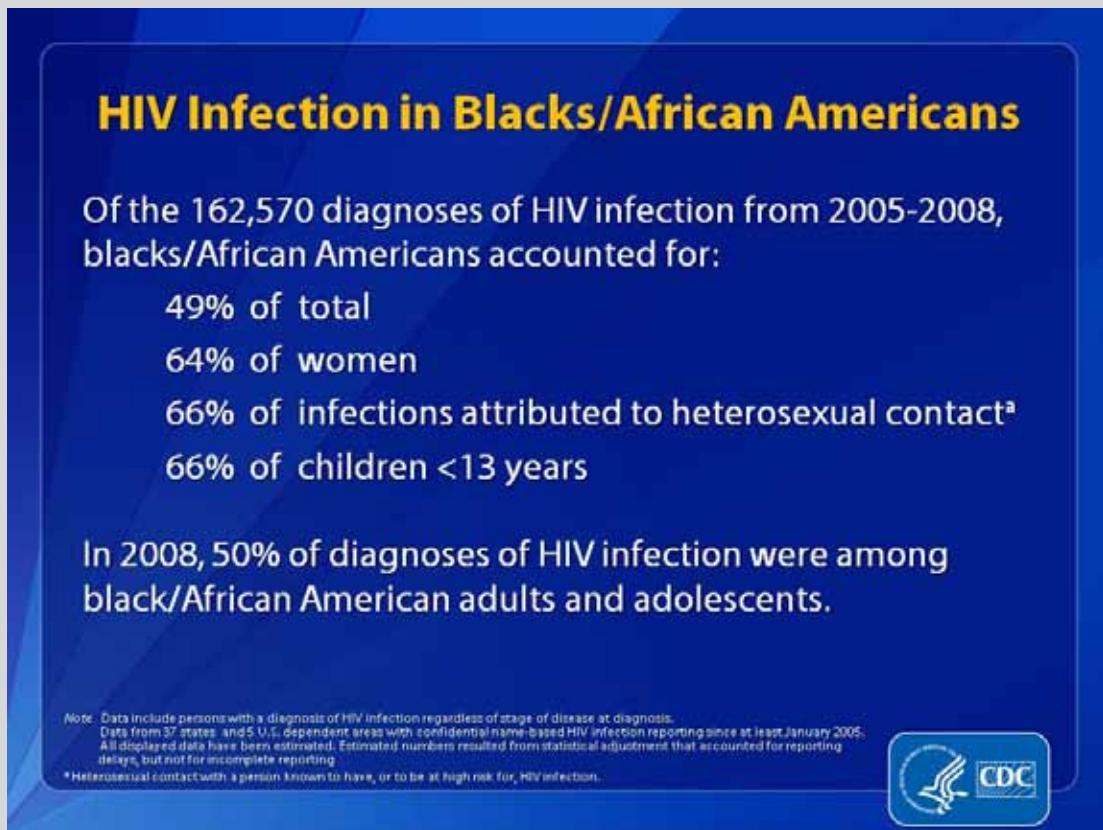
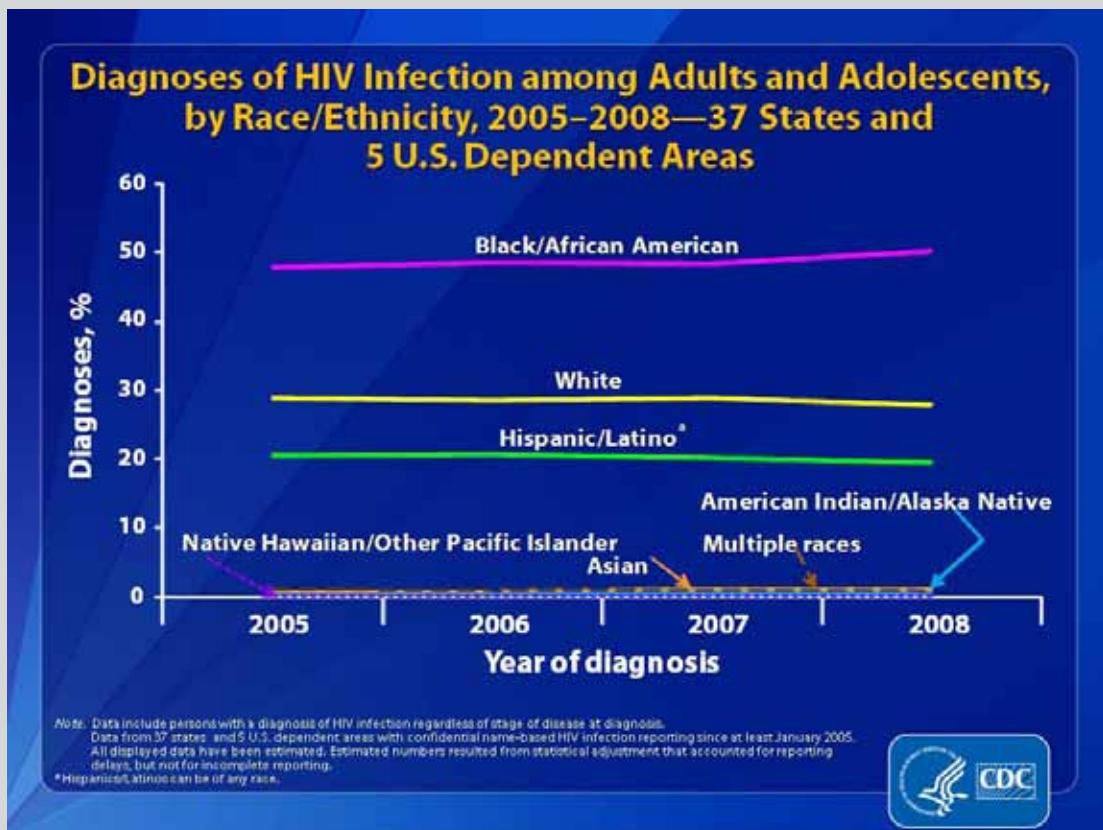
The Black Epidemic

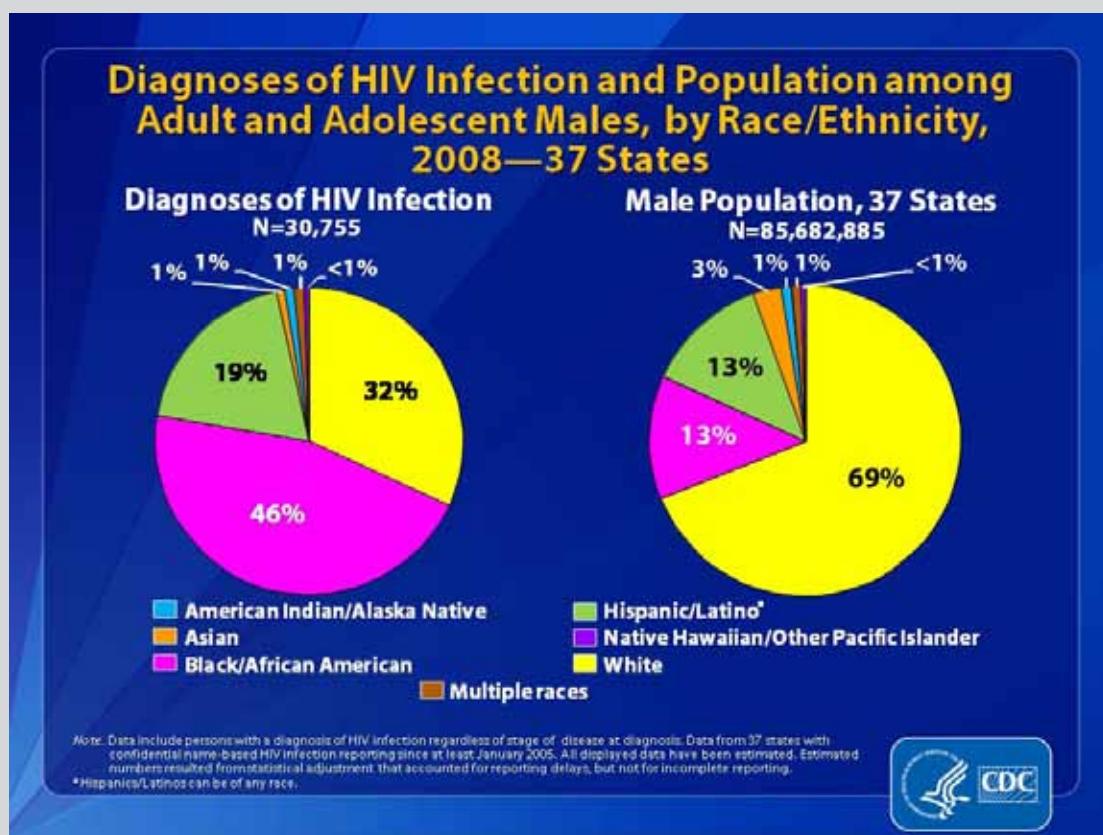
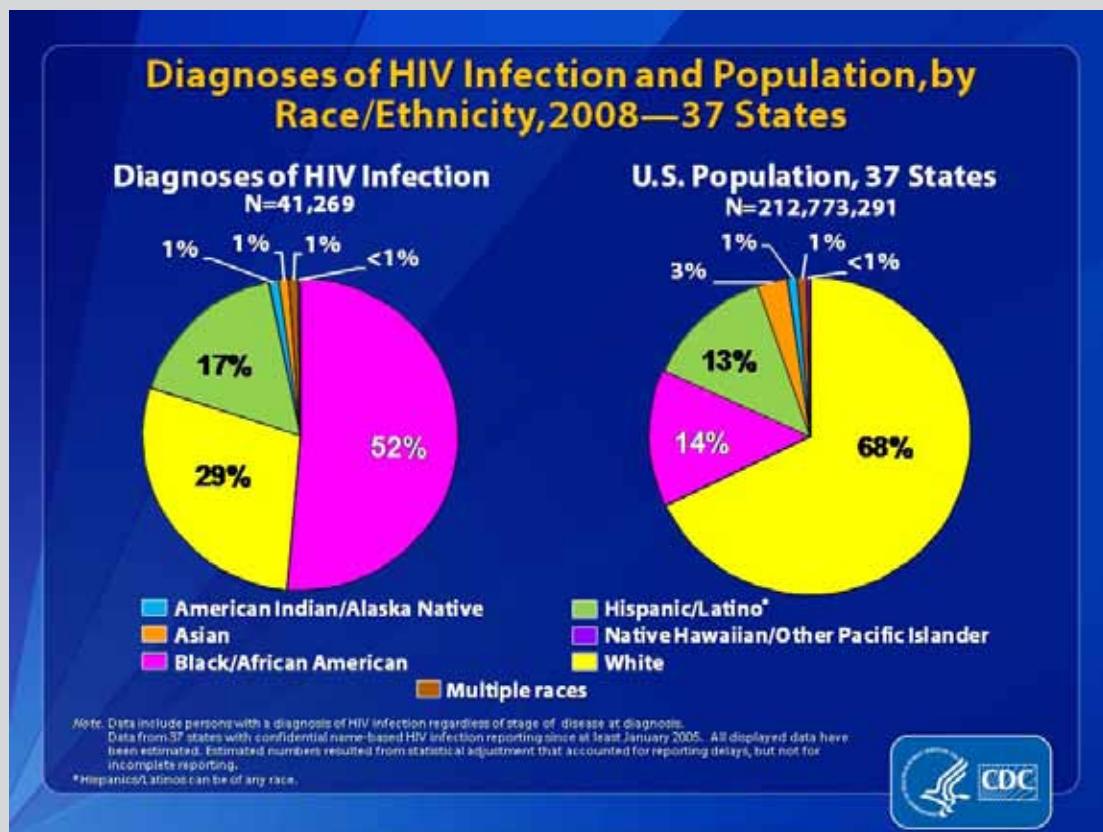
By the Numbers

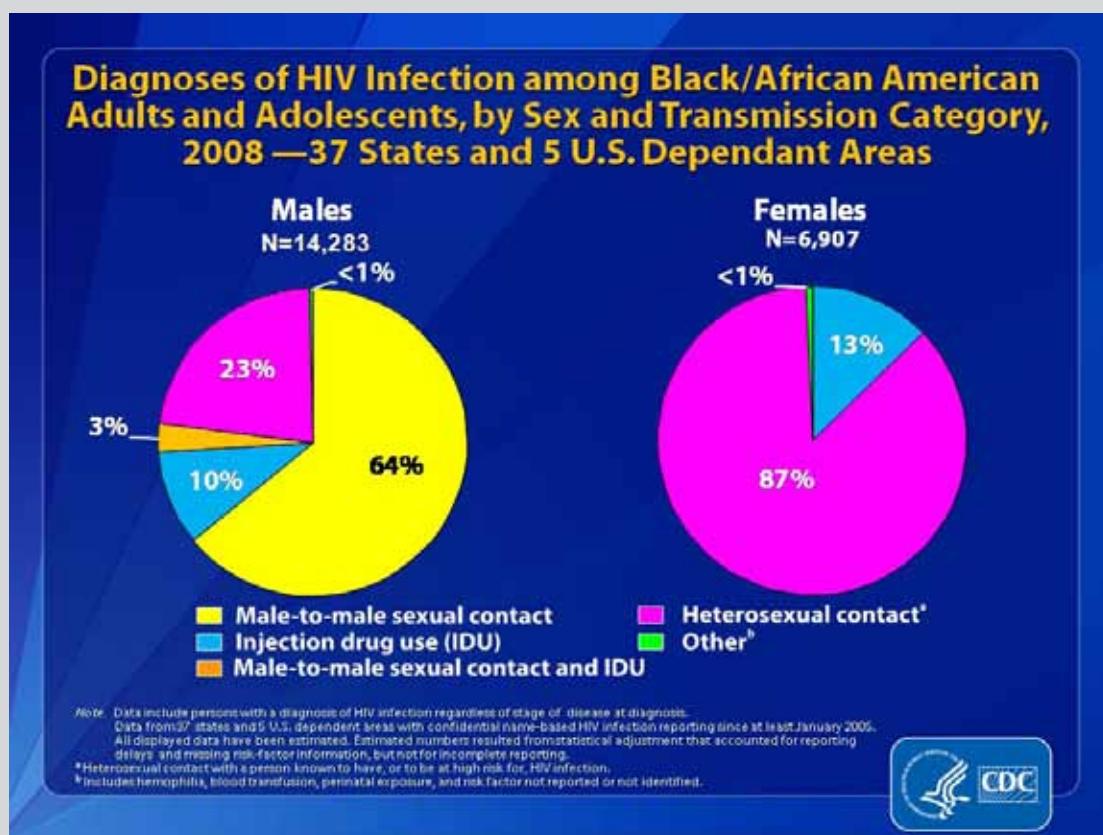
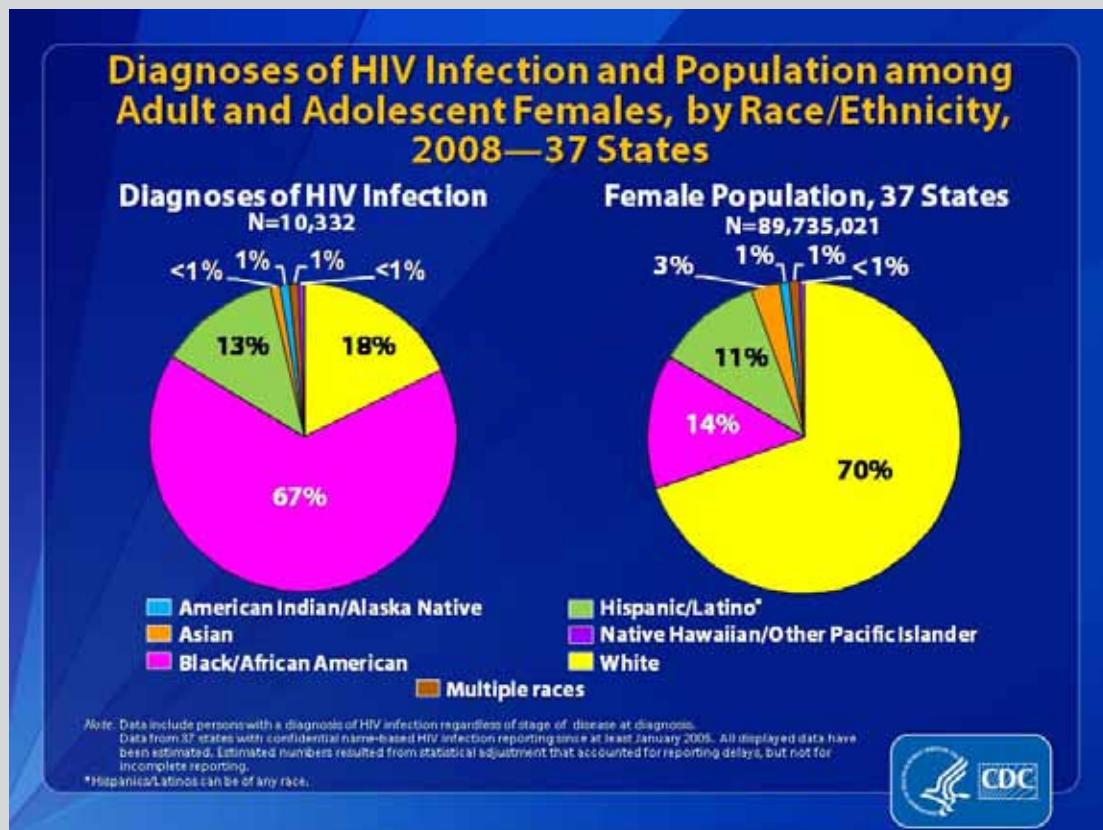
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Diagnoses of HIV Infection among Adult and Adolescent Males, by Race/Ethnicity, 2008—37 States

Race/ethnicity	No.	Rate
American Indian/Alaska Native	167	23.4
Asian	363	14.8
Black/African American	14,266	131.9
Hispanic/Latino ^a	5,742	52.3
Native Hawaiian/Other Pacific Islander	27	48.2
White	9,913	16.6
Multiple races	277	33.6
Total	30,755	35.9

Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis.

Data from 37 states with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

^aHispanic/Latinos can be of any race.



Diagnoses of HIV Infection among Adult and Adolescent Females, by Race/Ethnicity, 2008—37 States

Race/ethnicity	No.	Rate
American Indian/Alaska Native	52	6.9
Asian	78	3.0
Black/African American	6,902	56.0
Hispanic/Latino ^a	1,357	13.3
Native Hawaiian/Other Pacific Islander	6	10.6
White	1,833	2.9
Multiple races	104	11.9
Total	10,332	11.5

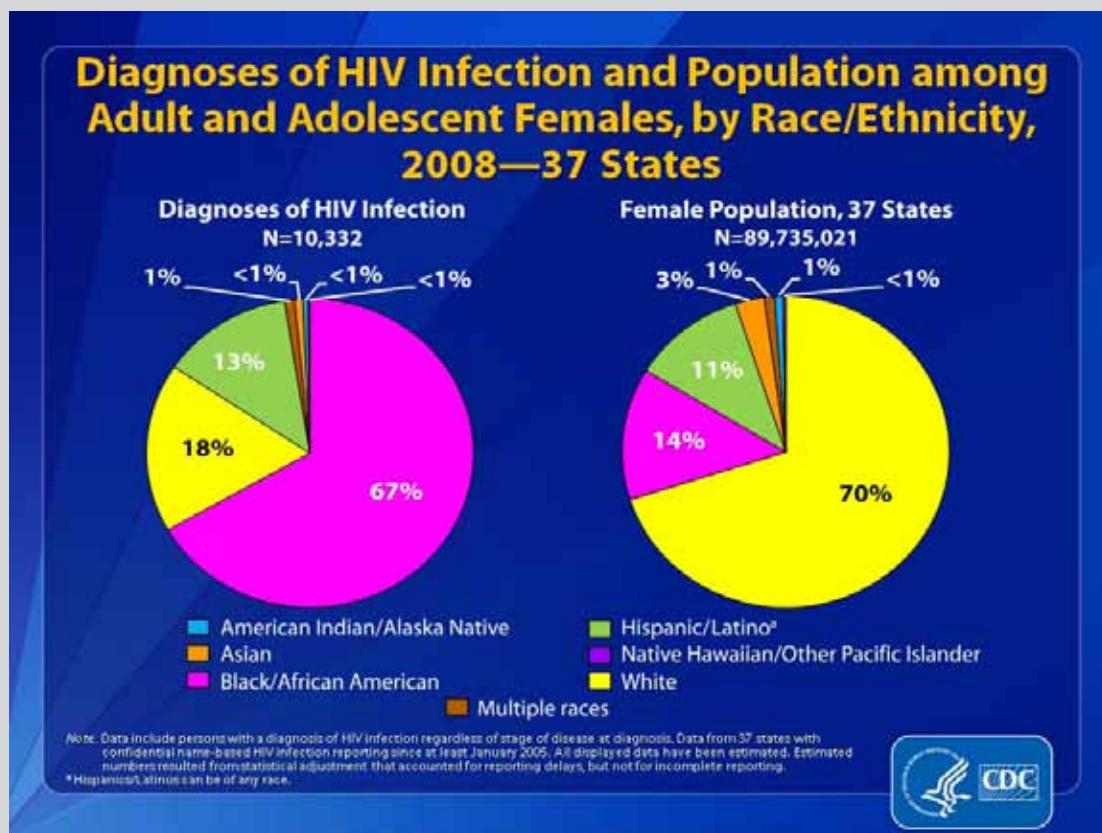
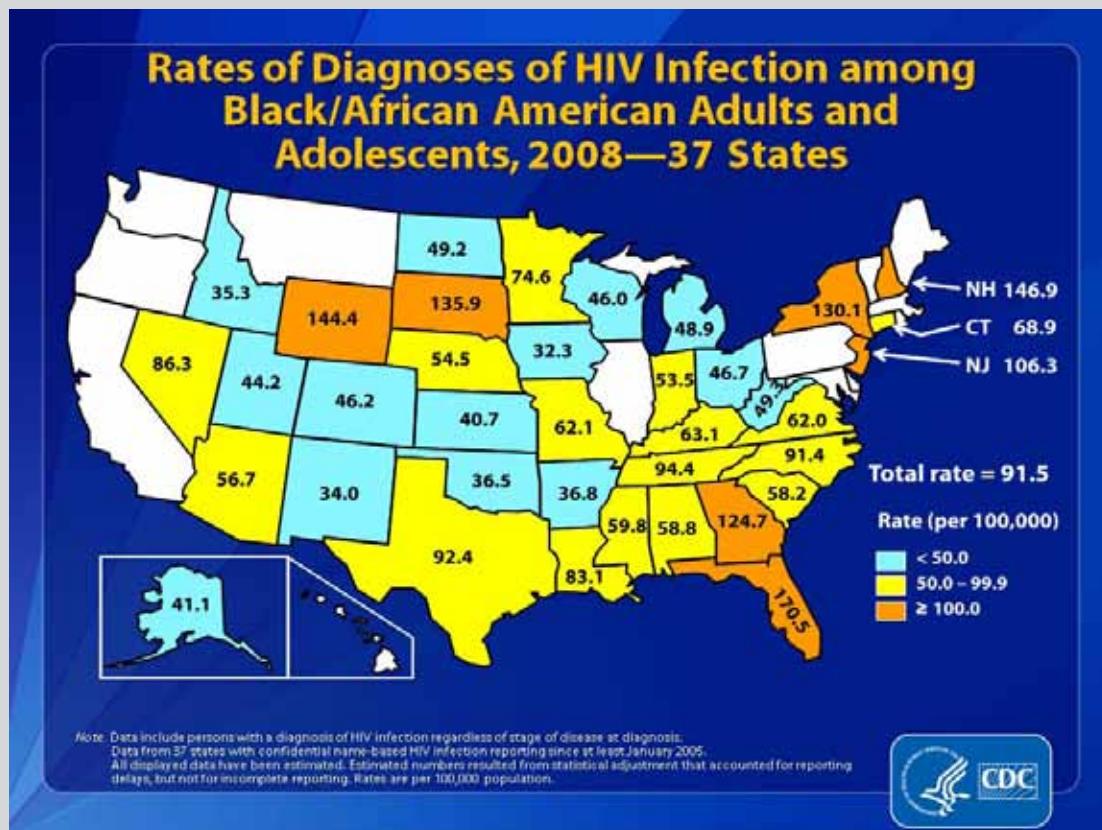
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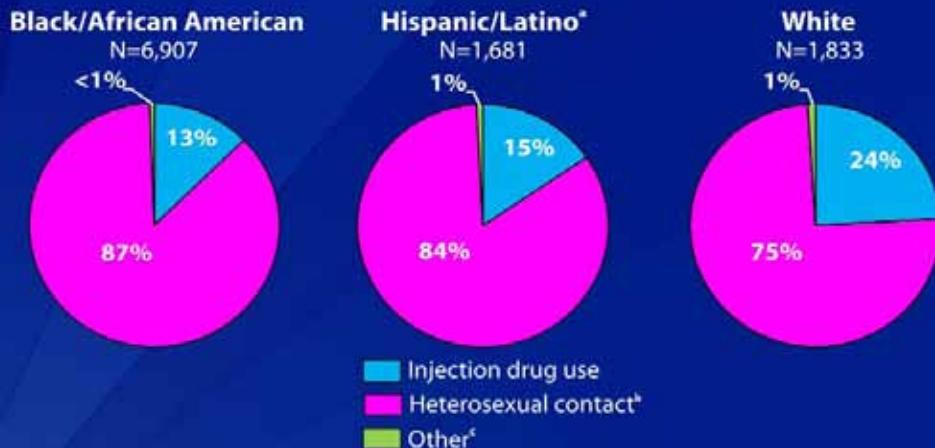
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^a Hispanics/Latinos can be of any race.

^b Because column totals for estimated numbers were calculated independently of the values for the subpopulations, the values in each column may not sum to the column total.



Diagnoses of HIV Infection among Adult and Adolescent Females by Race/Ethnicity and Transmission Category, 2008—37 States and 5 U.S. Dependent Areas



Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2005.

All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing risk-factor information, but not for incomplete reporting.

^a Hispanics/Latinos can be of any race.

^b Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

^c Includes blood transfusion, perinatal exposure, and risk factor not reported or not identified.



Diagnoses of HIV Infection among Adult and Adolescent Females, by Transmission Category and Age at Diagnosis, 2008—37 States and 5 U.S. Dependent Areas

Transmission category	Age at Diagnosis (in years)				
	13–19	20–24	25–34	35–44	≥45
	%	%	%	%	%
Injection drug use	9.5	10.4	13.1	15.7	18.9
Heterosexual contact ^a	90.5	89.5	86.7	83.9	79.3
Other ^b	<0.1	0.1	0.2	0.4	1.8
Total	100	100	100	100	100

Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing risk-factor information, but not for incomplete reporting.

^aHeterosexual contact with a person known to have, or to be at high risk for, HIV infection.

^bIncludes blood transfusion, perinatal exposure, and risk factor not reported or not identified.



Deaths of Adult and Adolescent Females with a Diagnosis of HIV Infection, by Race/Ethnicity, 2007—37 States

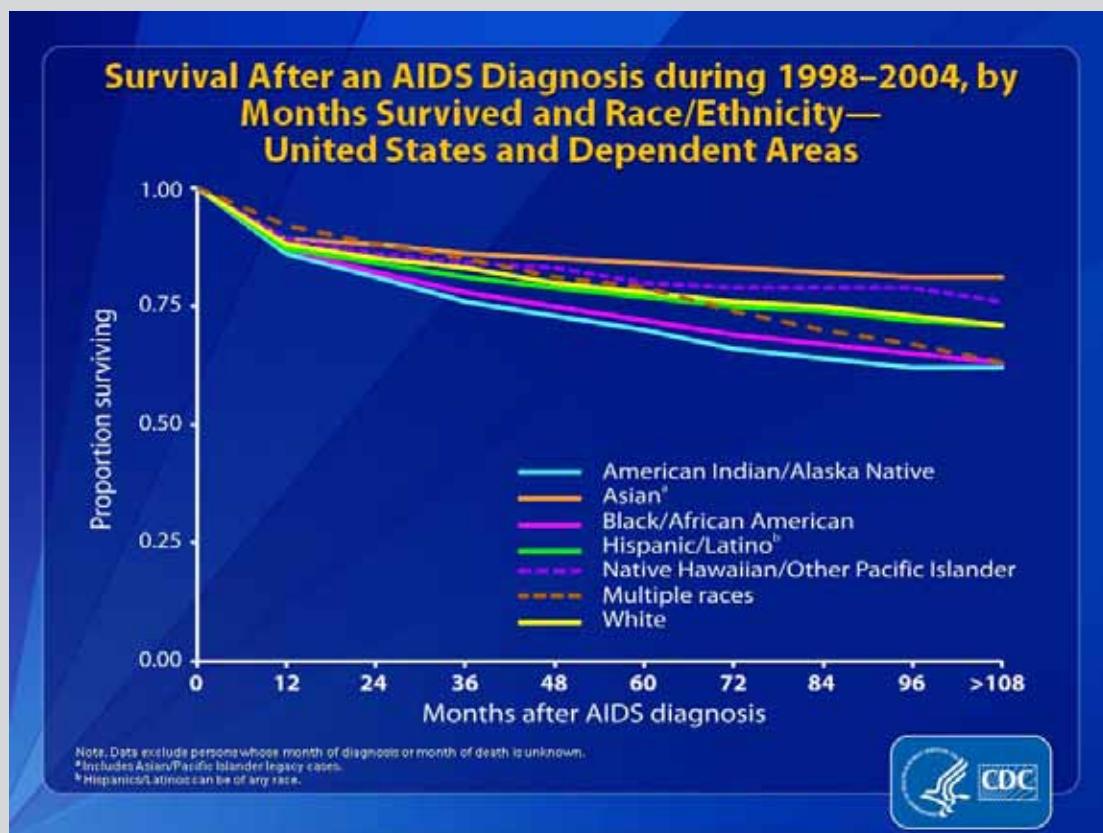
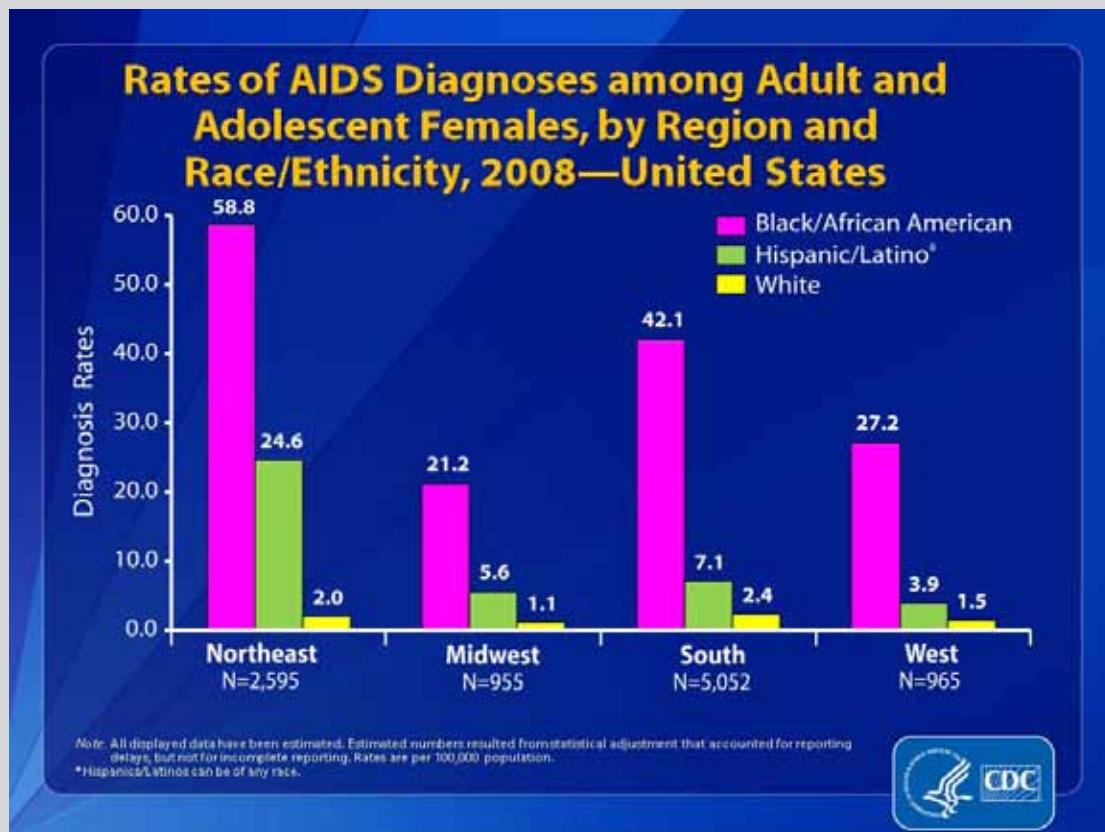
Race/ethnicity	No.	Rate
American Indian/Alaska Native	21	2.9
Asian ^a	12	0.5
Black/African American	3,129	25.7
Hispanic/Latino ^b	606	6.1
Native Hawaiian/Other Pacific Islander	3	4.7
White	771	1.2
Multiple races	120	14.2
Total	4,661	5.2

Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Deaths of persons with a diagnosis of HIV infection may be due to any cause. Data from 37 states with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

^aIncludes Asian/Pacific Islander legacy cases.

^bHispanic/Latino can be of any race.





Deaths of Persons with a Diagnosis of HIV Infection, by Race/Ethnicity, 2007—37 States

Race/Ethnicity	No.	Rate
American Indian/Alaska Native	75	4.1
Asian ^a	43	0.7
Black/African American	8,951	31.3
Hispanic/Latino ^b	2,513	9.1
Native Hawaiian/Other Pacific Islander	7	4.9
White	4,636	3.2
Multiple races	431	16.4
Total^c	16,659	7.9

Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis.

Data from 37 states with confidential name-based HIV infection reporting since at least January 2005.

All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

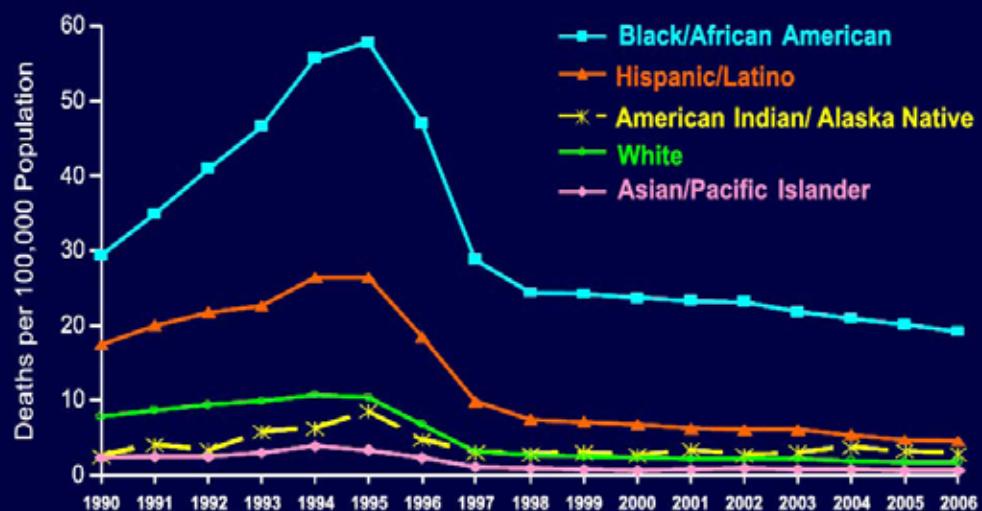
^aIncludes Asian/Pacific Islander legacy cases.

^bHispanic/Latino can be of any race.

^cIncludes persons of unknown race.



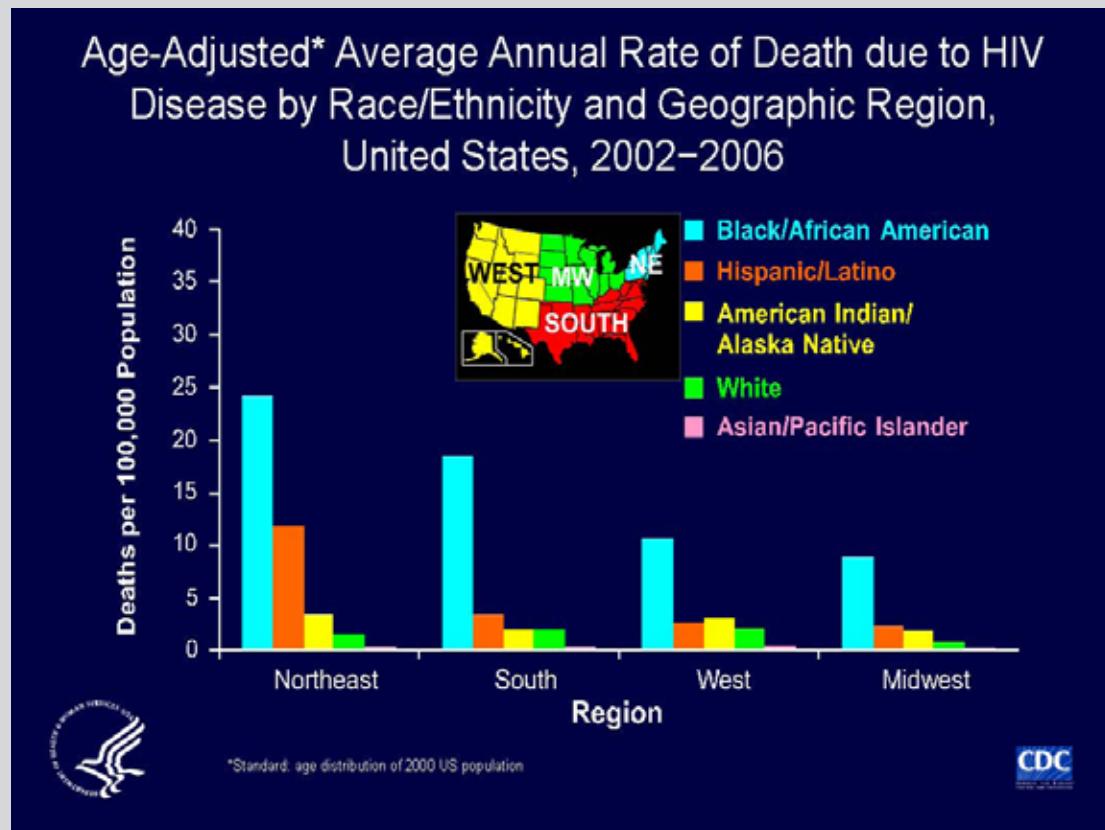
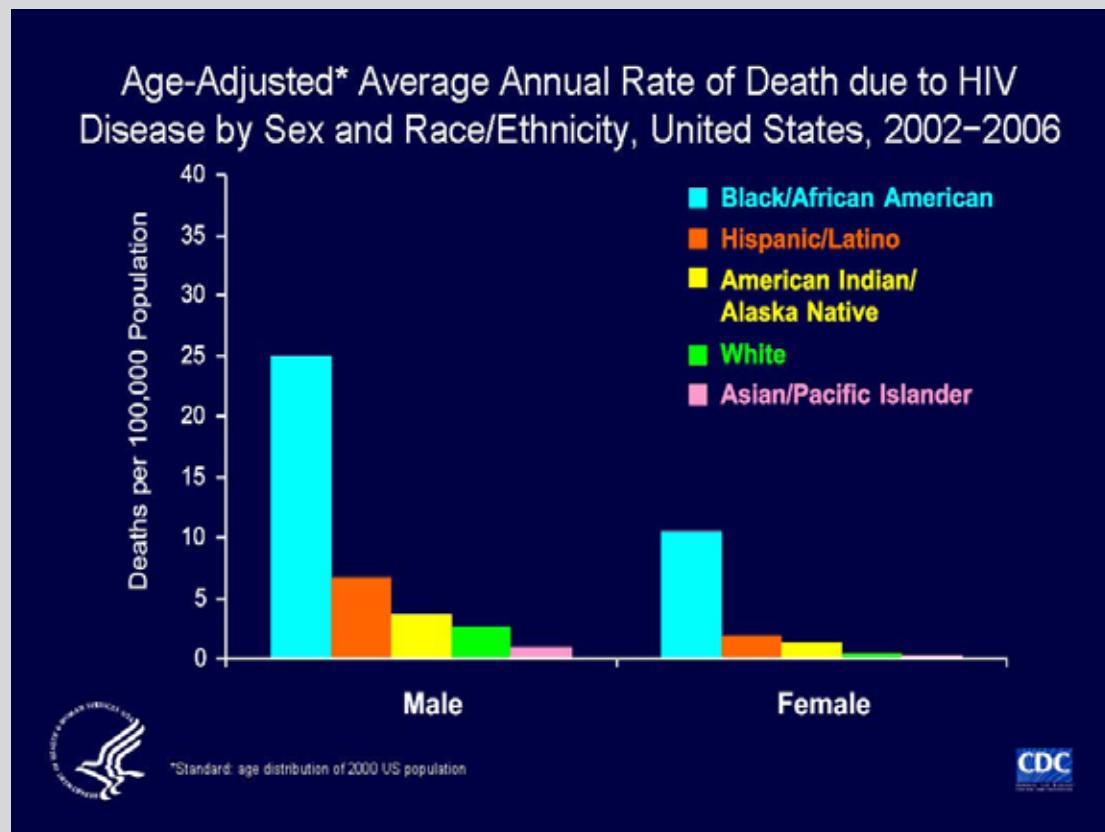
Trends in Age-Adjusted* Annual Rates of Death due to HIV Disease by Race/Ethnicity, United States, 1990–2006

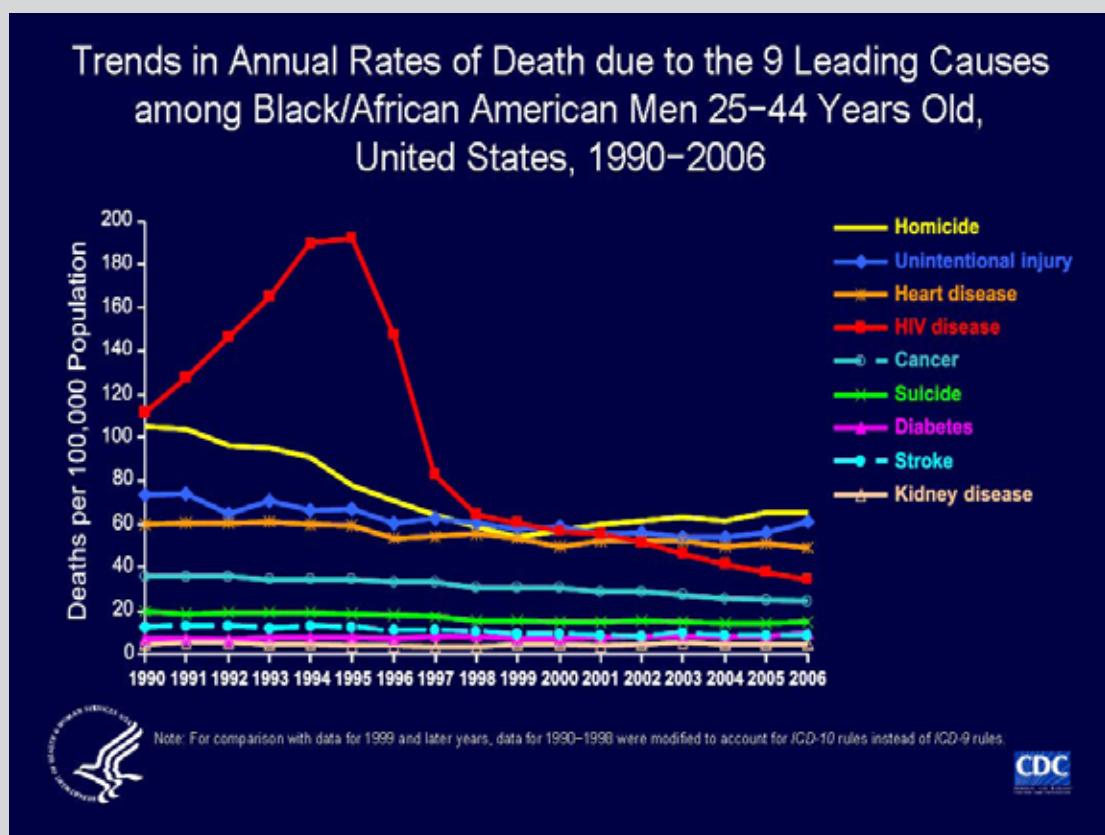
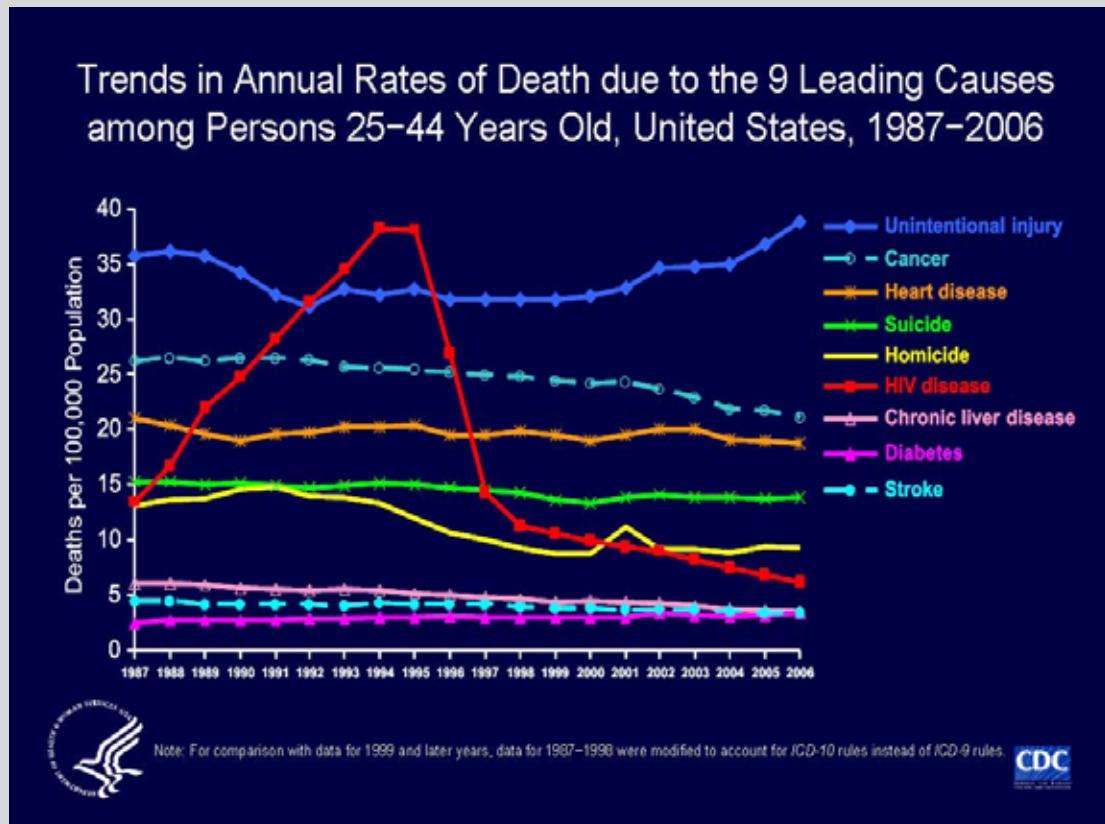


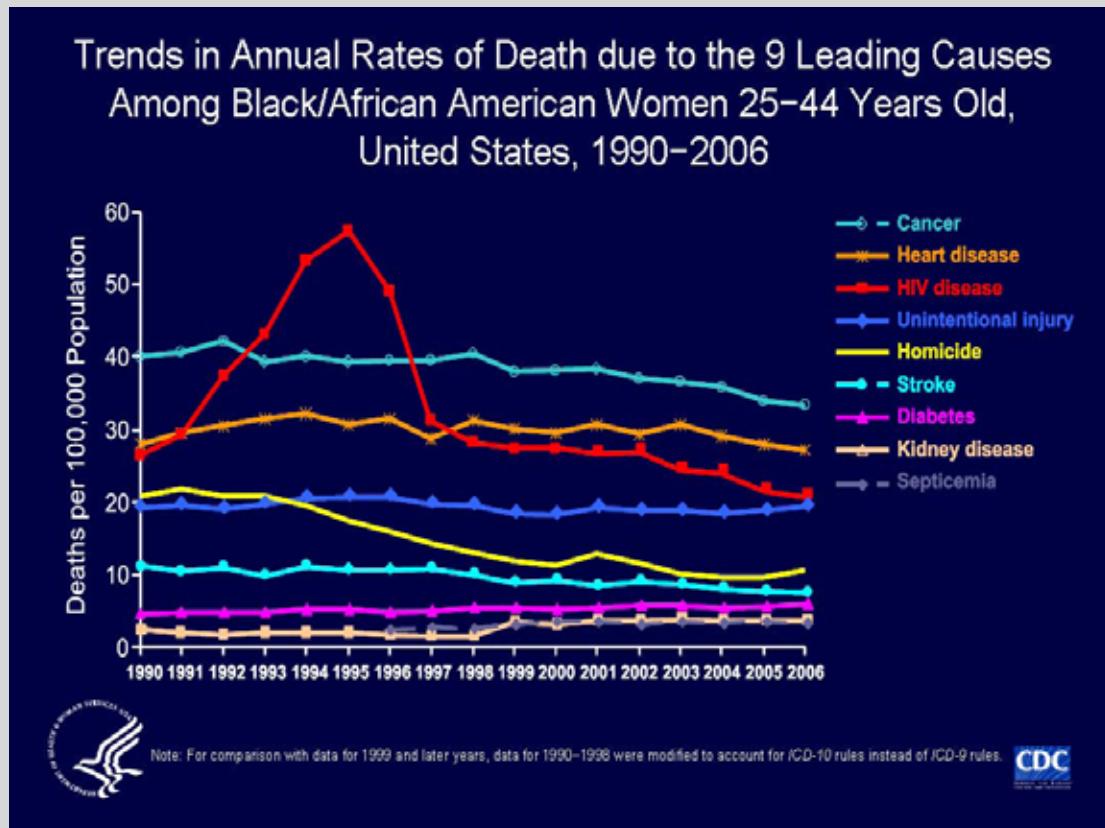
Note: For comparison with data for 1999 and later years, data for 1990–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.

*Standard: age distribution of 2000 US population

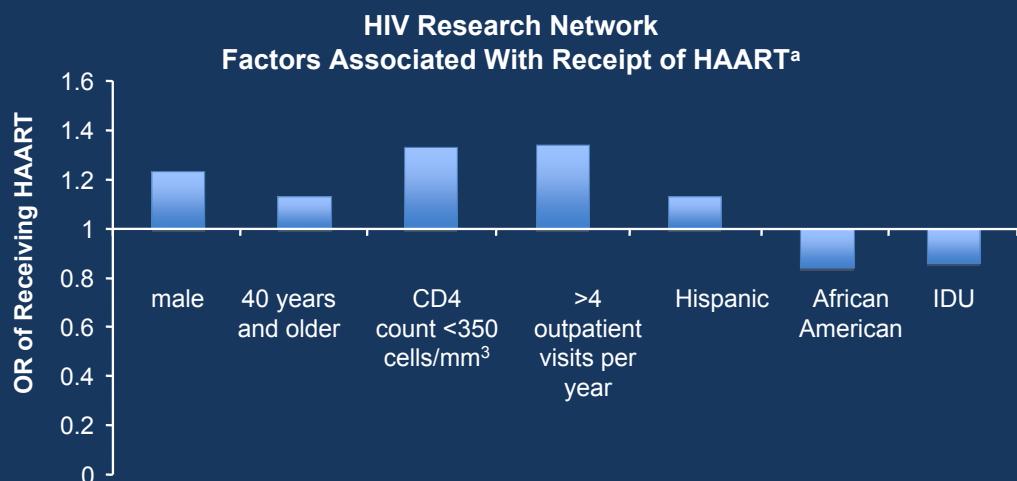








Race and Gender Disparities in Use of HAART



IDU, injection drug user; OR, odds ratio.

^a Multivariate analysis OR of receiving HAART at 10 primary care sites.

Adapted from Gebo KA et al. *J Acquir Immune Defic Syndr*. 2005;38:96-103.

Race Differences in HAART Use and Mortality Among HIV-infected Persons in Care

Cox Proportional Hazards Model of Factors Associated with Initiation of HAART

Factor	Multivariate Analysis	
	HR (95% CI)	P value
Black race	0.87 (0.79-0.97)	.009
Female sex	1.06 (0.95-1.19)	.30
IDU as risk factor for HIV infection	0.84 (0.72-0.98)	.030
AIDS diagnosis before first visit	1.24 (1.07-1.45)	.005
Age at first visit ^a	1.06 (1.01-1.11)	.027

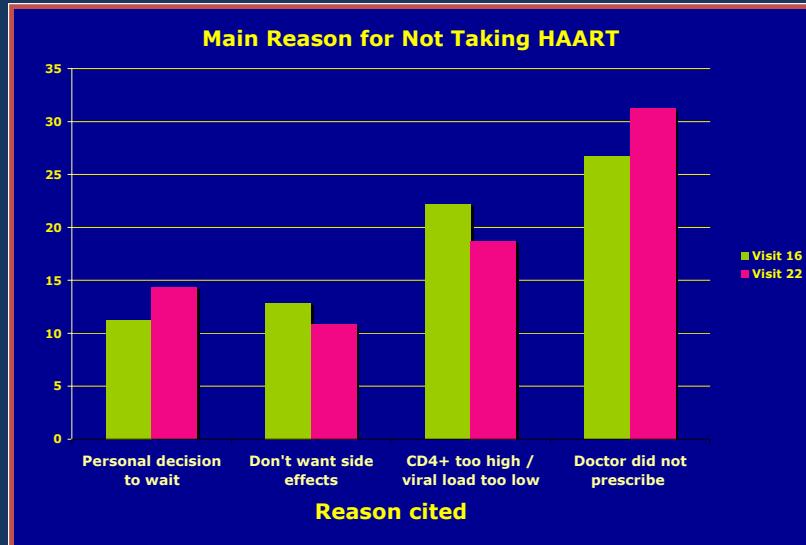
^aPer 10 years.

Lemly DC et al. *J Infect Dis.* 2009;199:991-998.

Multivariate Predictors of Not Using HAART 2005

- We found that 28% of women in WIHS who met indications for HAART in 2005 were *not receiving* HAART (N=390).
- Who were these women who were not on HAART?
- In multivariate analysis, we found these factors to be significant predictors of not being on HAART:
 - African American race (OR=2.0)
 - Heavy or moderate alcohol use (OR=2.3)
 - Depression (OR=1.3)
 - Being uninsured (OR=2.4)
 - Having private insurance (OR=2.1)
 - Key predictor of *receiving* HAART– ADAP (OR=0.54)

Reasons Why Women Weren't on HAART



Lillie-Blanton M, Stone VE et al. Am J Public Health 2010; 100 (8): 1493-1499.

Summary

- HIV/AIDS disproportionately affects Blacks in the U.S., and in 2008, 50% of all new HIV diagnoses were in Blacks
 - HIV/AIDS incidence in the U.S. has been highest in Blacks for 15 years and slowly but steadily increasing since 1995
 - Growing proportion of women infected heterosexually
 - Epidemic has grown in the US South, yet remains similarly substantial in the U.S. Northeast
 - Death rates even more disproportionate among Blacks
 - Treatment disparities are likely to be one of the factors contributing to disproportionate death rates

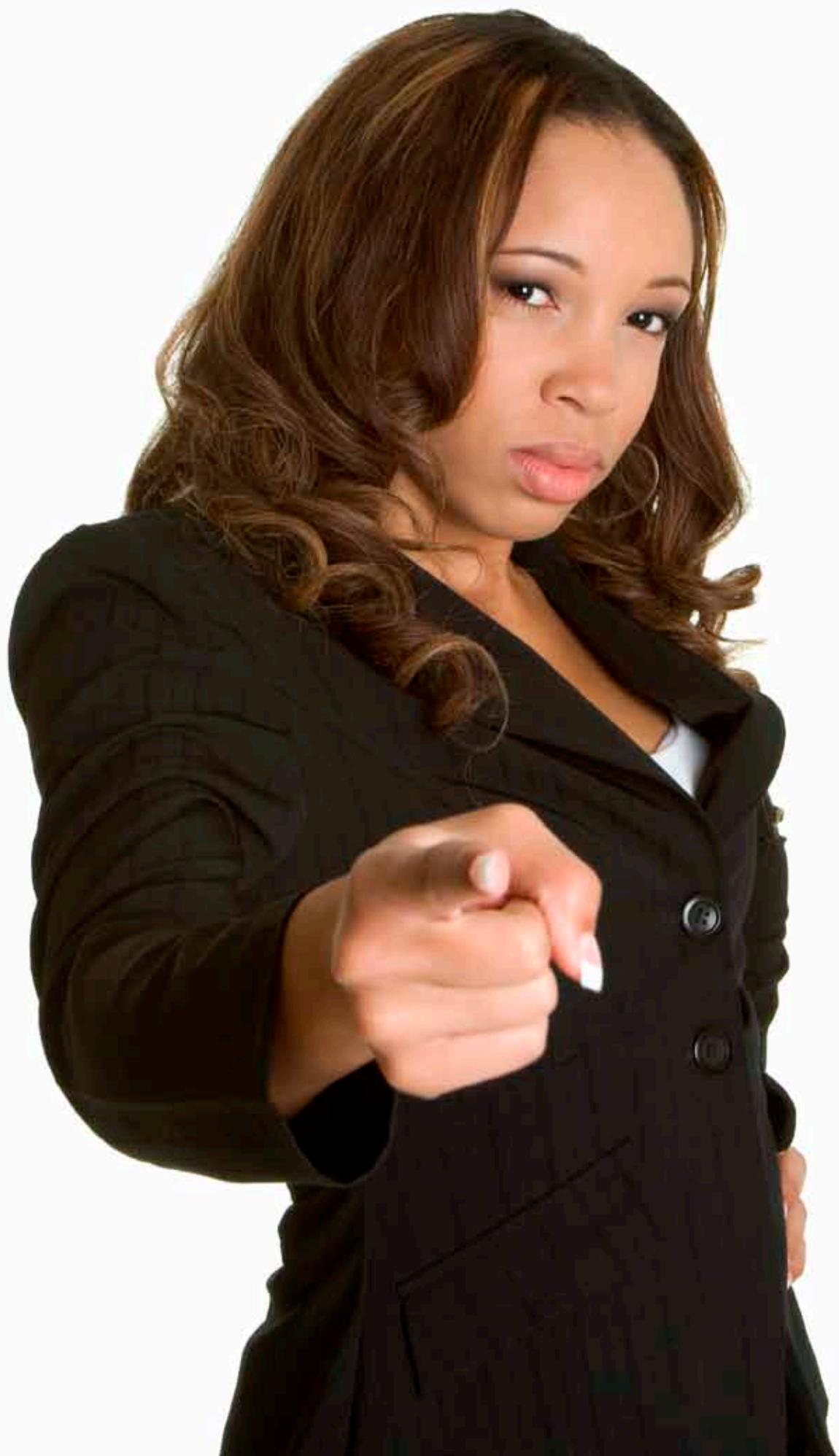
DECIDING MOMENT:

**“ASKING HER TO GET
TESTED WITH ME.”**



greaterthan.org/derrick
WE > AIDS





Recommendations

How to End the Black Epidemic

With such enormous advances having occurred in 2010—and with major new opportunities and challenges facing the AIDS response in 2011—the urgency of investing wisely, remaining steadfast and vigilant, and following through on our national commitments in the AIDS fight has never been clearer. With a new roadmap in place for a stronger, more effective AIDS response, even greater achievements are possible. Now more than ever, it is apparent that our 30-year fight against AIDS is winnable.

To ensure that we seize the opportunities that will present themselves in 2011 and that we successfully overcome key challenges, the Institute respectfully offers the following priority recommendations and urges their immediate implementation:

coverage is in the national interest—protecting the health and well being of families and workers, helping restrain rising health care costs, and contributing to a fairer and more equal society. By expanding Medicaid, closing costly loopholes in Medicare, and prohibiting discriminatory insurance practices, more than 30 million Americans who currently lack health insurance will be able to obtain health coverage. And the Congressional Budget Office and leading economists agree that health care reform is essential to reducing the federal deficit and placing America's fiscal house in order. America's leaders need to lead—by implementing health care reform on schedule and by fully funding its provisions.

Follow through on health care reform.

The AIDS crisis has served as a powerful lens to understand the acute deficiencies of our health care system. It has also operated as a laboratory for new approaches and new ideas. No constituency has more to gain from this major domestic reform than people living with HIV, and no racial or ethnic group is more affected by our threadbare health care safety net than Black America.

As experience in every other industrialized country has shown, universal health

Recommendations: At a Glance

- The country must implement and scale up health care reform.
- Steps should be taken to improve the evidence base for action to promote health care access for people living with HIV.
- Federal and state lawmakers should make wise and robust investments in life-saving, cost-effective AIDS programs.
- CDC should carefully monitor and report on HIV prevention spending.
- Federal officials and key stakeholders should collaborate to ensure the success of the CDC's new "12 cities" initiative.
- Steps should be taken to ensure that new biomedical prevention tools are rapidly assessed, and if effective, expeditiously implemented.
- Black communities throughout the U.S. should mobilize to support a strong and sustained AIDS response and to ensure the success of the national AIDS strategy.

Improve the evidence base for action in promoting health care access for people living with HIV.

In recent years, the country has learned a lot about the health care patterns that contribute to poor medical outcomes for people living with HIV—late HIV diagnosis, late entry to care, episodic and fragmented care, and poor treatment adherence. But while we know much more than in the past about how many people aren't receiving appropriate care, we know much less than we need to know about the reasons people do not receive the care

they need. This urgently needs to change.

As part of the implementation of the national AIDS strategy, the federal government should make major investments in research to improve our understanding of the root causes of these patterns. And operational research should be undertaken to help identify strategies for overcoming barriers to health care access and service utilization.

To promote innovation and best practices, the Health Resources Services Administration should implement financial incentives for states and cities under the Ryan White program to reduce unmet need for HIV primary care among people with diagnosed HIV infection.

Federal and state lawmakers should make wise and robust investments in life-saving, cost-effective AIDS programs.

Recognizing that a healthy population is a competitive and productive population in the global economy, federal lawmakers should exempt AIDS programs from cost-cutting initiatives and instead invest new resources in under-funded components of the AIDS response.

President Obama and Congress should work together to increase AIDS funding in Fiscal Year 2012, taking particular steps to increase investments in HIV prevention, eliminate funding shortfalls that have resulted in growing waiting lists for the AIDS Drug Assistance Program (ADAP), and ensure strong funding for HIV research efforts that are generating such enormous scientific advances.

For the first time ever, the U.S. has a thoughtful, comprehensive roadmap to guide the AIDS response, with clear milestones and outcome targets to drive progress and promote accountability for results. The

country needs to ensure that this strategy has the resources it needs to succeed. And state and local governments need to do their part, as well, focusing new resources on particular gaps in their own safety nets.

Monitor and report on federal HIV prevention funding.

Throughout most of the epidemic, it has been difficult to obtain a clear picture of how federal prevention resources are spent. In part, this stems from the fact that much of CDC's HIV prevention budget is allocated to state and local governments, which determine their own prevention priorities and make funding allocations. With a national AIDS strategy now in place, it is essential that CDC ensure that limited HIV prevention funding is being used as effectively and efficiently as possible. In the few instances where CDC has undertaken efforts to track how prevention funds are spent, it has become apparent that prevention priorities often fail to match up well with actual prevention needs.

While CDC understandably aims to empower states and localities to use prevention funds in ways that are appropriate to their local conditions, it is essential that those most at risk of becoming infected are sufficiently targeted by prevention programs. The Institute urges CDC to ensure that prevention spending follows the epidemic, with particular attention to the needs of Black Americans and gay men.

Ensure the success of the federal government's "12 cities" initiative.

As previously explained, CDC's "12 cities" project has rapidly evolved into a unique

opportunity to implement the national AIDS strategy, to focus resources on the hardest-hit communities, and to promote innovation and new ideas. To ensure the success of this initiative, the federal government needs to ensure continued and sufficient funding to make this an effective multi-year undertaking, mandate engagement of all relevant agencies in these 12 cities, support local planners to bring AIDS strategies to scale, and drive toward clearly documented population-level impact.

The cities engaged in this exciting initiative will require extensive technical support in a variety of areas, including strategic planning for combination HIV prevention, integration of prevention and treatment planning and services, public health surveillance and management of integrated data systems, and economic modeling to inform resource allocation decisions.

As CDC implements new HIV prevention cooperative agreements with cities and states, it should ensure that funding and operational principles emphasize the key themes of the "12 cities" initiative, including innovation, coordination, effectiveness, scale, integration, and population-level outcomes.

Prioritize steps to ensure that new prevention tools are rapidly and effectively assessed and implemented.

As prevention science rapidly evolves, it is critical that federal policy-makers collaborate with state and local health departments, health care providers, and affected communities to expedite their availability to those who need them. New prevention tools must not simply rest on the shelf, but should instead be mobilized to help achieve the national goal of reducing the number of new infections.

The first order of business is to seize the promise of pre-exposure prophylaxis (PrEP). Federal health officials have initiated a process to develop formal guidance for PrEP. Development of these guidelines should be expedited to clarify the science of PrEP and to inform its integration into the prevention continuum, taking steps to involve affected communities and other key stakeholders. The federal government should support pilot projects to identify best practices for implementation and to answer outstanding questions about the use of this new tool, such as adherence, acceptability, cost, patient education, and sexual behaviors of those using PrEP.

In implementing these field studies, energetic steps must be taken to ensure strong involvement of Black gay men. In developing guidance and mounting demonstration projects, federal officials and researchers must bear in mind the imperative to avoid having availability to this potentially groundbreaking new prevention determined based on ability to pay rather than on need and likelihood of success.

Federal officials should use the roll-out of PrEP as a learning experience that can help inform efforts to expedite other prevention tools that are likely to emerge in future years, including vaginal and rectal microbicides and antiretroviral therapy for HIV prevention.

on recent successes, Black leaders, community groups, churches and other traditional Black institutions should speak openly and loudly about the continuing urgency of the AIDS fight.

In particular, Black Americans should recognize the national AIDS strategy as a unique opportunity to generate real, long-lasting results. As advocates, service providers and community watchdogs, Black Americans should demand accountability—of themselves, their leaders, and their federal, state and local governments.

AIDS may not be as visible in the media as it once was, but the problem hasn't gone away. Black America will not have a healthy future unless it effectively addresses the AIDS epidemic. That reality should compel Black leaders and grassroots activists to remain engaged in the fight.

Black communities throughout the U.S. should mobilize to support a strong and sustained AIDS response and to ensure the success of the national AIDS strategy.

As the population most heavily affected by AIDS in the U.S., Black America needs to own and drive the AIDS response. Building



DECIDING
MOMENT:
“MY LIFE IS WORTH
PROTECTING.”

greaterthan.org/chauncey
WE ➤ AIDS



About the Black AIDS Institute

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

What We Do

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

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

African American HIV University

Aimed at strengthening Black organizational and individual capacity to address the HIV/AIDS epidemic in their communities, the African American HIV University is the comprehensive training and capacity building fellowship program developed by the Black AIDS Institute.



Black AIDS Weekly

Black AIDS Weekly is the Institute's e-newsletter of national HIV/AIDS related news, interviews and commentary relevant to Black Americans.

Black Gay Men's Network

The Black Gay Men's Network promotes the active participation of self-actualized

Black gay men in all aspects of community life. It provides opportunities for career development, social connections, loving relationships, educational outreach, skills-building, leadership development, physical and mental health, financial wealth and spiritual wellness. www.thebgmnetwork.com

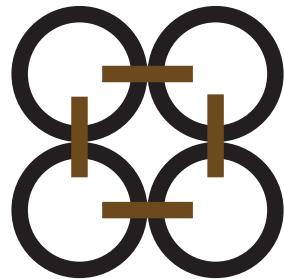


Black Hollywood Task Force

An initiative to bring together Black members of the entertainment industry to use their voice and influence to promote HIV/AIDS awareness in the Black community. The Institute engages them to participate in public service announcements, make personal appearances and integrate HIV/AIDS messages into their projects and performances.

Black Treatment Advocates Network

The Black Treatment Advocates Network focusses on training, mobilizing and networking. The only collaboration of its kind, links Black Americans with HIV into care and treatment, strengthens local and national leadership, connects influential peers, raises HIV science and treatment literacy in Black communities, and advocates for policy change and research priorities. www.Black-AIDS.org/btan



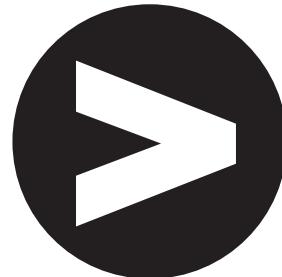
CitySheet Series

The CitySheet Series is a set of fact sheets that provide background, statistics and resources related to HIV/AIDS in local and regional Black communities. It is an invaluable resource for community stakeholders who want local information and potential

partners in one succinct document.

Greater Than AIDS

Greater Than AIDS, a collaboration between the Black AIDS Institute and the Kaiser Family Foundation, in collaboration with the U.S. Centers for Disease Control and Prevention, and in partnership with the Elton John AIDS Foundation, the MAC AIDS



Fund and the Ford Foundation, is a media campaign built around the message that, as Black Americans, we are greater than any challenge we have ever faced. We are greater than AIDS. www.greaterthan.org

Heroes in the Struggle

Heroes in the Struggle is a photographic tribute to African Americans who have made outstanding contributions in the fight against HIV/AIDS. The Heroes In The Struggle exhibit has traveled around the country, raising awareness, challenging individuals and institutions to get involved in their communities, and generating critical conversation about HIV testing and treatment. www.heroesin-thestruggle.com

Ledge

Ledge is the nation's first and only HIV/AIDS awareness, general health and lifestyle magazine written by and for students at historically Black colleges and universities. www.ledgemagazine.com

LIFE AIDS

Leaders In the Fight to Eradicate AIDS (LIFE AIDS) is a collegiate mobilization initiative whose mission is to educate Black college students on the causes and effects of



HIV/AIDS, and to create comfortable dialogues about sex and sexuality.

State of AIDS in Black America

The annual State of AIDS in Black America report comprehensively assesses the national picture of AIDS in Black communities from epidemiological, political, and cultural perspectives, and offers recommendations for policymakers and Black leaders. Each report assesses the progress made towards ending the AIDS epidemic in Black America and holds accountable those institutions and individuals which have advanced or hindered such progress.

A close-up photograph of two men smiling and laughing together. The man on the left is wearing a plaid flat cap and a green zip-up hoodie over a blue shirt. The man on the right is wearing a dark blue flat cap and a purple and grey striped sweater over a white shirt. They are outdoors, with a blurred background of trees and a building.

**DECIDING
M►MENT:
“WE TALK ABOUT
EVERYTHING-
INCLUDING HIV.”**

greaterthan.org/andre
WE > AIDS





For more information or more copies of this report, contact:

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