Left Behind

BLACK AMERICA: A NEGLECTED PRIORITY IN THE GLOBAL AIDS EPIDEMIC

Black AIDS Institute, August 2008

Left Behind: Black America: a Neglected Priority in the Global AIDS Epidemic by Phill Wilson, Kai Wright and Michael T. Isbell 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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FROM THE BOARD CHAIR

What if Black America Was a Country unto Itself?

Welcome to *Left Behind,* the latest in a series of reports on the state of AIDS in Black America by the Black AIDS Institute.

While the world wasn't looking, the AIDS epidemic in the United States refused to go away.

In fact, the domestic AIDS epidemic in the U.S. is much more serious than previously believed. According to analyses of epidemiological data by the Centers for Disease Control and Prevention, the annual rate of new HIV infections is nearly 50% higher than previously believed.

And as America lost interest in its own epidemic over the last decade, the disease became even more firmly implanted in Black America. Nearly 600,000 Black Americans are living with HIV, and as many as 30,000 become newly infected *each year.* In New York City, Blacks living with HIV have an age-adjusted death rate that is two and a half times higher than for HIV-infected whites.

According to public opinion surveys, Blacks regard AIDS as the country's most serious health threat. America's opinion leaders and policy makers apparently don't share this view. In recent years, domestic AIDS issues have virtually disappeared from the front pages of the nation's daily newspapers and from the evening news. And funding from governmental agencies and most foundations for essential programs to prevent new infections and treat people living with HIV in the U.S. has declined in real terms in recent years.

Jesse Milan, Jr., J.D.

For much of the AIDS epidemic, an impediment to progress in Black America has been the shortage of Black leadership, activism and mobilization to address the disease. This is no longer the case. Black leaders, political organizations, civil rights groups, churches and community groups across the U.S. are mobilizing to wage battle against this most serious of health problems facing Black America.

So what's missing?

In this report, we point out that Black America is lacking a partner in the federal government when it comes to fighting AIDS, and in many ways has been left behind by most foundations and almost all global health agencies. As America goes to the polls in 2008 to decide the country's future, this report argues that official neglect of the epidemic in Black America must become a thing of the past.

This report underscores the ironies in the U.S. government's failure to take AIDS in Black America seriously by juxtaposing the federal response to the domestic epidemic in recent years with its pioneering leadership on global AIDS issues. This isn't meant to suggest that U.S. leadership on the global epidemic is misplaced. On the contrary, helping lead the global response to AIDS is one of the most important actions the U.S. has taken in the international arena in decades. It might even be the one shining example in an otherwise dismal foreign policy agenda. The point of this report, rather, is that the same zeal, wisdom and courage our government is now showing on global issues must be brought to bear in the fight against AIDS at home.

By comparing AIDS in Black America with other parts of the world, this report also isn't meant to imply that the breadth and severity of the epidemic in the U.S. are equivalent to AIDS in the countries that have been most heavily affected by the disease in southern Africa. That would be like comparing apples with oranges. And yet while, for example, we would never suggest that the recent floods in the American Midwest were identical in their human impact to the 2004 Asian tsunami or to this year's cyclone in Myanmar, no reasonable person would suggest that the differences should mean that communities in Iowa, Missouri or Wisconsin shouldn't receive the support they need to recover from this year's disaster.

In fact, looking at AIDS in Black America in the context of the global epidemic yields important insights. The number of people living with HIV in Black America exceeds the HIV populations in seven of the 15 focus countries of the U.S. government's PEPFAR initiative. Many of the factors that make HIV so challenging in other countries are the same ones that drive the epidemic in Black America.

Were Black America a country on its own, it would undoubtedly attract the concern and strategic focus of the U.S. government. It is both a tragedy and an outrage that it has failed to do so simply because its AIDS epidemic occurs within the borders of the U.S.

For the U.S. government to have credibility as a genuine leader in the global AIDS response, it needs to lead the response to AIDS at home. If we are to have any hope of achieving the goal of a world without AIDS, Black America cannot be left behind. It is toward this goal that this report is dedicated.

Jesse Milan, Jr., J.D.
Chairman of the Board
Black AIDS Institute

If Black America was a country, its AIDS epidemic would be nearly the size of the AIDS epidemic in Côte d'Ivoire.

Think Global

A New Perspective on the Black Epidemic

Black communities throughout the United States continue to bear a disproportionate share of the AIDS epidemic. More than 500,000 Black Americans are living with HIV, and 20,000 or more become infected each year. Blacks living with HIV have an age-adjusted death rate more than twice as high as HIV-infected whites.

Dr. Helene D. Gayle

Yet as this new report by the Black AIDS Institute underscores, America is failing to respond effectively to the AIDS crisis in Black America. Essential AIDS programs on which Black Americans rely have barely grown in recent years—in some cases, failing to keep pace with inflation. The country's failure is especially striking when it comes to programs to prevent new HIV infections, which account for only 4¢ of every dollar the U.S. government spends on the domestic AIDS epidemic.

Ironically, the lethargic national response to AIDS in Black America is occurring at the same time that the U.S. government is displaying true leadership in the global AIDS response. While the U.S. government insists that the countries it helps have in place a national AIDS strategy, America itself has no strategic plan to combat its own epidemic. And as the threat posed by the epidemic grows ever more acute in Black communities across the country, overburdened community agencies are struggling to do more with fewer and fewer resources.

The Honorable Barbara Lee

This report uses a revealing lens to assess AIDS in Black America, asking how the U.S. government might respond if Black America were its own country. The picture is disturbing. Standing on its own, Black America has the 16th largest epidemic in the world, with a population of HIV-infected individuals that exceeds the HIV populations of seven of the

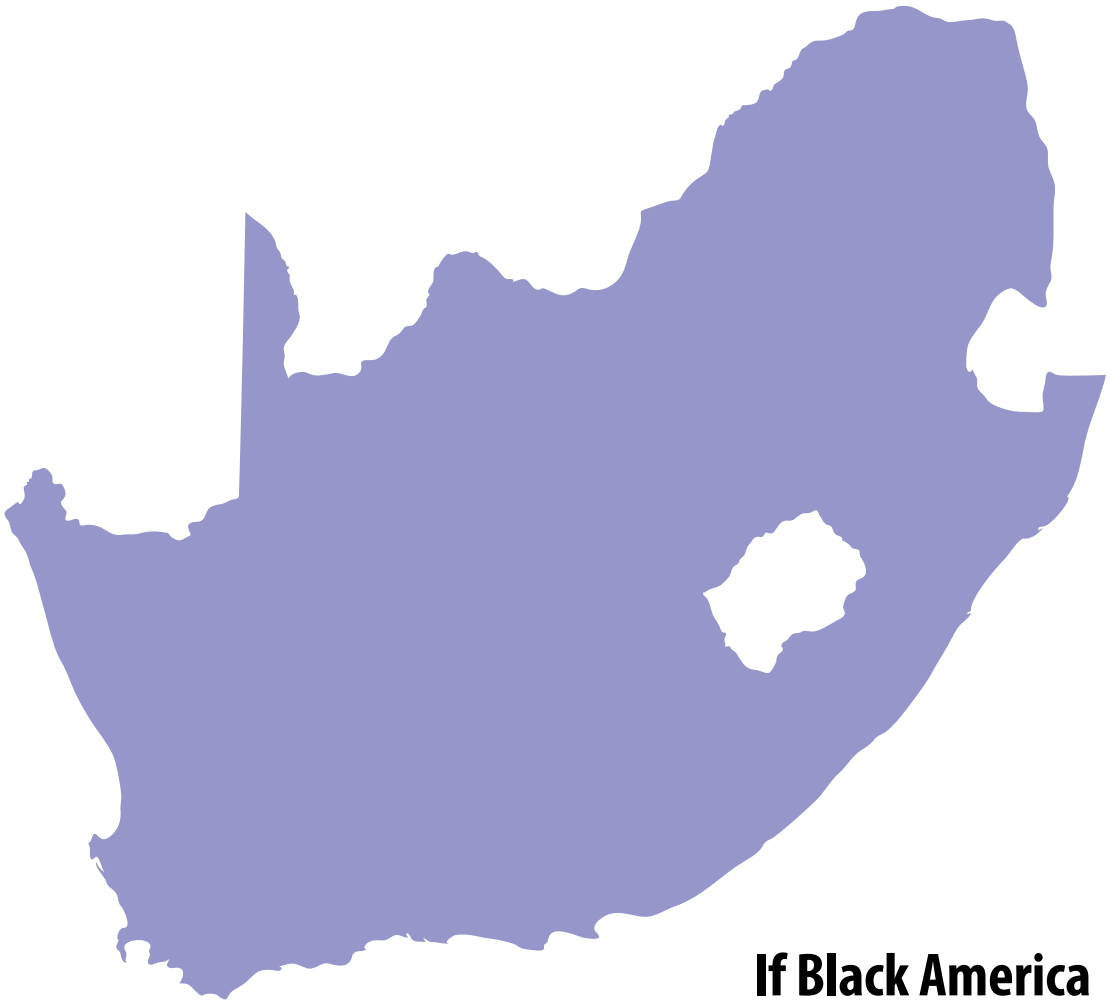
15 focus countries of the President's Emergency Plan for AIDS Relief. The disparities in life expectancy, infant mortality, poverty and economic opportunity for Black America are a glaring reminder of the legacy of inequality that has not been fully addressed in the United States and are in sharp contrast to other high-income countries of North America and Western Europe.

America's refusal to energetically address AIDS in America hardly represents enlightened behavior on the part of the world's most prosperous and powerful country. The greatest test of a nation's character is how it treats its most vulnerable, and the U.S. is presently failing this test. By bringing to the fight against AIDS in Black America the same energy and innovation America is now displaying in the broader global AIDS response, valuable lessons can be learned to strengthen national efforts in many countries, including our own.

It is our hope that this report will help ensure that AIDS in Black America receives the attention it deserves.

Dr. Helene D. Gayle
President and Chief Executive Officer
CARE

The Honorable Barbara Lee
Member, U.S. House of Representatives
9th Congressional District, California



If Black America was a country, its economy would be almost as large as that of South Africa.

EXECUTIVE SUMMARY

Black America and the Global Epidemic

Although there are more Black Americans infected with HIV than the total HIV populations in seven of the 15 President's Emergency Plan for AIDS Relief focus countries,[1] the U.S. government's response to what is perhaps the most serious health crisis facing Black America remains timid and lethargic. Ironically, were Black America a country on its own—with its current health, social and economic indicators, and with the same severe HIV epidemic it is presently experiencing—it would undoubtedly elicit major concern and extensive assistance from the U.S. government.

This new report by the Black AIDS Institute suggests that American policy-makers behave as if AIDS exists "elsewhere"—as if the AIDS problem in the U.S. has effectively been solved. This false dichotomy between the global and domestic epidemics not only blinds decision-makers to the serious epidemic in Black America, but leads the federal government to pursue an approach to AIDS in Black America that is strikingly at odds with its successful PEPFAR initiative.

While the U.S. government insists that all countries that receive PEPFAR support have in place a national strategy to tackle the AIDS epidemic, America has no strategy for its own epidemic. The U.S. government has dramatically scaled up funding for foreign AIDS assistance as the global epidemic has expanded, while cutting spending in real terms for domestic HIV prevention and care initiatives as HIV caseloads in Black America have sharply increased.

This report urges immediate action to address the growing AIDS crisis in Black America. It urges that America be held accountable for its failure to respond effectively to its own epidemic. And it urges that the U.S. government bring to bear all proven strategies—including those learned from experience in developing countries—that can help reduce the epidemic's burden on Black America.

What If Black America Was Its Own Country?

Standing on its own, Black America would constitute the world's 35th most populous country and its 28th largest economy. Yet although Blacks in the U.S. reside in the most economically powerful country on Earth, they do not benefit equally from the fruits of America's affluence. Black America would rank 105th among the world's countries in life expectancy and 88th in infant mortality; Blacks in the U.S. have a lower life expectancy than Algeria or the Dominican Republic, and the infant mortality rate in Black America is twice that of Cuba's. More than one-fifth of Black Americans lack health coverage, and nearly one in four live in poverty—patterns that differentiate Blacks in the U.S. from all other high-income countries. On every major health, social and economic indicator, Blacks in the U.S. score significantly more poorly than whites.

A free-standing Black America would rank 16th in the world in the number of people living with HIV. Outside of sub-Saharan Africa, only four countries—and only two in the Western Hemisphere—have adult HIV prevalence as high as the conservative estimate (2% among adults) for Black America. In the locales where HIV among Black Americans is heavily concentrated—such as Detroit, Newark, New York, Washington, D.C. and the Deep South—infection levels among Blacks approach those reported in the most heavily affected countries in Africa. For example, HIV prevalence among middle-aged Black men in the Manhattan borough of New York City is almost as high as overall prevalence in South Africa, which has the world's largest population of people living with HIV. Representing about one in eight Americans, Blacks account for one in every two people living with HIV in the U.S., and notwithstanding extraordinary improvements in HIV treatment, AIDS remains the leading cause of death among Black women between 25-34 years of age and the second leading cause of death in Black men between 35-44 years of age.

Black America and the Global AIDS Epidemic: Common Threads

In reality, no gulf separates Black America from the rest of the world in its experience of the AIDS epidemic. On the contrary, were policy-makers open to the many commonalities between the domestic and global epidemics, important lessons could be drawn that would strengthen the AIDS response in the U.S. and abroad.

Using the Proper Public Health Paradigm

With a relatively low overall HIV prevalence, the federal government has almost exclusively applied the prevention paradigm recommended for concentrated epidemics, focusing overwhelming attention on so-called "high-risk" groups. Yet as in many other countries throughout the world, AIDS in Black America is a generalized epidemic, with significant transmission beyond vulnerable populations, especially among heterosexuals. To effectively respond to the generalized epidemic in Black America, the U.S. must use more generalized approaches, supplementing targeted programs for high-risk populations with broader-based initiatives that mobilize entire communities and protect individuals whose low levels of risk behavior nevertheless place them at risk of HIV infection. In particular, effective strategies are urgently needed to address the role of concurrent partnerships in the

rapid spread of HIV transmission in social networks in both Black America and sub-Saharan Africa.

Addressing the Epidemic's Gender Dimensions

As in other parts of the world, many Black women in the U.S. are rendered vulnerable to HIV as a result of gender inequality. Fearing violence from their male partners, Black women are often unable to insist on abstinence or the use of condoms. Few proven interventions exist to promote more-equitable gender norms or to influence male behavior, underscoring a programmatic and research priority both in Black America and throughout the world. Development of female-initiated prevention methods is also a critical priority in all regions.

Protecting Young People from Infection

In both Black America and other parts of the world, young people are often at highest risk of infection. Young people share key elements of vulnerability—inadequate knowledge of HIV infection, a high prevalence of inter-generational relationships, and a shortage of youth-tailored HIV prevention programs.

Preventing HIV Transmission among Men Who Have Sex with Men

In all regions, men who have sex with men are at extremely high risk of HIV infection. Among men who have sex with men worldwide, Blacks in the U.S. may have the highest HIV prevalence, with a rate of infection more than twice as high as among their American white counterparts. American Black men who have sex with men share important attributes with their peers in other regions, including a common fluidity of sexual identity and the experience of severe stigma and discrimination that often impedes HIV prevention efforts.

Addressing Drug Use and HIV Infection

Drug use is the source of one in three new HIV infections outside sub-Saharan Africa and one of the leading modes of HIV transmission in the U.S., particularly among Blacks, who account for more than half of drug-related HIV infections in the U.S. With regard to drug use, Black America shares some of the same challenges to effective HIV prevention as other regions, including official hostility to evidence-based harm reduction strategies. American Blacks are also several times more likely to be affected by HIV in prisons, yet another parallel with international experience, as infection levels among incarcerated populations are almost uniformly much higher worldwide than in non-incarcerated populations.

Promoting Optimal Medical Outcomes among People Living with HIV

Just as Blacks living with HIV in the U.S. are significantly more likely to die than their white peers, survival in low- and middle-income countries where antiretrovirals are accessible are 28% poorer than in high-income countries. The same factors that impede favorable HIV-related outcomes in American Blacks are the same that contribute to excessive death and morbidity in developing countries—late initiation of treatment, a high prevalence of co-occurring medical conditions, and impediments to treatment adherence.

Reversing the AIDS Epidemic in Black America: An Action Agenda

No single actor or constituency can alone reverse the legacy of neglect that has contributed to the present severity of the AIDS epidemic in Black America. Rather, diverse stakeholders and communities must join together to give AIDS in Black America the attention it deserves. Linking the AIDS response in Black America to the fight against the global epidemic can buttress efforts in all regions and accelerate progress in achieving international AIDS goals.

Black Communities

Where national AIDS responses have succeeded, communities have mobilized to fight stigma, overcome prejudice and promote solidarity in the fight against the epidemic. While leading Black organizations, publications and constituencies are placing increasing priority on the fight against AIDS, they are typically doing so without the support of the U.S. government. Lacking sufficient resources, the efforts of these groups have yet to achieve maximum impact. Enhanced support for community mobilization in Black America is urgently needed.

The U.S.-Based Public and Private Sectors

Support for the scale-up of essential HIV prevention, treatment and care services in Black America should be significantly increased. In particular, increasing funding for HIV prevention efforts in Black America is a critical priority.

International Agencies

Global AIDS leaders should break the silence on AIDS in Black America. Although the U.S. government should be lauded for its landmark PEPFAR initiative, it should also be held accountable for its failure to address the epidemic within its borders. The fact that the U.S. is one of about 40 countries that failed to submit national AIDS progress reports to UNAIDS in 2008 is telling.

Researchers

Government and non-government funders should step forward with greater resources to fill the gaps in the evidence base for effective AIDS action. In particular, funders should prioritize research on HIV-related issues that Black America shares in common with other countries.

Notes

1. Over the last five years, the President's Emergency Plan for AIDS Relief (PEPFAR) has provided more than $3 billion annually in assistance for scaling up HIV prevention, treatment, care and support in low- and middle-income countries. PEPFAR focuses heightened assistance on 15 countries: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

A Neglected Priority in the Global AIDS Epidemic

AIDS in Black America continues to worsen, with as many as 30,000 new HIV infections among Blacks occurring each year. Yet the response of the U.S. to what is perhaps the most serious health crisis facing Black America remains remarkably timid.

This report by the Black AIDS Institute examines the sources and ramifications of America's apathy in the face of an epidemic that grows more acute with each passing year. It does so by comparing America's low-priority effort on AIDS in Black America with the U.S. government's vigor in addressing the global AIDS epidemic. By asking how the U.S. government might respond to Black America's AIDS problem were Black America a separate country of its own, useful lessons can be drawn about how the federal government can reinvigorate efforts to mitigate and control America's domestic epidemic.

In allowing the AIDS crisis in Black America to grow ever more severe, the U.S. government is failing to adhere to its own successful strategies for responding to the global AIDS epidemic. While insisting that every foreign country that receives U.S. assistance have a national AIDS strategy, the U.S. government still has no national strategy to fight its own epidemic almost three decades after AIDS first appeared. The U.S. government has dramatically scaled up funding for foreign AIDS assistance as the global epidemic has expanded, while cutting spending in real terms for essential HIV prevention and care initiatives on which Black America depends. And by pretending that its own epidemic is wholly distinct from the global AIDS epidemic, the U.S. government is ignoring reality and failing to learn critical lessons that could be applied at home and abroad.

The widespread belief that AIDS is a foe that has been vanquished in the U.S. reflects something more—the astonishing invisibility of the continuing AIDS in Black America.

The Forgotten Epidemic

Soon after the emergence of Highly Active Antiretroviral Therapy (HAART) in the mid-1990s, one of America's leading political commentators, himself HIV-positive, wrote an influential commentary in the *New York Times Magazine* heralding "the end of AIDS."[1] Ten years later, as the world marked the 25th anniversary of the AIDS epidemic, this sentiment that therapeutic advances had effectively conquered the disease in the United States had become accepted wisdom in many circles. As one HIV clinician put it, "[O]nce treatment was available, the challenge seemed to be elsewhere."[2]

Over the last 10-12 years, America's opinion leaders, policy-makers and news media have come to believe that the AIDS challenge is indeed "elsewhere"—that America's AIDS problem has been solved thanks to a proliferating array of effective medications. The unquestioning belief in the capacity of science to eradicate the most intractable of problems is quintessentially American. Yet the widespread belief that AIDS is a foe that has been vanquished in the U.S. reflects something more—the astonishing invisibility of the continuing AIDS crisis in Black America.

AIDS in America is a Black disease. Although Black people represent only about one in eight Americans, one in every two people living with HIV in the U.S. is Black. Despite extraordinary improvements in HIV treatment, AIDS remains the leading cause of death among Black women between 25-34 years and the second leading cause of death in Black men between 35-44 years of age.[3]

AIDS illustrates the degree to which there are "two Americas"—one white,[4] wealthy and healthy, and the other Black, poor and unhealthy. These unconscionable socioeconomic disparities are matched by the world's apathy regarding the continuing AIDS emergency in Black America. As America rightly devotes billions of dollars to address global health disparities, it tolerates growing racial differences between basic health indicators within its own borders.

In reality, HIV-related health disparities between whites and Blacks have actually widened as medical advances have made HIV treatable. More than a decade since the emergence of HAART, HIV-positive Blacks in New York City have an age-adjusted death rate that is 2.5 times higher than white New Yorkers living with HIV. Meanwhile, Blacks are eight times more likely than whites to become newly infected with HIV.

This report argues that the prevailing understanding of two epidemics—one global, another domestic—presents a false dichotomy. AIDS today is better understood as a global problem divided along color lines—one white, the other Black.

In fact, the epidemic in Black America is an important part of the global epidemic and merits a commensurate political response and financial commitment. Many of the challenges confronting the global AIDS response are the same that impede more effective HIV prevention and treatment in Black America. Moreover, America's failure to respond to its own epidemic among its Black citizens undermines its credibility in addressing the AIDS epidemic in Africa and across the African diaspora. By developing and implementing more effective AIDS-fighting strategies in Black America, we can learn important lessons that will benefit countries and communities worldwide. And by recognizing Black America's place in the

world as a whole, the U.S. can similarly gain insights into how to improve the response to AIDS among Black people in America. In particular, lessons learned in countries that are addressing generalized epidemics may have particular applicability in combating AIDS in Black America.

With sufficient financing, political leadership and community engagement, dramatic progress can be achieved against AIDS in Black America. A strong foundation exists on which to build a more robust AIDS response, thanks to the presence of a vibrant civil society infrastructure in the Black community. Civil rights organizations, churches, Black elected officials, the media and other community institutions and thought leaders have a potentially vital role to play in fighting AIDS in Black America, but efforts to mobilize them have been critically underresourced.

For the U.S. to be a global AIDS leader, it must put its own house in order. AIDS in Black America must be tackled with the same zeal currently being mobilized to such extraordinary effect in scaling up AIDS responses in other regions. This report aims to advance progress toward this goal.

The United States of Black America: A Profile

With nearly 39 million people[5], Black America would be the 35th most populous country in the world if it stood on its own.[6] Based on income earned in 2006, Black America would rank as the 28th largest economy in the world.[7] Black America boasts almost 45,000 physicians and surgeons, 80,000 post-secondary teachers, nearly 50,000 lawyers, and more than 52,000 chief executives.[8]

Yet although Blacks in the U.S. reside in the most economically powerful country on Earth, they do not benefit equally from the fruits of America's affluence. And with respect to HIV, Black America looks more like many developing countries than like the high-income North in which it is geographically located.

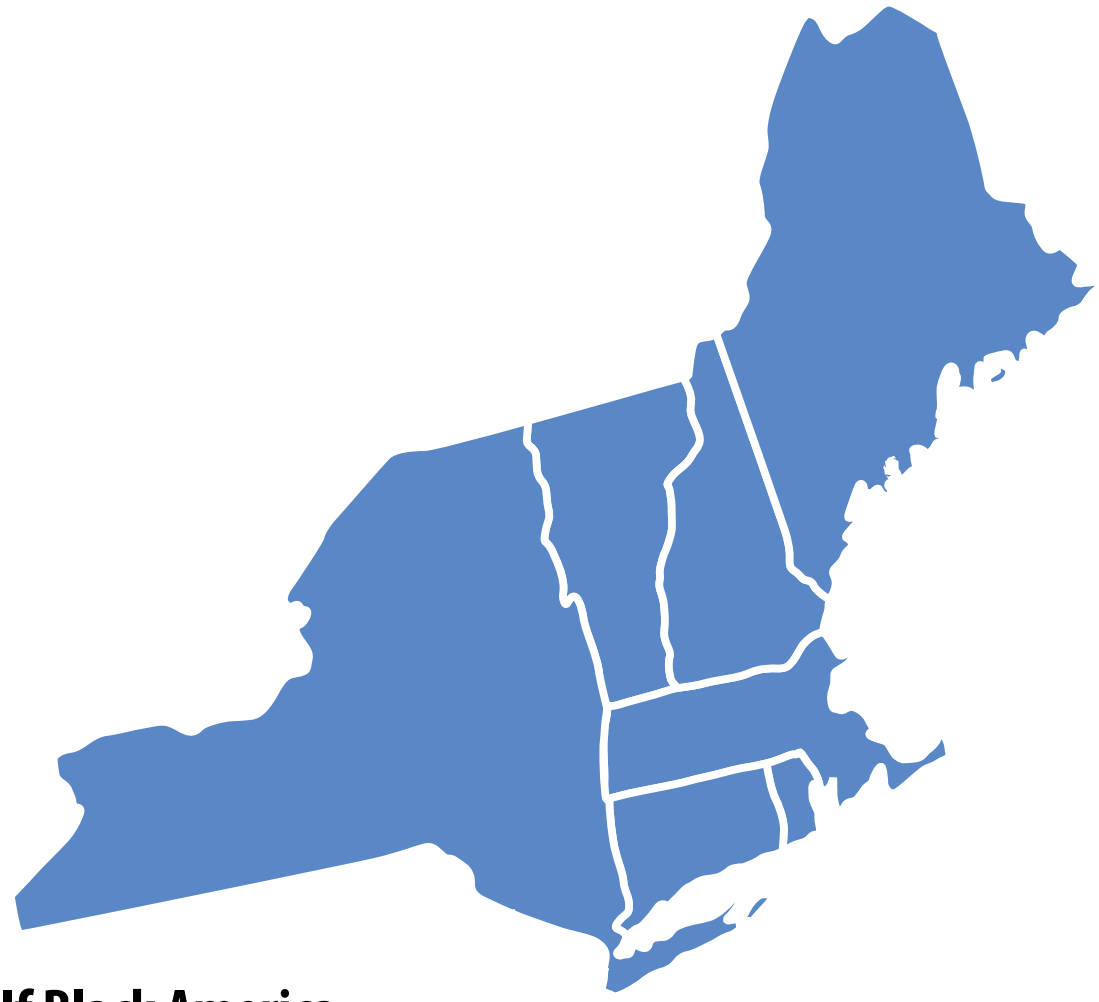
Two Americas: The Economic and Social Reality of Black America

Key indicators definitively demonstrate the existence of "two Americas," divided by race, wealth and vulnerability to disease. Moreover, these indicators reveal that Black America fares poorly in comparison with other countries, possessing an economic, social and health profile that more nearly resembles populations in many developing countries.

Life Expectancy

Black America would rank 105th among countries[9] in life expectancy (73.1) years.[10] Life expectancy for U.S. Blacks in 2004 was 5.2 years lower than for whites.[11] Black Americans' life expectancy is lower than

With respect to HIV, Black America looks more like many developing countries than like the high-income North in which it is geographically located.

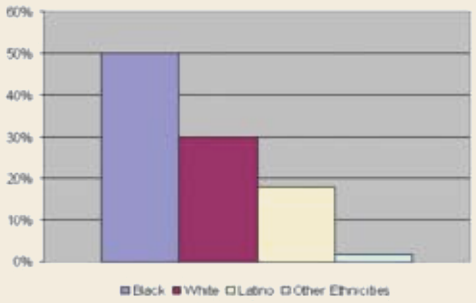


If Black America were a country, it would have about the same population as New York, Massachuetts, Connecticut, Rhode Island, New Hampshire, Vermont and Maine combined.

New Diagnoses

Racial/Ethnic Percentages of New HIV/AIDS Diagnoses in 2006

Black: 49 percent
White: 30 percent
Latino: 18 percent
Other Ethnicities: 2 percent



Source: CDC. HIV/AIDS by Race/Ethnicity slide set, slide 12. Accessed online at www.cdc.gov/hiv/topics/surveillance/resources/slides/race-ethnicity/slides/race-ethnicity_12.pdf on June 10, 2008. Data includes 33 states with long-term name-based HIV tracking systems.

in Algeria, Dominican Republic and Sri Lanka.[12]

Health Coverage

More than one in five (21%) Blacks lacked health insurance in 2006, compared to 10.8% of whites.[13] Blacks' rate of health coverage compares poorly to rates in other high-income countries, all of which but the U.S. ensure universal health coverage.

Infant Mortality

The infant mortality rate in Black America (13.6 per 100,000 live births[14])— twice as high as the rate in Cuba and markedly higher than rates reported in Belarus, Bosnia and Herzegovina, Estonia and Russia[15] — would rank it 88th among countries.[16] The infant mortality rate among infants born to Black women in America is 2.5 times higher than for white newborns.[17]

Income

Median income in 2006 in Black households was 61% of median incomes for whites.[18] One in four Blacks (24.3%) lived in poverty in 2006—a rate three times higher than for whites[19]—and a rate substantially higher than in any of the 27 countries in the European Union.[20]

Unemployment

The unemployment rate for Blacks in April 2008 (8.6%) was nearly twice that of whites (4.4%).[21] In 2007, 105 countries had an unemployment rate lower than the rate reported in April 2008 for Black America. The unemployment rate in Black America is higher than in Laos, Myanmar, the Philippines, Russia and Tajikistan.[22]

Prison Population

The 872,000 of its people who were in prisons or jails in 2005[23] would rank Black America ahead of all but three countries (e.g., U.S., China, Russia).[24] With a total population comparable to Black America, Poland (2008 est. pop. 38.5 million[25]) imprisons only one-tenth the number of Blacks who are incarcerated in the U.S.[26] Blacks are nearly seven times more likely than whites to be in prison or jail.[27] Although the U.S. has the highest population-based rate of inmates of any country in the world[28], the number of Black male inmates per 100,000 population is more than *six times higher* than the U.S. average.[29]

Two Americas: HIV and Black America

Similarly, with respect to HIV, Black America is more comparable to many low- and middle-income countries than to whites in the U.S.

Even when AIDS was widely regarded by the news media and the general public as an epidemic of white gay men in the 1980s, the disease was affecting Black people in numbers substantially greater than their share of the U.S. population. Between 1981 and December 1983, at a time when Blacks made up 12% of the U.S. population, they accounted for 26% of the nation's first 3,000 AIDS cases.[30]

The epidemic's burden on Black America has dramatically worsened in the intervening 25 years. The imbalance in AIDS case rates for Blacks, as compared to whites, more than doubled between 1991[31] and 2006.[32] The CDC now estimates that more than 500,000 Blacks are living with HIV/AIDS, and it is believed that between 20,000 and 30,000 Blacks become newly infected with HIV each year.

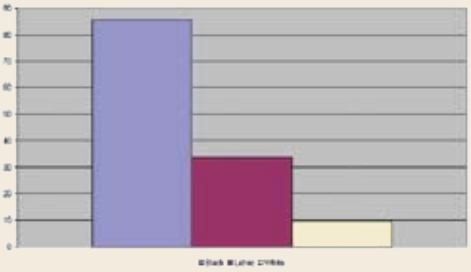
Even though there are more than six times more whites living in the U.S. than Blacks, the cumulative number of AIDS deaths among Blacks (218,000) nearly equals the number of whites who have died of AIDS (239,529).[33] In 2006, nearly twice as many Blacks (7,426) died of AIDS as whites (3,860).

A free-standing Black America would rank 16th in the world in the number of people living with HIV. The number of Black people in America living with HIV exceeds the HIV population in some of the world's most heavily affected countries, including

Infection Rates

Estimated Rate of HIV/AIDS Infection Per 100,000 Adults by Race/Ethnicity in 2006

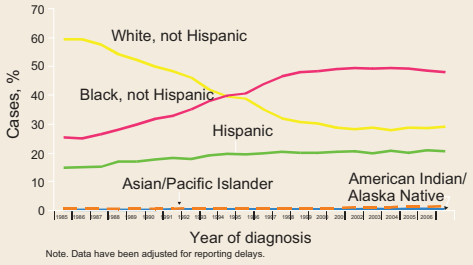
Black: 85.6
Latino: 33.7
White: 9.6



Source: CDC. HIV/AIDS Surveillance Report, 2006. Vol. 18, Table 5b. Data includes 33 states with long-term name-based HIV tracking systems.

America's Two Epidemics

Proportions of AIDS Cases among Adults and Adolescents, by Race/Ethnicity and Year of Diagnosis 1985-2006—United States and Dependent Areas



Source: CDC. HIV/AIDS Surveillance by Race/Ethnicity slide set, slide 2. Accessed online at www.cdc.gov/hiv/topics/surveillance/resources/slides/race-ethnicity/slides/race-ethnicity_2.pdf on June 10, 2008.

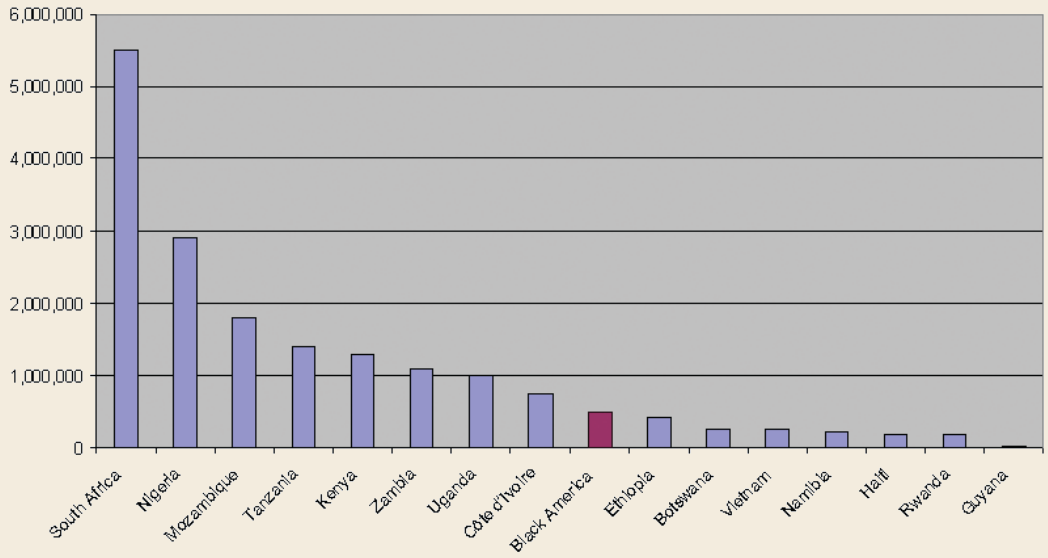
Botswana, Côte d'Ivoire, Lesotho, Swaziland and Ukraine. The number of Black Americans living with HIV is greater than the HIV population of seven of the 15 PEPFAR focus countries. Outside sub-Saharan Africa, only four countries have HIV prevalence higher than the conservative 2% estimate for Black America. In the Western Hemisphere, only two countries—the U.S. and Brazil—have a larger number of people living with HIV

Here and There

The Bush administration has been lauded for its investment in global AIDS. In 2003, President Bush launched his President's Emergency Plan for AIDS Relief, which directs heightened aid to HIV programs in 15 hard-hit countries. If Black America were its own country, it would have a larger HIV-positive population than seven of those selected for aid.

HIV Population of Countries Receiving Emergency U.S. Aid, by Rank

South Africa: 5,500,000
Nigeria: 2,900,000
Mozambique: 1,800,000
Tanzania: 1,400,000
Kenya: 1,300,000
Zambia: 1,100,000
Uganda: 1,000,000
Côte d'Ivoire: 750,000
Black America: 500,000-600,000
Ethiopia: 420,000-1,300,000
Botswana: 270,000
Vietnam: 260,000
Namibia: 230,000
Haiti: 190,000
Rwanda: 190,000
Guyana: 12,000



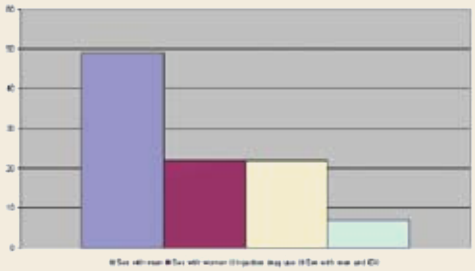
Source: Pepfar.gov, 2008 Country Profiles

How Black Men Get Infected

The largest risk factor for Black men, by far, is still unprotected sex with other men.

Transmission Routes of Black Men Living with HIV as of 2006

Sex with men: 49 percent
Sex with women: 22 percent
Injection drug use: 22 percent
Sex with men and IDU: 7 percent



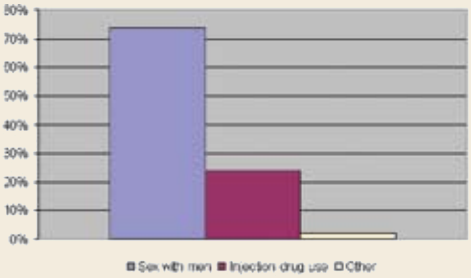
Source: CDC. HIV/AIDS Surveillance Report, 2006. Vol. 18, Table 9.

How Black Women Get Infected

The overwhelming risk for Black women is unprotected sex with men. A striking thing about our knowledge of Black women's risks, however, is how much we don't know. The vast majority of women infected through sex with men in 2006 could not identify their male partner's risk factor.

Transmission Routes of Black Women Living with HIV/AIDS in 2006

Sex with men: 75 percent
Injection drug use: 23 percent
Other: 2 percent



Source CDC. HIV/AIDS Surveillance Report, 2006. Vol. 18, Table 9.

than Black America on its own.[34] HIV infection levels are especially high (3.6%) among Blacks aged 40-49, with males in this age band having an HIV prevalence (4.5%)[35] approaching the region-wide prevalence in sub-Saharan Africa (5.0%).[36]

Although these national statistics are sufficiently dire on their own, they fail to fully convey the epidemic's extraordinary impact in the cities and states where Blacks have been most heavily affected:

■ Blacks comprise 26% of the population of Alabama but represented 69% of all new HIV/AIDS case reports in 2006.[37]In Detroit, reported HIV prevalence is 5% or greater in nine zip codes. Based on experience in high-prevalence countries, leading epidemiologists consider 5% prevalence to be the threshold at which epidemics often spin out of control. In these nine zip codes in Detroit, levels of HIV infection are higher than national HIV prevalence in Kenya, one of the world's most heavily affected countries.[38] Citywide prevalence of reported HIV/

AIDS cases is 3%[39] – higher than in Rwanda (2.8%)[40]—and Blacks account for 89% of all cases.[41]

■ More than 2.2% of Blacks in Essex County, New Jersey (Newark) have been diagnosed with HIV or AIDS, with actual prevalence (including undiagnosed cases) presumably much higher.[42] Blacks account for 42% of the population in Essex County[43] but make up more than 79% of people living with HIV/AIDS. The prevalence of diagnosed HIV infection in Newark is higher than overall prevalence (both diagnosed and undiagnosed cases) in Ethiopia, one of 15 high-prevalence countries targeted for support by the U.S. government's President's Emergency Plan for AIDS Relief (PEPFAR).

■ In Georgia, Blacks make up 30% of the population[44] but account for 70% of all people living with AIDS as of December 2006.[45]

■ In Jackson, Mississippi, 84% of people living with AIDS are Black.[46]

■ In New York City, an estimated 3.3% of Blacks are HIV-infected—a rate higher than Nigeria's (3.1%).[47] In the city's Manhattan borough, one in six (17%) middle-aged Black men (aged 40-54) is HIV-infected—a level of infection that approaches national HIV prevalence in South Africa (18%), the country with the largest number of people living with HIV.[48]

■ In 2007, 62% of HIV diagnoses in North Carolina were among Blacks,[49] who make up less than 22% of the state's population.[50]

■ In Washington, D.C., where more than 80% of HIV cases are among Blacks, estimated HIV prevalence in the city is 5%[51]—a rate that approaches the levels of infection documented in Uganda (5.4%).[52] Ironically, HIV prevalence in the capital city of the world's most powerful country exceeds HIV prevalence in Port-au-Prince, capital of the poorest country in the Western Hemisphere.[53]

Prison Nations

A free-standing Black America would have more people behind bars than all but three countries. That's a theoretical comparison with real-world implications: A host of studies have found that high incarceration rates in actual America are helping to fuel the Black epidemic.

These sobering statistics reflect a profound failure on the part of the world's most powerful country to protect its own citizens, while demonstrating shocking similarities between Black America's AIDS epidemic and the epidemic in some of the world's most impoverished nations. Yet even against this backdrop, it is clear that opportunities exist to strengthen the AIDS response in Black America. In recent years, AIDS awareness has significantly improved among Black Americans, and strong grassroots support is evident for a more vigorous fight against the epidemic. In a 2006 survey, Black Americans, alone among racial and ethnic groups in the U.S., ranked HIV/AIDS as the single most urgent health problem.[54] Eighty percent of Black Americans believe the federal government spends too little to fight AIDS in the U.S., compared to just over half (52%) of the general public. More Blacks (56%) believe the U.S. is losing ground on AIDS than making progress (32%).[55]

The extensive civil society infrastructure in Black America is also giving greater priority to AIDS issues. The Congressional Black Caucus spearheaded creation of the Minority AIDS Initiative, which seeks to close gaps in the HIV prevention and treatment continuum in hard-hit minority communities. At the 2006 International AIDS Conference, 25

leaders representing many of Black America's leading institutions joined together to launch a national call to action and declaration of commitment to reverse HIV infection among Blacks by 2011; these leaders also called on Congress to repeal the longstanding ban on federal funding for needle and syringe exchange. Many of these organizations have already developed their own strategic action plans to make good on these commitments.

Increased awareness of HIV among Blacks appears to be encouraging more widespread knowledge of HIV serostatus. Two-thirds of Blacks report having ever been tested for HIV, compared to 45% for whites.[56] Experience also teaches that favorable behavior change can curb the spread of HIV in Black communities; HIV/AIDS rates in Florida, for example, decreased fastest among Blacks between 1999-2004, and CDC concluded that this drop reflects the beneficial effects of widespread changes in sexual behavior.[57]

These and other favorable signs are the building blocks on which to establish the kind of high-level response that the AIDS crisis in Black America deserves. However, so long as the media, the American public and key decision-makers continue to view domestic AIDS issues as a secondary concern, the epidemic in Black America will never be attacked with the requisite degree of urgency and commitment.

Given these sobering facts, were Black America its own country, it would undoubtedly elicit a high level of concern from the U.S. government and would qualify as a PEPFAR country. In the real world, however, the U.S. has lost interest in the AIDS crisis in Black America.

Black America: A Neglected Dimension of the Global AIDS Epidemic

In 2000, the global community committed through the Millennium Development Goals to halt and begin to reverse the global AIDS epidemic by 2015. With the rate of new HIV infections in the U.S. roughly 50% higher than previously believed[58]—and with Black Americans experiencing a risk of infection several times higher than other groups—it is clear that progress in reducing the epidemic's toll in Black America will advance achievement of the worldwide Millennium Development Goals. A new approach to the AIDS emergency in Black America—one that recognizes the links between the U.S. AIDS response and efforts to address the global epidemic—is urgently needed.

In reality, what we refer to as the "global epidemic" is a collection of a nearly infinite number of individual epidemics in specific countries, districts, communities and populations. Each of these epidemics is unique. However, there are important parallels between the epidemic in Black America and the AIDS challenge in many other parts of the world. Lessons learned in fighting AIDS in Black America can help inform AIDS strategies in low- and middle-income countries, and disease control efforts in the U.S. could similarly benefit from insights gained in other countries.

A Generalized Epidemic in Black America

AIDS policy in the U.S. continues to rely on a paradigm that has limited relevance to the AIDS challenge in Black America. Specifically, the U.S. relies on an approach that is recommended for less-severe epidemics, while in fact AIDS in Black America belongs to the most serious class of AIDS epidemics.

UNAIDS categorizes national epidemics according to overall HIV prevalence and to the vulnerability of specific populations. There are three primary types of epidemic:

- In *low-level* epidemics, HIV prevalence remains low both in the general population and in the groups that are most vulnerable to HIV (e.g., men who have sex with men, injection drug users, and sex workers).
- In *concentrated* epidemics, low overall prevalence occurs alongside elevated HIV infection levels (i.e., 5% or higher) in vulnerable groups.
- Epidemics are said to be *generalized* when adult HIV prevalence exceeds 1% and when one or more populations has HIV infection levels of 5% or greater. Generalized epidemics are typified by substantial heterosexual transmission and significant numbers of HIV-infected children.

While the U.S. as a whole fits the definition of a concentrated epidemic, the epidemic in Black America is generalized. HIV prevalence for Blacks exceeds 2%, and specific vulnerable groups (e.g., gay and bisexual men and drug users) have extraordinarily high levels of infection (as the subsequent discussion reveals).

Like other generalized epidemics, AIDS in Black America involves significant transmission among heterosexuals, in addition to the heavy concentration of infections in

The nearly exclusive concentration of prevention efforts in the U.S. on "risk groups" is an important reason why a broad-based community-wide mobilization has yet to occur in Black America.

The Risk Paradox

The epidemic among Africans and Black Americans shares many traits, and among them is the disconnect between risk behavior and likelihood of contracting HIV and other STIs. Both populations have high levels of HIV infection despite relatively low levels of risky sexual behavior. One reason for this disconnect is that both populations report relatively high numbers of concurrent partnerships within dense, overlapping sexual networks.

In sub-Saharan Africa…

- Young people have HIV prevalence several times higher than their peers in any other part of the world, but do not appear more likely to initiate sex at an early age or to have more sexual partners;
- The primary HIV risk factor for many African women is not their own personal behavior but rather the sexual behavior of their husbands or male sex partners.

In Black America…

- Young Blacks with low levels of risk behavior are 25 times more likely to be infected with HIV than young whites with similar behavior;
- Black "men who have sex with men" are as much as nine times more likely to be HIV-positive but are significantly less likely to use drugs or have unprotected anal intercourse.

vulnerable groups. In 2006, heterosexual intercourse was the source of 75% of prevalent HIV infections in Black women and accounted for 22% of infections in Black males.[59] In Alabama, where Blacks account for almost 70% of new HIV and AIDS diagnoses, the share of cases stemming from heterosexual exposure now approaches the percentage of infections in men who have sex with men.[60] In Washington, D.C., where 1 in 20 residents are HIV-infected, heterosexual contact is now the leading transmission mode for new HIV diagnoses.[61] In Newark, women account for 40% of all people living with HIV/AIDS.[62]

Although widespread implementation of services to prevent mother-to-child transmission has dramatically reduced HIV incidence among newborns, roughly 8,500 children who contracted HIV from their mothers have been diagnosed with full-blown AIDS in the U.S. In 2005, Blacks accounted for 65% of HIV-infected newborns.[63]

While low-level and concentrated epidemics are primarily centered in urban areas, generalized epidemics tend to involve substantial transmission in rural areas, as well. In Africa, many rural communities are being devastated by HIV.[64] Likewise, in Black America, significant numbers of HIV infections have been documented in rural, as well as urban, areas. In particular, HIV prevalence in the Mississippi Delta approaches levels seen in urban areas in the U.S., with particularly high prevalence observed among young Blacks between ages 13-24.[65] Such patterns are similar to those seen in rural districts around Lake Victoria in Kenya, where HIV prevalence is much higher than in Nairobi and other urban centers.[66]

In both Africans and U.S. Blacks, studies have demonstrated that sexual networks in rural areas can often involve extensive overlapping partnerships, rendering them highly conducive to the spread of HIV among lower-risk groups. In a study in Likoma Island, Malawi, for example, researchers found that more than one quarter of young adults were linked through multiple independent chains of sexual relationships.[67] Similarly, studies in the rural Southern U.S. have identified the presence of dense social networks among

Black heterosexuals that facilitate the rapid spread of HIV and other sexually transmitted infections.[68]

The generalized nature of AIDS in Black America has an important impact on the type of HIV prevention approach needed. In low-level and concentrated epidemics, UNAIDS recommends that HIV prevention efforts overwhelmingly emphasize services for populations most at risk, with only limited focus on the general population. This approach recognizes that countries with low-level or concentrated epidemics can protect vulnerable groups and prevent HIV from spreading into new populations by focusing on where significant HIV risk exists. By contrast, countries in which HIV has spread to the general population must couple intensive prevention services for vulnerable groups with broader-based prevention efforts in schools, the mass media, workplaces and other community settings. In short, generalized epidemics require more generalized responses in order to curb the spread of infection.[69]

Gearing its AIDS strategies to the concentrated nature of the national epidemic, the U.S. has pursued a strategy that is overwhelmingly focused on the delivery of targeted HIV prevention services for high-risk groups. Comparatively little priority has been given to efforts to alter sexual norms in the broader heterosexual population. However, in settings where HIV is generalized, controlling the epidemic requires energetic pursuit both of efforts targeting groups most at risk and measures affecting the general population.

Much has been learned in the course of the epidemic about optimal strategies for mobilizing communities to respond to HIV/AIDS.[70] However, by divorcing the domestic AIDS response from learning derived from experience in heavily affected low- and middle-income countries, America's policy-makers may be inhibiting the development of a diverse, multi-faceted community mobilization in Black America to address the AIDS threat. Blinded to potential international precedents, policy-makers in the U.S. almost instinctively look to previous experience in urban gay communities in the 1980s when thinking about community mobilization to fight AIDS, even though this unique history of gay AIDS activism has only limited relevance to the challenge confronting Black America. As in all other epidemics, intensive prevention services focused on especially vulnerable populations are essential components of an effective AIDS response in Black America, but these efforts must be supported by broader, population-wide initiatives, such as those used to such powerful effect in Uganda, where widespread changes in sexual behavior resulted in major declines in HIV prevalence and incidence.[71]

A Shared Paradox: Low Risk Behaviors and High HIV Risk

Controlled trials have validated the efficacy of dozens of program models to change sexual and drug-using behavior, yet comparatively few HIV prevention interventions have been specifically designed for Black Americans.[72] The large majority of model behavioral interventions focused on Blacks are individual or small-group programs grounded in one or more cognitive behavioral theories.[73] Yet the marginal changes in behavior for which such programs aim have somewhat limited potential in circumstances where the makeup and functioning of social groups, rather than individual behavior, are the principal factors driving the epidemic.

Both Africans and Black Americans experience extremely high rates of HIV infection even though most do not engage in high levels of sexual risk behavior. For example,

although young people sub-Saharan Africa have HIV prevalence several times higher than among young people in any other part of the world, they do not appear on average more likely to initiate sex at an early age or to have more sexual partners.[74] Similarly, numerous studies have found that the primary HIV risk factor for many African women is not their own personal behavior but rather the sexual behavior of their husbands or male sex partners.[75]

A similar paradox of high HIV risk in the context of low risk behaviors is apparent among Black Americans. In a seven-city survey of young men who have sex with men, Blacks were nine times more likely than whites to be HIV-infected even though they did not engage in higher rates of sexual behavior or drug use.[76] In comparison to whites with similar behavioral characteristics, young Blacks with low levels of risk behavior are 25 times more likely to be infected with HIV.[77]

A growing body of data suggests that concurrent partnerships within dense sexual networks play a key role in the exceptionally high levels of HIV infection in southern Africa.[78] A similar phenomenon is apparent in Black America. [79] Data from a national survey indicate that Blacks are more than 2.5 times more likely than the U.S. population as a whole to have had concurrent sexual partnerships in the previous year.[80]

Black America and sub-Saharan Africa share a common factor driving high rates of concurrent partnerships—the frequent absence of men from local communities. While in sub-Saharan Africa a typical cause of male absenteeism is migration for work, frequent incarceration is the principal cause for the absence of males in many Black communities in the U.S.[81] For example, in Washington, D.C., where an estimated three-quarters of Black males will be imprisoned at some point in their lives, there are only 60 males for every 100 females in some of the neighborhoods with the highest incarceration rates.[82] In the rural South, high incarceration rates are strongly correlated with the rapid spread of HIV infection within social networks.[83]

Programs to change individual behavior will remain a cornerstone of HIV prevention—both in Black America and in southern Africa. However, there is an urgent need to develop prevention strategies to change social norms to disfavor concurrency and to encourage safer behaviors in communities with high rates of male absenteeism. Greater investments in strategies to affect sexual networks in Black America could yield worldwide benefits.

Women, Gender Norms and HIV Vulnerability

Globally and in Black America, a disease that was once primarily one of men has involved steadily increasing numbers of women and girls. Worldwide, women account for half of all people living with HIV and for more than 60% of infections in sub-Saharan Africa.[84] While infection levels among women are lower in the U.S. than in Africa, the HIV/AIDS burden among American women has also substantially grown over the years, with especially severe effects in Black America. While women accounted for only 13% of AIDS diagnoses in 1991[85], women made up 27% of new AIDS diagnoses in the U.S. in 2006.[86] In the 33 states with mature HIV reporting systems, Black women represented 65% of new HIV/AIDS diagnoses among women in 2006.[87] In the U.S., Black women are 23 times more likely to be diagnosed with AIDS than white women.[88]

Male dominance, reinforced by societal gender norms, reduces women's ability to protect themselves from infection. According to a recent study in Botswana, individuals with discriminatory gender beliefs (such as

the belief that extra-marital sex is less permissible for women than for men) are nearly three times more likely than those without such beliefs to have unprotected sex with a non-marital partner in the previous year.[89] In the U.S., computer-assisted interviews with 713 Black women between ages 15-21 found that many young women at high risk of infection experience male-dominated power imbalances that make it difficult for them to negotiate condom use.[90]

Anywhere from a third to one-half of

Surrendering at Home

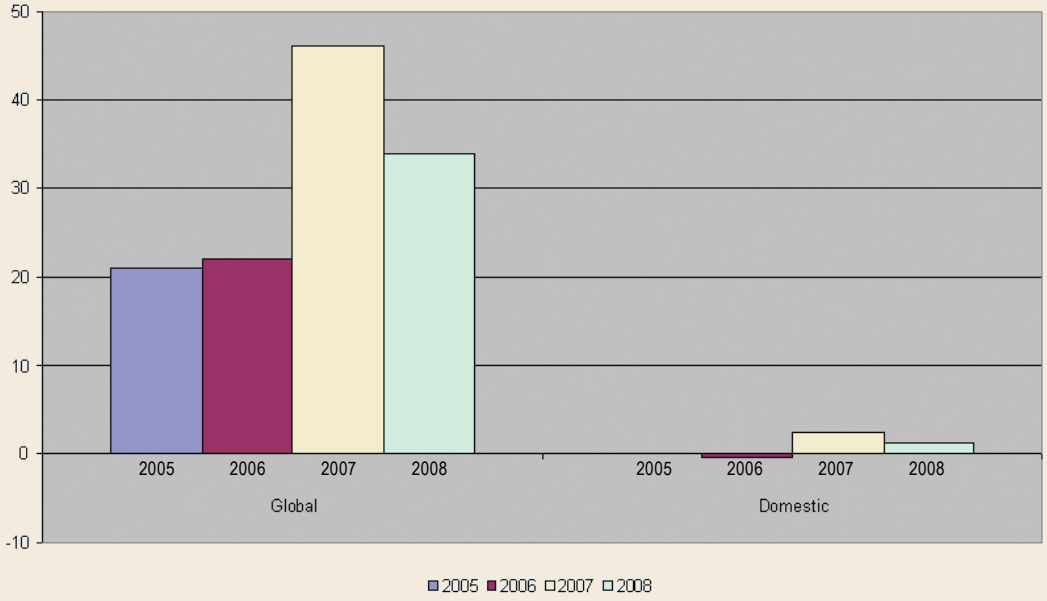
Over the last five years, the White House and Congress have increased spending on HIV prevention, treatment and support programs for low-income countries dramatically – at the same time that domestic spending has remained all but flat. Domestic spending remains by far the largest share of the U.S. AIDS budget, but primarily in the form of mandatory expenditures on Medicaid, Medicare and Social Security, which account for roughly half of overall U.S. HIV/AIDS spending. Congress must pay a fixed share of the expenses for these programs, regardless of how high the cost grows. The graph below compares global spending with discretionary domestic spending, or the budget Congress and the White House decide upon each year for all prevention programs and treatment and support programs for the uninsured.

Year-to-Year Change in U.S. HIV/AIDS Spending, Fiscal Years 2004 to 2008

Year	Global change*	Domestic discretionary change**
2005	+21%	+ 0%
2006	+22%	–0.4%
2007	+46%	+2.5%
2008	+34%	+1.2%

*Does not include international research
**Does not include mandatory spending such as Medicaid, Medicare and Social Security

Source: Kaiser Family Foundation. U.S. Federal Funding for HIV/AIDS fact sheets for fiscal years 2004-2008.



Black women report having been sexually abused, with higher levels reported for HIV-positive women.[91] Likewise, according to surveys in Bangladesh, Ethiopia, Peru, Samoa, Thailand and the United Republic of Tanzania, 40% to 60% of women said they had been physically and/or sexually abused by their intimate partners.[92] Studies in various African countries suggest that the risk of HIV infection is up to three times higher among women who have experienced gender-based violence compared to those who have not.[93]

The role of gender dynamics in elevating women's risk of infection has highlighted the need to improve prevention strategies aimed at altering male sexual behavior.[94] Yet few evaluated prevention strategies have specifically aimed to change the sexual behavior of heterosexual men.

Similarly, the evidence base on strategies to generate healthier gender norms remains limited.[95] Studies on interventions to empower Black women and to alter male attitudes and behaviors could not only benefit the response to AIDS in the U.S., but also inform more effective approaches in developing countries.

The enduring effects of women's disempowerment also underscore the need for prevention methods that women can initiate on their own, such as vaginal microbicides, pre-exposure chemoprophylaxis, or women-controlled barrier methods. Such prevention tools are needed to address women's limited capacity to insist on abstinence, monogamy or condom use by their male partners. Here, too, additional research is warranted both in the U.S. and in other regions.

Gender Bias Kills

Both globally and among Black women, male dominance, reinforced by societal gender norms, reduces women's ability to protect themselves from infection. Yet, the evidence base on strategies to generate healthier gender norms remains limited. Studies on interventions to empower Black women and to alter male attitudes and behaviors could not only benefit the response to AIDS in the U.S., but also inform more effective approaches in developing countries.

- In Botswana, a recent study found individuals with discriminatory gender beliefs (e.g., extra-marital sex is less permissible for women than for men) are nearly three times more likely to have unprotected sex with a non-marital partner;
- In the U.S., a study found Black women between ages 15-21 who are at high risk of infection experience male-dominated power imbalances that make it difficult for them to negotiate condom use;
- Anywhere from a third to a half of Black women report having been sexually abused, with higher levels reported for HIV-positive women;
- Studies in various African countries have found the risk of HIV infection to be as much as three times higher among women who have experienced gender-based violence compared to those who have not.

Preventing HIV among Young People

The centrality of young people to the epidemic's future reveals yet another challenge that Black America shares with other parts of the world. By investing in research to improve strategies to prevent HIV transmission among adolescent and young adults in Black America, the U.S. could also strengthen a critical component of the global AIDS response.

Globally, people under age 25 are believed to account for 45% of new infections.[96] In the U.S., roughly 5,000 young people (aged 13-24) are diagnosed each year[97], although due to low HIV testing rates in young people it is believed that these diagnosis figures significantly understate the extent of actual new HIV infections. Infections among young Americans are heavily concentrated in Black communities. In 2004, Blacks made up 70% of new HIV diagnoses among teenagers.[98] Between 2001 and 2006, the number of HIV/AIDS diagnoses among young Black men who have sex with men (ages 13-24) nearly doubled.[99]

Black teenagers are more likely than white or Hispanic adolescents to have ever had sexual intercourse and to have had four or more sexual partners. However, in 2005, Black teenagers were significantly more likely than other groups to have used a condom during their last episode of sexual intercourse and less likely to have had sex while intoxicated.[100]

HIV prevention efforts focused on young people share key challenges in Black America and in other parts of the world. For example, young American Blacks, like many young people globally, often have dangerous misconceptions about HIV, worsening AIDS stigma and potentially discouraging young people from taking necessary precautions to prevent transmission. Globally, only 40% of young males (ages 15-24) and 36% of young females had accurate, comprehensive knowledge regarding HIV—significantly below the 95% global target for 2010.[101]

Studies have long documented poor knowledge and inaccurate beliefs among Black adolescents,[102] although the above-average condom use documented among Black teenagers suggests that certain information deficits detected earlier in the epidemic may have improved, at least among Black teens who are sexually active. Recent surveys in the U.S. find that Blacks and people with lower educational levels are more likely than other Americans to harbor erroneous beliefs about how HIV is transmitted.[103] In a recent survey of residents of public housing projects in heavily Black central Harlem in New York City, one-third of individuals surveyed believed mosquitoes could transmit HIV.[104] Clearly, improved strategies are urgently needed—both in Black America and globally—to equip young people with life-saving knowledge about ways to avoid HIV exposure.

Both globally and among young Black Americans, a high prevalence of inter-generational relationships increases the risk that young people will acquire HIV infection. Surveys of Black teenagers indicate that many young Black girls enter into relationships with older men, frequently obtaining gifts or other financial support.[105] Likewise, U.S. studies involving young gay and bisexual men (aged 23-29) have found that higher infection risk among Blacks is associated with having older partners than white peers.[106]

A similar phenomenon has been observed in sub-Saharan Africa, leading to particularly detrimental effects on girls and young women. Three out of four unmarried, sexually experienced adolescent girls in Uganda say they have received gifts or money in exchange for sex, usually from an older man.[107] Adolescent girls in Africa are two to four and a half times more likely than adolescent boys to be infected with HIV,[108] in large part as a result of the tendency of girls in the region to have sex with older men.[109]

Few prevention initiatives have specifically sought to change social norms on inter-generational sex, and little evidence is available on successful strategies in this regard.[110] As in many other areas, research on prevention strategies to benefit Black youth would have potential relevance in other countries, as well.

Heightened Risk among Men Who Have Sex with Men

In all regions, "men who have sex with men"—the public health term for homosexual and bisexual men—experience high rates of HIV infection. Much more so than white men in the U.S., Black gay and bisexual men share many behavioral and cultural characteristics with their peers in other regions, underscoring the potential worldwide benefits of enhanced research and programmatic investments in Black MSM communities.

An estimated one in three men who have sex with men in Latin America is living with HIV,[111] and a recent survey indicates that 28% of such men in Bangkok are also HIV-infected.[112] Emerging evidence also finds that men who have sex with men are at especially high risk in sub-Saharan Africa, with HIV prevalence as high as 43% documented among homosexually active men in Mombasa, Kenya.[113]

In the U.S., gay and bisexual men represent the largest single share of HIV/AIDS diagnoses by exposure group, and Blacks are at significantly greater risk of infection than other racial or ethnic groups. A five-city study of urban gay and bisexual men in the U.S. found that 46% of Black men were infected—a rate more than twice as high as reported for whites (21%), and significantly higher than infection levels in Asia, Africa, Eastern Europe and Latin America.[114] In New York City's predominantly Black and Latino house ball community, Blacks were recently found to have HIV prevalence (26%) 10 times higher than among Latinos.[115]

Many gay and bisexual Black men in the U.S. exhibit attitudes and behavioral patterns that are consistent with international studies involving their peers in other regions. In a survey of HIV-infected gay and bisexual men, 34% of Black men reported also having sex with women, compared to 13% of white men.[116] In New York City, the population rate of Black men who report having sex with both men and women is four times higher than among whites.[117] These patterns are similar to those reported in other regions; in Asia, for example, surveys indicate that one in five men who have sex with men also have sex with women.[118]

Homosexually active Black men are markedly less likely to self-identify as "gay" than their peers from other racial or ethnic groups in the U.S.[119] The fluidity of sexual identification among homosexually active men is also common in many low- and middle-income countries, where development of gay community consciousness is often in a nascent stage.[120] Studies in the U.S. suggest that homosexually active men who do not identify as gay engage in behavior patterns that tend to differ from gay-identified men. Younger men who identify as gay tend to initiate sex at an earlier age and have a higher number of sex partners than non-gay-identified, young MSM.[121] A recent study among more than 4,000 MSM in New York City found that non-gay-identified MSM, who disproportionately tend to be men of color, have fewer sex partners than their gay-identified counterparts but are less likely to use condoms or be tested for HIV.[122]

The stigma associated with same-sex attraction impedes effective HIV prevention and treatment efforts for men who have sex with men both globally and among Blacks in the U.S. Qualitative studies in the U.S. consistently find that Black gay and bisexual men perceive significant stigma in their families, communities and churches, reducing their willingness to disclose their attraction to men or to seek social or spiritual support.[123] Social pressure to conform to heterosexual norms may also cause homosexually active men to seek female sexual partners, increasing the physical and emotional risks to women.

Likewise, recent reports underscore how stigma and discrimination impede effective HIV prevention efforts among men who have sex with men in many developing countries. For example, officially sanctioned discrimination against men who have sex with men, including a public campaign launched by the country's president, is reported to have driven many homosexual and bisexual men into hiding in Senegal, where they are more difficult to reach with HIV prevention services.[124] Anti-gay violence is commonplace in Jamaica, where the murder of the country's leading gay rights activist in 2004 was celebrated by demonstrators who chanted homophobic lyrics from popular songs.[125] It was also reported this year that Uganda had omitted men who have sex with men from its national HIV prevention efforts, even though other vulnerable groups are targeted and the chair of the National AIDS Commission had acknowledged that "gays are one of the drivers of HIV in Uganda."[126]

Prevention strategies that are effective in the face of stigma and social isolation are urgently needed for men who have sex with men in all regions, regardless of whether they identify as gay or bisexual. HIV prevention efforts focusing on Black homosexual and bisexual men should help inform, and benefit from, targeted HIV prevention strategies in other parts of the world.

Preventing HIV Infection among Transgender Populations

Transgender individuals face exceptionally high risk of HIV infection—both in Black America and globally. In numerous Asian countries, for example, studies have found extremely high infection rates among transgender sex workers.[127]

In the U.S., seroprevalence data from anonymous testing sites in San Francisco have documented HIV prevalence as high as 63% among Black transgender individuals.[128] A separate recent study in San Francisco found HIV prevalence among Black male-to-female transgenders of 42%—a level of infection nearly twice as high as reported among Latina transgenders and more than three times higher than among Asian/Pacific Islanders.[129] A recent meta-analysis found average HIV seroprevalence among male-to-female transgenders of 27% in the U.S., with Black transgender individuals having a risk of infection twice as high as other groups.[130]

In all regions, stigma and discrimination impede effective HIV prevention for the transgender population. Among more than 300 male-to-female transgender individuals surveyed in San Francisco, 32% reported experiencing daily ridicule, 37% had been victimized by violence, and 61% had been harassed by police.[131]

While the HIV prevention discourse has at times addressed issues relating to transgender individuals as a subset of homosexual and bisexual issues, transgender individuals face specific challenges and frequently have unique community networks that should be taken into account in carefully focused prevention efforts. Additional research and programmatic investments are needed for prevention programs focusing on transgender communities.

Drug Use and HIV Transmission

Injection drug use plays a key role in the continued expansion of the AIDS epidemic—both in Black America and in other regions. Persons exposed to HIV through injection drug use represent the third largest group of prevalent HIV/AIDS diagnoses in the U.S. Blacks account for more than half (53%) of HIV/AIDS diagnoses among injection drug users in 2006 in the 33 states

with mature HIV reporting systems. In these 33 states, more than 50,000 Blacks exposed to HIV through injection drug use were living with HIV in 2006.[132]

Injection drug use is the driving force in AIDS epidemics in Eastern Europe, as well as in parts of Asia and Latin America. Nearly two-thirds of HIV infections in Eastern Europe and Central Asia—and nearly half of infections in China—stem from injection drug use. [133]

Both in the U.S. and in other regions where injection drug use is a major source of HIV infection, official hostility toward evidence-based HIV prevention strategies represents a primary obstacle to sustained progress on HIV/AIDS. For two decades, the U.S. government has prohibited the use of federal funds for needle and syringe exchange projects, while effective drug substitution therapies are barred in Russia and other countries with high rates of drug use. Community opposition to harm reduction programs and harassment of drug users by law enforcement personnel are common barriers to effective HIV prevention efforts in many countries.

In the case of injection drug use, Black America has potentially useful lessons for other regions grappling with the role of drug use in national AIDS epidemics. As state and local governments and private funders have begun to fill the funding gap created by the federal ban on support for needle exchange, harm reduction programs have expanded throughout the U.S. As harm reduction coverage has improved, HIV infection rates stemming from injection drug use have sharply declined. In New York City, new infections among injection drug users fell by nearly 80% between 1990 and 2002.[134] In diverse settings across the U.S., prevention programs have developed effective strategies to alleviate community opposition to harm reduction and have partnered with law enforcement agencies to avert police practices that might discourage drug users from accessing harm reduction programs. Disproportionately represented among HIV-infected injection drug users, Blacks in the U.S. have been principal beneficiaries of these HIV prevention successes.

In countries where antiretrovirals have only recently become available, health care providers often have limited expertise in engaging HIV-infected drug users in care, ensuring continuity of care, and promoting treatment adherence. Citing widespread hostility of health care providers and other factors, civil society groups report that injection drug users in many countries do not have equal access to antiretroviral therapy.[135] Experience in the U.S. can potentially aid other countries in devising effective training and sensitization strategies to reduce stigmatizing attitudes among health care providers. Likewise, U.S. practice is potentially instructive in developing strategies to promote health care access and treatment adherence among drug users.

HIV and Prisons

HIV prevalence among inmates in federal, state and local prisons and jails is three times higher than the national average.[136] Between 20-26% of Americans living with HIV/AIDS are believed to be incarcerated at some point each year.[137]

Just as Blacks are more likely than other racial and ethnic groups to be imprisoned in the U.S., they are also more heavily affected by HIV in correctional settings. In New York State correctional facilities, for example, HIV prevalence is six times higher among Black inmates than among their white counterparts.[138]

The disparity in infection rates between the correctional and non-correctional population in the U.S. is consistent with international patterns. In virtually all countries studied, HIV prevalence is markedly higher

in prison populations than in the non-incarcerated general population.[139]

At least in the U.S., it is believed that the vast majority of HIV-positive prisoners contract HIV before they become incarcerated.[140] This stems from the fact that some of the very factors that place individuals at risk of HIV infection—i.e., illicit drug use and sex between men—also place people at higher risk of imprisonment. However, it is also clear—both in the U.S. and in other countries—that many prisoners engage in behaviors during their incarceration that can result in HIV transmission, including sexual behavior, drug use, and tattooing. As in the rest of the world,[141] U.S. prisons lag in the provision of life-saving HIV prevention services to inmates. Only two prisons and five jail systems in the U.S., collectively covering less than 1% of prisoners, currently make condoms available to inmates.[142] Although prisons in at least eight countries have begun introducing needle and syringe exchange services,[143] no correctional facility in the U.S. offers such prevention services to inmates.[144]

Even though correctional systems in the U.S. are constitutionally obligated to provide medically necessary care to incarcerated individuals, 38% of correctional care providers recently surveyed said no HIV specialist was available to see patients in the facilities where they work.[145] HIV-related death rates (per 100,000 prison inmates) were 3.5 times higher among Black inmates than among their white counterparts in 2006.[146] Globally, few prison systems provide antiretroviral treatment for HIV-infected prisoners.[147]

Policy reforms that enhance HIV prevention and treatment services in prison settings are required to promote the health of HIV-infected inmates in Black America and globally. Research, advocacy and capacity-building initiatives should focus on improving HIV services for Black prison inmates, and information and lessons gleaned from such studies should be rapidly communicated globally.

Promoting Knowledge of HIV Serostatus

People who are diagnosed late in the course of HIV infection have a much poorer prognosis than individuals whose HIV diagnosis is more timely. In New York City, individuals whose HIV and AIDS diagnoses occur within 31 days of one another are twice as likely to die within four months of

Stuck on Needles

Injection drug use plays a key role in the continued expansion of the AIDS epidemic both in Black America and in many developing world countries. And both in the U.S. and abroad, official hostility toward evidence-based HIV prevention strategies represents a primary obstacle to sustained progress.

For two decades, the U.S. government has banned federal funding for syringe exchange projects, while effective drug substitution therapies are barred in Russia and other countries with high rates of drug use. Community opposition to harm reduction programs and harassment of drug users by law enforcement personnel are also common barriers.

But Black America has useful lessons for other regions grappling with this issue. As state and local governments and private funders have filled the resource gap created by the federal funding ban on needle exchange, harm reduction programs have expanded throughout the U.S.—and infection rates stemming from injection drug use have sharply declined.

diagnosis as people with a non-concurrent AIDS diagnosis.[148] Early knowledge of HIV infection plays a key role in reducing HIV-related morbidity and mortality.

Both globally and in Black America, however, many HIV-infected individuals are diagnosed only in response to symptoms, usually several years after initial exposure to the virus. While testing rates have increased in low- and middle-income countries, most HIV-infected people worldwide are unaware of their infection.[149]

In the U.S., nearly four in 10 (38%) Blacks diagnosed with AIDS in 2006 had only learned of their positive HIV status in the previous 12 months.[150] In New York City, more than 26% of Blacks diagnosed with HIV in 2006 received an AIDS diagnosis within one month.[151] In Washington, D.C., late diagnosis among Blacks is even more apparent; in a city where 81% of new diagnoses are among Blacks, 69% of AIDS cases were diagnosed with HIV less than a year earlier.[152]

According to surveys in six U.S. cities, Black homosexual and bisexual men are eight times more likely than their white peers to be unaware of their infection.[153] Among HIV-positive Black homosexual and bisexual men who participated in a CDC-sponsored multi-city study, 67% were previously unaware of their infection.[154] In a recent study of participants (55% Black) in New York City's house ball community, 73% who tested HIV-positive had not known of their infection prior to the survey, with Blacks more likely than others to be infected.[155]

In both the U.S. and in low- and middle-income countries, the need to increase knowledge of HIV serostatus has prompted implementation of new policies and public health initiatives. In the U.S., for example, CDC's *Advancing HIV Prevention* initiative, which provides the strategic framework for current CDC-sponsored HIV prevention efforts, prioritizes testing promotion and effective linkage to care. Likewise, many developing countries, especially in southern Africa, are energetically promoting HIV testing through public awareness campaigns, door-to-door outreach, and other means.[156] In the U.S., as in many other countries, increasing use is being made of rapid testing technologies, and public health agencies are aiming to make HIV testing a routine component of medical care. Additional efforts are merited both in Black America and in other countries to document "best practices" in the promotion of HIV testing.

Addressing HIV Stigma

Black America shares yet another paradox with sub-Saharan Africa. Extensive awareness and concern about AIDS is accompanied by sometimes-serious stigmatization of the disease, which impedes efforts to translate public concern into effective action.

Just as Blacks in the U.S. display the greatest concern about AIDS of any racial or ethnic group, sub-Saharan Africa exhibits the highest levels of concern about the global epidemic. According to surveys in 47 countries conducted by the Henry J. Kaiser Family Foundation and the Pew Global Attitudes Project, Africa is the only region where national publics consistently rank AIDS as the world's greatest threat.[157]

Yet stigmatizing attitudes about AIDS and people living with HIV inhibit effective national and community responses in both Black America and sub-Saharan Africa. Surveys in the U.S. have consistently found widespread AIDS stigma among Black Americans, with several studies indicating that stigmatizing attitudes are higher among Blacks than among other racial or ethnic groups.[158] High levels of AIDS stigma have similarly been reported in Africa and other regions.[159]

Fear of contagion and prejudicial assumptions about people living with HIV are the primary sources of AIDS stigma.[160] These roots of AIDS stigma can be addressed through various public awareness programs and policy responses, although such anti-stigma measures have often not been brought to scale, and many have not been rigorously evaluated.

Alleviating AIDS stigma is vital to progress in controlling HIV/AIDS. Where HIV/AIDS is highly stigmatized, individuals are discouraged from learning their HIV serostatus, disclosing their HIV infection to others, or from seeking HIV prevention or treatment services. AIDS stigma also reduces the willingness of leaders to prioritize the AIDS response.

The Role of STI Control in HIV Prevention

Although studies have consistently determined that sexually transmitted infections significantly increase the likelihood of HIV acquisition and transmission—potentially by several orders of magnitude[161]—evidence has yet to demonstrate how best to use STI control to slow the spread of HIV in mature epidemics.[162]

In 2005, Black Americans were 18 times more likely than whites to be diagnosed with gonorrhea and five times more likely to have syphilis.[163] In 2008, CDC reported that one in two Black adolescent girls had an STI—a rate twice as high as for American teenagers as a whole.[164] Black homosexual and bisexual men have higher prevalence of lifetime and current STIs than their white counterparts.[165] As in the case of HIV infection, differences in individual behavior do not explain these wide disparities in STI prevalence.[166]

High prevalence of sexually transmitted infections has also been found in sub-Saharan Africa and other regions.[167] In some parts of Africa, up to 70% of adults are infected with herpes simplex virus type 2, which significantly increases the likelihood of HIV transmission.[168]

Although it is clear that STI prevention has a role in averting new HIV infections, studies to date of the HIV prevention potential of STI control strategies have often been disappointing. Most recently, international trials found that community-based acyclovir treatment for HSV-2 did not reduce rates of new HIV infections.[169]

Additional study is urgently needed to identify optimal strategies to mobilize STI control for HIV prevention. Like others worldwide, Black America has a critical stake in such research.

Finding Out Too Late

While testing rates have increased in low- and middle-income countries, most HIV-infected people worldwide are still unaware of their infection. The same is true for Black America, where many HIV-infected individuals are diagnosed online in response to symptoms—usually several years after initial exposure to the virus. These late diagnoses mean Black Americans share the global treatment challenge of initiating care at an advanced stage of infection.

Share of Blacks Diagnosed with AIDS within 12 Months of Testing Positive, 2006

4 in 10 (38%)

Reducing Inequities in Medical Outcomes

Although many Blacks in the U.S. are benefiting from antiretroviral therapy, medical outcomes tend to be more favorable in HIV-positive whites than among Blacks living with HIV. An analysis of medical statistics from 140 counties across the U.S. found that Black-white differences in HIV-related mortality have actually widened since advent of combination antiretroviral therapy in the mid-1990s.[170]

In New York City, Blacks living with HIV/AIDS have an age-adjusted death rate that is nearly 2.5 times higher than among HIV-positive white people.[171] HIV-positive people living in the largely Black, low-income Manhattan neighborhood of central Harlem were more than twice as likely to die in 2006 as HIV-infected residents of the affluent, predominantly white Chelsea neighborhood.[172] While 86% of Hispanics in Washington, D.C. were alive 10 years after their AIDS diagnosis, only 59% of Blacks had survived.[173]

These patterns are similar to those seen globally. Although improved treatment access is extending the lives of millions of people worldwide in all regions,[174] medical outcomes nevertheless remain poorer in low- and middle-income countries than in high-income countries such as the U.S. At both six and 12 months after initiation of antiretrovirals, survival is at least 28% lower in resource-limited settings than in high-income countries.[175]

Several factors contribute to less favorable treatment outcomes in resource-limited settings, including initiation of antiretrovirals later in the course of infection in low-income countries, greater frequency of co-occurring medical conditions (such as tuberculosis, hepatitis or malnutrition) in such settings, and sub-optimal adherence with medication regimens.[176] These same factors are also the ones that can inhibit effective treatment among Blacks in the U.S.

Late Initiation of Treatment

In addition to the large percentage of Blacks who are diagnosed late in the course of infection, many Blacks who test HIV-positive are not effectively linked to care, potentially delaying the timely initiation of therapy. For example, Blacks in New York City are nearly 60% less likely to have entered HIV primary care within three months of their HIV diagnosis.[177]

Other Health Conditions

Like many people living with HIV in other regions, HIV-positive Blacks often

Trying to Survive

HIV positive people in both Black America and in low-income countries are having a harder time beating back the virus, even once in therapy. Several factors contribute to less favorable treatment outcomes in both settings, including later initiation of antiretrovirals and greater frequency of unrelated but complicating medical problems, such as tuberculosis, malnutrition and heart disease.

- In the U.S., an analysis of medical statistics from 140 counties found that Black-white differences in HIV-related mortality have actually widened since the advent of combination antiretroviral therapy in the mid-1990s;
- Globally, studies have found that survival is at least 28% lower in resource-limited settings than in high-income countries, when measured at both six and 12 month periods after starting antiretrovirals.

suffer from other health conditions that can contribute to illness and death. Blacks represent a disproportionate share of HIV infections from injection drug use and consequently are more frequently co-infected with Hepatitis C.

Treatment Adherence

Although surveys in the U.S. and in other regions demonstrate that high levels of treatment adherence are achievable in patients with multiple health, social and economic challenges, difficulties associated with poverty and co-occurring conditions can interfere with treatment adherence. In New York City, for example, Blacks make up 62% of HIV-infected homeless people.[178]

By investing in strategies to address the factors that contribute to unequal medical outcomes in the US, funders can help learn lessons that benefit the worldwide AIDS treatment agenda.

Financial Resources

As AIDS in the U.S. transitioned from a disease primarily centered in white men—and as public interest turned from the domestic epidemic to the global AIDS crisis—financial commitment to address continuing high rates of infections among Blacks in America has lagged. Here again, the epidemic in Black America echoes shortcomings in the global response. While financing for HIV programs in low- and middle-income countries has significantly increased, the sums mobilized to date are far short of the amounts needed to achieve the international goal of halting and beginning to reverse the global AIDS epidemic by 2015.[179]

Thanks to the leadership of the Congressional Black Caucus, Congress in 1998 established the Minority AIDS Initiative, with the aim of reducing racial and ethnic disparities in HIV-related medical outcomes by creating focused prevention, treatment and care initiatives in heavily affected communities of color. In establishing the Minority AIDS Initiative, Congress recognized that broad-based AIDS programs, while vital, were failing to address the epidemic's disproportionate burden in Black America and other minority communities.[180]

During the decade in which the Minority AIDS Initiative has existed, the epidemic's toll in Black America has deepened, with up to 300,000 new HIV infections occurring in Black communities across the country. Yet funding for this essential program has failed to reflect the urgency of the crisis in Black America. Between 1999 and 2008, federal appropriations for the Minority AIDS Initiative roughly doubled, rising from $199 million to $403 million. During the same period, by contrast, U.S government funding for global AIDS programs (excluding research) rose 37-fold—from $146 million to $5.5 billion.[181] Since 2004, appropriations for the Minority AIDS Initiative have remained flat, while global AIDS spending from the U.S. government (excluding research) nearly tripled.[182]

Especially striking is the U.S. government's meager commitment to HIV prevention at a time when high infection rates continue in Black America. While international spending on AIDS by the U.S. government increased more than 14-fold between 1995 and 2004, HIV prevention spending rose by a mere 46%, or at a rate roughly comparable to the increase in the cost of living.[183] In 2008, spending on HIV prevention programs in the U.S. represents only 4% of all federal outlays for AIDS.[184]

The Absence of a National Strategic AIDS Plan in the U.S.: Another Way Black America's Fight Against AIDS is Shortchanged

The federal government's divergence in strategic approach between its international and domestic program is illuminating. For its global AIDS efforts, the federal government is guided by a strategic plan, clear benchmarks (e.g., the prevention of 7 million HIV infections by 2010), and annual progress reports to Congress. By contrast, no strategic plan exists for the AIDS response in the U.S., and no national target has been established for reducing the number of new HIV infections.[185]

When the U.S. sets out to help a country address its AIDS epidemic, one of the first things the U.S. ensures is that a national AIDS strategy is in place. In tackling its own epidemic, which has not ceased growing from year to year, the U.S. fails to follow the advice it energetically dispenses in developing countries.

America's failure to adopt a strategy to fight AIDS in the U.S. also ignores the advice of global authorities. According to UNAIDS, every country should have a national multisectoral AIDS strategy and costed action plan. To ensure achievement of global commitments to move towards universal access to HIV prevention, treatment, care and support by 2010, UNAIDS recommends that countries establish clear national targets and monitor progress. Ironically, the U.S. government is the third largest contributor to UNAIDS yet fails to heed UNAIDS guidance when it comes to America's own epidemic.

Reversing the HIV Epidemic in Black America: An Action Agenda

It is clear that the AIDS epidemic in Black America shares key features of the AIDS challenge in low- and middle-income countries. It is equally plain, given the magnitude and severity of the epidemic among Blacks, that progress in fighting AIDS in Black America will greatly contribute to advancing the global AIDS response.

No single actor or constituency can alone reverse such a legacy of neglect. Rather, diverse stakeholders and communities must join together to give AIDS in Black America the attention it deserves.

Black Communities

In developing countries where national AIDS epidemics have been reversed, strong political leadership has combined with the active and fearless engagement of diverse people from all walks of life, including religious leaders, media, celebrities and opinion leaders, business and industry, affected communities, and people living with HIV.[186] Where national AIDS responses have succeeded, communities have mobilized to fight stigma, overcome prejudice and promote solidarity in the fight against the epidemic. This was especially the case in Uganda, Thailand and Brazil, where courageous national leadership forged working partnerships with civil society to wage an effective national campaign against the epidemic.[187]

Although much has been learned about how to stimulate effective community responses and indigenous leadership on AIDS, these lessons are often not put to use in the U.S. While leading Black organizations, publications and constituencies are placing increasing priority on the fight against AIDS, they are typically doing so without the support of the U.S. government. Lacking sufficient resources, the efforts of these groups have yet to achieve maximum impact.

The U.S.-Based Public and Private Sectors

Support for the scale-up of essential HIV prevention, treatment and care services in Black America should be significantly increased. As the epidemic's burden in Black America has intensified over the last decade, targeted funding for AIDS initiatives in Black communities has stalled. Funding for the Minority HIV/AIDS Initiative has remained flat for the last three fiscal years, and President Bush has proposed a cut in the program for FY2009. Meanwhile, support for Ryan White treatment and care services, HIV prevention and substance abuse services has generally failed to keep pace with inflation.[188]

Official neglect of HIV prevention is especially striking. Under the President's FY2009 budget request, HIV prevention would account for only 4% of all HIV-related expenditures in the upcoming fiscal year.[189] Given that lifetime costs for treatment of a case of HIV infection in the U.S. now exceeds $618,000,[190] the paltry sums currently spent to support HIV prevention are unconscionable on both humanitarian and fiscal grounds.

Where national AIDS responses have succeeded, communities have mobilized to fight stigma, ovecome prejudice, and promote solidarity in the fight against the epidemic.

An Action Agenda

Urgency

We must build a new sense of urgency in Black America, so that no one accepts the idea that the presence of HIV and AIDS is inevitable.

Leadership

The AIDS story in America is mostly one of a failure to lead. Black leaders—from traditional Black ministers and civil rights leaders to hip hop artists and Hollywood celebrities—must join in a collective national call to action and declaration of commitment to end the AIDS epidemic in Black America.

Knowledge

Black America must get informed about the science and facts about AIDS. Knowledge is a powerful weapon in the war against AIDS.

Testing

Black Americans must get tested and find out their HIV status. Half of HIV positive Black people in the U.S don't know they are infected—and people who don't know they're infected are less likely to protect their partners and completely unable to receive treatment. Knowing your HIV status early can save your life.

Policy

The federal ban on funding for needle exchange programs should be lifted. Risk reduction programs should be developed and implemented in Black communities.

Comprehensive, age-appropriate, culturally competent AIDS prevention efforts—with messages inclusive of abstinence, delayed sexual activity, sexual responsibility, proper condom use and negotiated safety—that give young people the tools to protect themselves should be expanded.

Stigma

A massive effort to address the disproportionate impact this epidemic is having on Black youth, women, injecting drug users, and men who have sex with men must be embarked upon.

Mobilization

AIDS is not just a health issue. It is a human rights issue. It is an urban renewal issue. It is an economic justice issue. The fight against HIV and AIDS is actually a broader fight against an environment in which poverty; homelessness, unemployment, incarceration, marginalization, homophobia and violence exacerbate the risk Black people face daily, including their risk for HIV and AIDS. The only way to end the AIDS epidemic in Black America is to build a broad base mass mobilization.

In the final analysis, this epidemic isn't terribly complicated: When we allow politics, subjective notions of morality and profit-driven health economics to reign over public health, the most vulnerable in our society are left behind. When we make a genuine commitment to meet people where they are, with the resources they need to chart a healthy path and stay on it, we find success. When we have the courage to act we make progress; when we don't we lose ground.

Financing of HIV/AIDS activities by U.S.-based philanthropic and corporate entities increased by 8% in 2006. However, both the magnitude and share of such funding directed toward domestic AIDS programs fell in 2006. In 2006, only 9% of HIV-related contributions by the US private sector focused on domestic programs.[191]

In an era when America's reputation in the world continues to suffer, the leader-

ship of American foundations and corporations in contributing to the AIDS response serves as a potent reminder of the generosity and goodwill of the American people. It is essential that America's engagement in the global AIDS response continue and grow even further. Yet it is equally imperative that funders recognize that the epidemic in Black America is a critical component of the global epidemic.

In Black America, the U.S. is losing its own fight against AIDS. U.S. funders should do more to ensure that effective HIV prevention, treatment and care services are brought to scale here at home.

International Agencies

In the advocacy by the leading international and multilateral organizations, Black America is a forgotten component of the AIDS response. Few global AIDS leaders even acknowledge the seriousness of the epidemic in Black America or refer to it as an important element of the global AIDS crisis. Unfortunately, the U.S. government contributed to this oversight in 2008 by being one of the few countries to fail to submit a report to UNAIDS on progress in implementing the 2001 Declaration of Commitment on HIV/AIDS.[192]

Global AIDS leaders should break the silence on AIDS in Black America. In 2004, even as Thailand was hosting the International AIDS Conference in Bangkok, the United Nations Development Program issued a highly critical report on the country's failure to sustain its commitment to HIV prevention.[193] Similarly, Black America needs the leaders of the global AIDS movement to speak honestly about America's failure to address the serious epidemic within its own borders.

Researchers

Funders should prioritize research on HIV-related issues that Black America shares in common with other countries. As this report has described, Black America lacks key tools needed to ensure a successful response to AIDS. The range of validated prevention strategies for key Black populations is too limited, and proven interventions are needed to address the factors that increase HIV vulnerability and contribute to the continuing burden in Black communities. Efforts to improve treatment outcomes for HIV-positive Blacks would benefit from a stronger evidence base, including effective strategies to encourage knowledge of serostatus, promote access to care, and increase treatment adherence. Government and non-government funders should step forward with greater resources to fill the gaps in the evidence base for effective AIDS action.

The discussion above reveals that these gaps not only impede effective action to fight AIDS in Black America, but also slow progress in the global AIDS response. Funders and technical agencies should establish meaningful mechanisms for the timely sharing of information and perspectives between Black America and other countries and communities throughout the world.

Notes

1. Sullivan A, "When Plagues End," *New York Times Magazine*, 10 November 1996.

2. Verghese A, "AIDS at 25: An Epidemic of Caring," *New York Times*, 4 June 2006.

3. CDC, *National Vital Statistics Report*, 2007;56(5).

4. When referring to 'whites,' this report is referring to individuals who are white, but not Hispanic/Latino.

5. U.S. Census Bureau, Population Division, *Annual Estimates of the Population by Sex, Race, and Hispanic Origin for the United States: April 1, 2000 to July 1, 2007*, released 1 May 2008.

6. Central Intelligence Agency, *The World Factbook* (2008 estimates), accessed 13 May 2008 at www.cia.gov/library/publications/the-world-factbook/rankorder/2119rank.html.

7. Based on calculations from the U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, 2007 (U.S. Census Bureau Poverty Report), and from Central Intelligence Agency, *The World Factbook* (2007 estimates), accessed 23 May 2008 at https://www.cia.gov/library/publications/the-world-factbook/rankorder/2001rank.html

8. U.S. Census Bureau, *African Americans by the Numbers*, 2007, accessed 23 May 2008 at www.infoplease.com/spot/bhmcensus1.html.

9. Central Intelligence Agency, *The World Factbook* (2008 estimates), accessed 13 May 2008 at www/cia.gov/library/publications/the-world-factbook/rankorder/2012rank.html.

10. National Center for Health Statistics, *Health, United States, 2007*, US Department of Health and Human Services, 2007.

11. National Center for Health Statistics, 2007.

12. Central Intelligence Agency, 2008.

13. U.S. Census Bureau Poverty Report, 2007.

14. National Center for Health Statistics, *Overall Infant Mortality Rate in U.S. Largely Unchanged: Rates Among Black Women More than Twice that of White Women*, news release, 2 May 2007, accessed 9 May 2008 at www.cdc.gov/nchs/pressroom/07newsreleases/infantmortality.htm.

15. U.S. Census Bureau, International Data Base.

16. U.S. Census Bureau, International Data Base, accessed 9 May 2008 at www.infoplease.com/ipa/A0934744.html.

17. National Center for Health Statistics, 2007.

18. U.S. Census Bureau Poverty Report, 2007.

19. U.S. Census Bureau Poverty Report, 2007.

20. European Commission, Directorate-General for Employment, Social Affairs, and Equal Opportunities, *Joint Report on Social Protection and Social Inclusion*, 2007. Accessed 9 June 2008 at http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report_en.pdf.

21. Bureau of Labor Statistics, *Employment Situation Summary—April 2008*, accessed 23 May 2008 at www.bls.gov/news.release/empsit.nr0.htm.

22. Central Intelligence Agency, *The World Factbook* (2007 estimates), accessed 13 May 2008 at www.cia.gov/library/publications/the-world-factbook/rankorder/2129rank.html.

23. National Center for Health Statistics, 2007.

24. International Center for Prison Studies, *World Prison Brief*, King's College, London, 2008, accessed 16 June 2008 at www.kcl.ac.uk/depsta/law/research/icps/worldbrief/. *See* Walmsley R, Global Incarceration and Prison Trends, *Forum on Crime and Society* 3:65-78.

25. Central Intelligence Agency, *The World Factbook* (2008 estimate), Poland, accessed 16 June 2008 at https://www.cia.gov/library/publications/the-world-factbook/geos/pl.html.

26. *See* Hartney C, *US Rates of Incarceration: A Global Perspective*, Fact Sheet, National Council on Crime and Delinquency, 2006.

27. National Center for Health Statistics, 2007.

28. Liptak A, U.S. prison population dwarfs that of other nations, *International Herald Tribune,* 23 April 2008.

29. *See* National Center for Health Statistics, 2007.

30. CDC, Update: Acquired Imunodeficiency Syndrome (AIDS)—United States, *MMWR* 1984;32:688-691.

31. CDC, Update: Acquired Immunodeficiency Syndrome—United States, 1991, *MMWR* 41:63-468.

32. CDC, *HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2006*, Vol. 18, 2008.

33. CDC, *2006 HIV/AIDS Surveillance Report*, 2008.

34. *See* UNAIDS, 2008.

35. McQuillan GM et al., Prevalence of HIV in the US Household Population: The National Health and Nutrition Examination Surveys, 1988 to 2002.

36. UNAIDS, *Report on the global AIDS epidemic*, 2008.

37. Alabama Department of Health, *HIV and AIDS Cases by Demographic Group and Exposure Category,* 2008, accessed 20 May 2008 at www.aidsalabama.org/HIVandAIDSFirstQuarter2007Demo.pdf.

38. UNAIDS, 2008.

39. Michigan Department of Community Health, *Quarterly HIV/AIDS Analysis: Detroit*, January 2008.

40. UNAIDS, 2008.

41. Michigan Department of Community Health, January 2008.

42. Newark EMA HIV Health Services Planning Council, *2005 Needs Assessment*, 2005.

43. U.S. Census Bureau, *State & County QuickFacts—Essex County*, 2006 estimates, accessed 20 May 2008 at http://quickfacts.census.gov/qfd/states/34/34013.html.

44. U.S. Census Bureau, *2006 American Community Survey, Data Profile Highlights—Georgia*, accessed 18 May 2008 at http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&_state=04000US13&_lang=en&_sse=on.

45. Henry J. Kaiser Family Foundation, *Georgia: Distribution of Persons Estimated to be Living with AIDS, by Race/Ethnicity, at the End of 2006*, accessed 18 May 2008 at http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&_state=04000US13&_lang=en&_sse=on.

46. Henry J. Kaiser Family Foundation, *An Overview of HIV/AIDS in Black America*, 2007, accessed 15 June 2008 at www.kff.org/hivaids/upload/7660.pdf.

47. Nguyen T, Population-Based Prevalence Estimates of Diagnosed and Undiagnosed HIV and Associated Risk Behaviors among New York City Adults—2004, New York City Department of Health and Mental Hygiene, 2007, accessed 24 May 2008 at www.nyc.gov/html/doh/html/dires/epi_posters.shtml. See UNAIDS, 2008.

48. UNAIDS, 2008.

49. North Carolina Department of Health and Human Services, *North Carolina HIV/STD Quarterly Surveillance Report: Vol. 2007, No. 4*, 2008, accessed 20 May 2008 at www.epi.state.nc.us/epi/hiv/pdf/vol07no4.pdf.

50. U.S. Census Bureau, *State and County QuickFacts—North Carolina*, accessed 20 May 2008 at http://quickfacts.census.gov/qfd/states/37000.html.

51. District of Columbia Department of Health, *District of Columbia HIV/AIDS Epidemiology Annual Report 2007.*

52. UNAIDS, 2008.

53. World Health Organization et al., *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Haiti*, 2006, accessed 16 June 2008 at www.who.int/GlobalAtlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_HT.pdf.

54. Henry J. Kaiser Family Foundation, *Survey of Americans on HIV/AIDS*, 2006.

55. Henry J. Kaiser Family Foundation, *Kaiser Family Foundation Survey of Americans on HIV/AIDS: Part Three—Experiences and Opinions by Race/Ethnicity and Age*, August 2004.

56. Henry J. Kaiser Family Foundation, *Survey of Americans on HIV/AIDS*, 2006.

57. CDC, HIV/AIDS Diagnoses Among Blacks—Florida, 1999-2004, *MMWR* 56:69-73.

58. Chase M, McKay B, Upward Revision of U.S. AIDS Cases Likely, *Wall Street Journals*, 1 December 2007. CDC is expected to publish revised current and historical estimates of HIV incidence in 2008, but such estimates had not been released as of publication of this report.

59. CDC, *2006 HIV/AIDS Surveillance Report*, 2008.

60. Alabama Department of Health, 2008.

61. District of Columbia Department of Health, 2007.

62. Newark EMA HIV Health Services Planning Council, *2005 Epidemiological Profile*, 2005.

63. CDC, *Fact Sheet: HIV/AIDS Among African Americans*, 2007, accessed 4 June 2008 at www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm.

64. Food and Agriculture Organization, *AIDS—A threat to rural Africa*, 2003. *See* Voeten H et al., Sexual Behavior Is More Risky in Rural Than in Urban Areas Among Young Women in Nyanza Province, Kenya, *Sex Trans Dis* 2004;31:481-487.

65. Hall HI et al., HIV in predominantly rural areas of the United States, *J Rural Health,*

2005;21:245-253.

66. Kenya Ministry of Health, *Status and Trends of Millennium Development Goals in Kenya*, accessed 9 June 2008 at www.health.go.

67. Helleringer S, Kohler H, Sexual network structure and the spread of HIV in Africa: evidence from Likoma Island, Malawi, *AIDS* 2007;21:2323-2332.

68. Adimora AA et al., HIV and African Americans in the southern United States: sexual networks and social context, *Sex Transm Dis* 2006;33(Supp. 7):S39-S45.

69. UNAIDS, *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*, 2007.

70. Piot P et al. (in press) Coming to terms with complexity: A call to action for HIV prevention. *Lancet*.

71. *See* USAID, Synergy Project, *What Happened in Uganda? A Case Study—Declining Prevalence, Behavior Change and the National Response*, 2002.

72. *See* Bing EG et al., Research Needed to More Effectively Combat HIV among African-American Men Who Have Sex with Men, *J Natl Med Assn* 2008;100:52-56; Darbes LA et al., Systematic Review of Behavioral Prevention Interventions to Prevent HIV Infection in Communities of Color, University of California San Francisco, 2006.

73. *See* Lyles CM et al., Best-Evidence Interventions: Findings from a Systematic Review of HIV Behavioral Interventions for U.S. Populations at High Risk, 2000-2004, *Am J Pub Health* 2007;97:133-143.

74. Bearinger LH et al. (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention and potential, *Lancet* 369:1220-1231.

75. *See* Global Coalition on Women and AIDS, *Keeping the Promise: An Agenda for Action on Women and AIDS*, 2006.

76. Harawa NT et al., Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the US, *J Acquir Immune Defic Syndr* 2004;35:526-536.

77. Halifors DD et al., Sexual and Drug Behavior Patterns and HIV and STD Racial Disparities: The Need for New Directions, *Am J Pub Health* 2007;97:125-132.

78. *See* Halperin DT, Epstein H, Why is HIV prevalence so severe in southern Africa.? The role of multiple concurrent partnerships and lack of male circumcision—implications for HIV prevention, *South African J HIV Med* 2007;8:19-41.

79. Wyatt GE et al., African-American Sexuality and HIV/AIDS: Recommendations for Future Research, *J Natl Med Assn* 2008;100:44-50. *See* Fullilove RE et al., An Epidemic No One Wants to Talk About, *Washington Post,* 21 March 2008, at A17.

80. Adimora AA et al., Concurrent Sexual Partnerships Among Men in the United States, *Am J Pub Health* 2007;97:2230-2237.

81. The U.S. incarcerates more people than any other country in the world—2.3 million in 2006. (Bureau of Justice Statistics, *Corrections Statistics*, Accessed 18 May 2008 at www.ojp.usdoj.gov/bjs/glance/incrt.htm.) Black men in America are most likely to be incarcerated, experiencing an imprisonment rate that is 6.6 times higher than among white males. (Sabol WJ et al., *Prison and Jail Inmates at Midyear 2006*, Bureau of Justice Statistics, 2007.) Accounting for only 13% of the U.S. population, Blacks comprise 44% of all correctional inmates in the U.S. (Sabol, 2007.) Estimates suggest that more than one in four Black men (28.5%) in the US will be imprisoned sometime during their lives. (Bonczor JP, Beck AJ, *Lifetime Likelihood of Going to State or Federal Prison*, Bureau of Justice Statistics, Accessed 18 May 2008 at www.ojp.usdoj.gov/bjs/glance/incrt.htm.)

82. Bramon D, Families and Incarceration, in Mauer M, Chesney-Lind M, eds, *Invisible Punishment: The Collateral Consequences of Mass Imprisonment*, 2002 (cited in Harawa N, Adimora A, Incarceration, African Americans and HIV: Advancing a Research Agenda, *J Natl Med Assn* 100:57-61).

83. Adimora, 2006.

84. UNAIDS, *AIDS Epidemic Update*, 2007.

85. CDC, 1991.

86. CDC, *2006 HIV/AIDS Surveillance Report*.

87. CDC, *2006 HIV/AIDS Surveillance Report*.

88. CDC, *HIV/AIDS among African Americans*, Fact Sheet, 2007.

89. Physicians for Human Rights, *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland*, 2007.

90. Crosby RA et al., Sexual Agency Versus Relational Factors: A Study of Condom Use Antecedents Among High-Risk Young African-American Women, *Sexual Health* 5:41-47.

91. Wyatt GE, 2008.

92. García-Moreno C et al., *WHO Multi-country Study on Women's Health and Domestic Violence against Women:* Initial results on prevalence, health outcomes and women's responses, 2005.

93. *See* Dunkel et al., Gender-based violence, relationship power, and risk of HIV infection among women attending antenatal clinics in South Africa, *Lancet* 2004;363:1415-1421; Marnan S et al., HIV-1 positive women report more lifetime experiences with violence: Findings from a voluntary HIV-1 counseling and testing clinic in Dar es Salaam, Tanzania, *Am J Pub Health* 2002;92:1331=1337.

94. *See* UNAIDS, 2008.

95. *See* Barker G et al., *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions,* World Health Organization, Geneva, 2007.

96. UNAIDS, 2008.

97. CDC, *Health Youth!: Young People, Sexual*

Risk Behaviors, Fact Sheet, accessed 29 June 2008 at www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm.

98. GET CITATION FROM KAI

99. CDC, Trends in HIV/AIDS Diagnoses Among Men Who Have Sex with Men—33 States, 2001-2006, *MMWR* 2008;57:681-686.

100. CDC, Trends in HIV-Related Risk Behaviors Among High School Students—United States, 1991-2005, *MMWR* 55:851-854.

101. UN Secretary-General, Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals, Report of the Secretary-General, UN General Assembly, 62nd session, A/62/780, 1 April 2008.

102. *See* Stevenson HC et al., HIV prevention beliefs among urban African-American youth, *J Adolesc Health* 1995;18:316-323.

103. Herek GM et al., When sex equals AIDS: Symbolic stigma and heterosexual adults' inaccurate beliefs about sexual transmission of AIDS. *Social Problems* 52:15-27.

104. Harlem United Community AIDS Center, *Program Evaluation*, January 2008.

105. National Campaign to Prevent Teen Pregnancy, *This Is My Reality: The Price of Sex*, 2004.

106. Bingham TA et al., The effect of partner characteristics on HIV infection among African American men who have sex with men (MSM) in the Young Men's Survey, Los Angeles, 1999-2000, *AIDS Ed Prev* 2003;15:Supp. A:39-52.

107. Darabi L et al., *Protecting the Next Generation in Uganda: New Evidence on Adolescent Sexual and Reproductive Health Needs*, Guttmacher Institute, New York, 2008.

108. Bearinger, 2007.

109. Dupas P (2006). *Relative Risk and the Market for Sex: Teenagers, Sugar Daddies and HIV in Kenya*. Accessed 3 January 2008 at http://ipc.umich.edu/edts/pdfs/DupasRelativeRisks.pdf.

110. *See* UNAIDS, 2008.

111. Baral S et al., Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000-2006: A Systematic Review, *PLoS Med* 2008;14:e339.

112. Gouws E et al., Short-term estimates of adult HIV incidence by mode of transmission: Kenya and Thailand as examples, *Sexually Transmitted Infections* 2006;82:iii5l–5.

113. Sanders EJ et al., HIV-1 infection in high risk men who have sex with men in Mombasa, Kenya, *AIDS* 2007;21:2513-2520.

114. CDC, HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex with Men—Five U.S. Cities, June 2004-April 2005, *MMWR* 54:1149-1153 (CDC MSM Survey).

115. Murrill CS et al., HIV Prevalence and Associated Risk Behaviors in New York City's House Ball Community, *Am J Pub Health* 2008;98:1074-1080.

116. Montgomery JP et al., The extent of bisexual behavior in HIV-infected men and implications for transmission to their female sex partners, *AIDS Care* 2003;15:829-837.

117. Sackoff J, Coffee L, Are Bisexual Men a Bridge Population for HIV Transmission to Women in NYC? New York City Department of Health and Mental Hygiene, 11th Conference on Retroviruses and Opportunistic Infections, San Francisco, February 2004.

118. Monitoring the AIDS Pandemic Network, *Male-Male Sex and HIV/AIDS in Asia*, 2005.

119. *See* multiple citations in Wyatt GE, 2008.

120. *See* Monitoring the AIDS Pandemic Network, 2005.

121. Garofalo R et al., The association between health risk behaviors and sexual orientation among a school-based sample of adolescents, *Pediatrics* 1998 May;101:895-902.

122. Pathela P et al., Discordance between sexual behavior and self-reported sexual identity: a population-based survey of New York City men, *Ann Intern Med* 2006;145(6):416-25.

123. *See* Kegeles SM et al., The intersection of stigma and HIV in young African American men who have sex with men's (YAAMSM) lives, International Conference on AIDS, abstract no. WePeD6400, 2004.

124. Kaisernetwork.org, *Discrimination, Stigma Against MSM Hindering HIV/AIDS Programs in Senegal,* Globe and Mail *reports*, 4 June 2008.

125. Human Rights Watch, *Hated to Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic*, 2004, accessed 29 June 2008 at www.hrw.org/reports/2004/jamaica1104/.

126. Nyakairu F, *Uganda Shuns Gays in Anti-HIV Drive*, Reuters, 2 June 2008 (summarized in *Kaiser Daily HIV/AIDS Report*, Henry J. Kaiser Family Foundation, 3 June 2008).

127. *See* Pisani E et al., HIV, syphilis infection, and sexual practices among transgenders, male sex workers, and other men who have sex with men in Jakarta, Indonesia, *Sex Transm Infect* 2004;80:536-540.

128. Clements-Nolle K et al., HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention, *Am J Pub Health* 2001;91:915-921.

129. Keatley JG, *Social Stigma, Marginalization, Injection Drug Use, and HIV Risk Among MTF Transgenders*, University of California San Francisco Health Studies for People of Color Project, accessed 9 June 2008 at www.hawaii.edu/hivandaids/ Social%20Stigma%20Marginalization%20Injection%20Drug%20Use%20keatley%20slides1.ppt.

130. Herbst JH et al., Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review, *AIDS & Behavior* 2008;12:1-17.

131. Keatley.

132. CDC, *2006 HIV/AIDS Surveillance Report.*

133. *See* UNAIDS, 2008.

134. Des Jarlais DC et al., HIV Incidence Among Injection Drug Users in New York City, 1990 to 2002: Use of Serologic Test Algorithm to Assess Expansion of HIV Prevention Services, *Am J Pub Health* 2005;95:1439-1444.

135. Human Rights Watch, Thai AIDS Treatment Action Group, *Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand,* 2007; International Treatment Preparedness Coalition, *Missing the Target #5: Improving AIDS Drug Access and Advancing Health Care for All*, 2007.

136. Maruschak LM, *HIV in Prisons—2006*, US Bureau of Justice, 2008, Accessed 18 May 2008 at www.ojp.usdoj.gov/bjs/pub/pdf/hivp06.pdf.

137. Hammett TM et al., The burden of infectious disease among inmates of and releases from US correctional facilities, 1997, *Am J Pub Health* 2002;92:1789-1794.

138. Wang L et al., *Seroincidence among Inmates Entering New York State Correctional System*, 2002, accessed 16 June 2008 at www.retroconference.org/2002/Posters/12665.pdf.

139. Dolan K et al., HIV in prisons in low- and middle-income countries. *Lancet Infect Dis* 2007;7:32-41.

140. The frequency of HIV transmission in correctional settings in the U.S. remains a topic of some debate. Because few prison systems in the U.S. test inmates for HIV upon discharge, a definitive estimate of HIV incidence in correctional populations has not proven feasible. A retrospective study by the CDC of the Georgia state prison system suggests that HIV transmission among inmates may be rarer than some believe. (CDC, HIV Transmission Among Male Inmates in a State Prison System—Georgia, 1992-2005, *MMWR* 2006;55:421-426.) The Georgia study, though, found that Black inmates were at highest risk of having HIV infection.

141. UNAIDS reports that comprehensive HIV prevention and treatment services for imprisoned drug users are available in only three countries. UNAIDS, *Report on the global AIDS epidemic*, 2008.

142. Harawa & Adimora, 2008 (citing Braithwaite RL, Arriola KR, Male prisoners and HIV prevention: a call to action ignored, *Am J Pub Health* 2003;93:759-763; Hammett TM, HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden and an appropriate response, *Am J Pub Health* 2006;96:974-978).

143. Lines R et al. (2006). *Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience.* Canadian HIV/AIDS Legal Network, Toronto.

144. CDC, HIV/AIDS education and prevention programs for adults in prisons and jails and juveniles in confinement facilities—United States, 1994, *MMWR* 1996;45:268-271.

145. Harawa & Adimora, 2008 (citing Sylla M, HIV Treatment in US Jails and Prisons, *Bulletin of Experimental Treatments for AIDS,* in press, www.sfaf.org/beta/).

146. Maruschak, 2008.

147. Wilson D et al., HIV Prevention, Care and Treatment in Two Prisons in Thailand, *PLoS Med* 2007;e204.

148. Hanna DB et al., Concurrent HIV/AIDS Diagnosis Increases the Risk of Short-Term HIV-Related Death among Persons Newly Diagnosed with AIDS, *AIDS Patient Care STDS* 2007;20 (e-pub ahead of print).

149. *See* WHO et al., *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, 2008.

150. CDC, *2006 HIV/AIDS Surveillance Report*, 2008.

151. New York City Department of Health and Mental Hygiene, *HIV Epidemiology & Field Services Semiannual Report*, October 2007.

152. District of Columbia Department of Health, 2007.

153. MacKeller DA et al., Unintentional HIV exposures from young men who have sex with men who disclose being HIV-negative, *AIDS* 2006;20:1637-1644. *See* Millett G et al., Explaining disparities in HIV infection among black and white men who have sex with men: a meta-analysis of HIV risk behaviors, *AIDS* 2007;21:2083-2091.

154. CDC MSM Survey, 2006.

155. Murrill CS et al., 2008.

156. *See* UNAIDS, 2008.

157. Henry J. Kaiser Family Foundation, Pew Global Attitudes Project, *A Global Look at Public Perceptions of Health Problems, Priorities and Donors*, 2007, accessed 26 May 2008 at http://pewglobal.org/reports/pdf/259.pdf.

158. *See* Buseh AG, Stevens PE, Constrained but not determined by stigma: Resistance by African American women living with HIV, *Women & Health* 2007;44:1-18; Foster PH, Use of stigma, fear and denial in development of a framework for prevention of HIV/AIDS in rural African American communities, *Family & Community Health* 2007;30:318-327; Moutsiakis DL, Chin PN, Why Blacks do not take part in HIV vaccine trials, *J Natl Med Assn* 2007;99:254-257; Emiet CA, Understanding HIV Stigma and Disclosure Among Older Adults Living with HIV/AIDS, Society for Social Work and Research, 14 January 2006, accessed 1 May 2008 at sswr.confex.com/sswr/2006/techprogram/P4311.HTM

159. *See* UNAIDS, 2008; Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response*, 2008.

160. UNAIDS, *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes, A resource for national stakeholders in the HIV response*. Geneva, 2008 (UNAID Stigma Report).

161. CDC, *The Role of STD Detection and Treatment in HIV Prevention—CDC Fact Sheet*, 2008, accessed 9 June 2008 at www.cdc.gov/std/hiv/STDFact-STD&HIV.htm.

162. Sexually transmitted infections facilitate HIV transmission and acquisition by causing genital ulcers that expose blood or membranes to HIV and by activating immune cells that are especially receptive to the virus. In the 1990s, studies on the potential of STI control to reduce HIV incidence reached seemingly contrary conclusions in Tanzania and Uganda. Subsequent analysis of these findings led to agreement that STI control may be a more potent tool for HIV prevention at an earlier stage of an epidemic, before infection is widely generalized. (For a discussion of these trial results, *see* UNAIDS, WHO, *Consultation on STD interventions for preventing HIV: What is the evidence?* 2000.) At the International AIDS Conference in Toronto in 2006, WHO sponsored an international expert consultation to review evidence on STI control for HIV prevention, resulting in agreement that focused STI interventions can help slow the spread of HIV. (WHO, *Treatment for sexually transmitted infections has a role in HIV prevention*, News release, 16 August 2006.

163. CDC, *Sexually Transmitted Disease Surveillance, 2005,* CDC, 2006.

164. Forhan S et al., *Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES), 2003-2004*, 2008 National STD Prevention Conference, Oral Abstract D4a, 11 March 2008.

165. Millett G et al., 2007; Torian LV et al., HIV infection in men who have sex with men, New York City Department of Health sexually transmitted disease clinics, 1990-1999: A decade of serosurveillance finds that racial disparities and associations between HIV and gonorrhea persist, *Sex Transm Dis* 2002;29:73-78. *See* CDC, *STDs in Men Who Have Sex with Men: Sexually Transmitted Disease Surveillance, 2005*, accessed 18 May 2008 at www.cdc.gov/std/stats05/slides.htm.

166. Kraut-Becher J et al., Examining Racial Disparities in HIV: Lessons From Sexually Transmitted Infections Research, *J Acquir Immune Defic Syndr* 2008;47(Supp. 1):S20-S27.

167. *See* Johnson LF et al., Sentinel surveillance of sexually transmitted infections in South Africa: a review, *Sex Transm Infect* 2005;81:287-293; Yourad MV, Torgal J, STD prevalence & representations of AIDS among university students in Angola, Cap Verde, Mozambique, STome, International Conference on AIDS, July 2000, abstract no. TuPeD3614.

168. Hogrefe W et al., Detection of herpes simplex virus type 2-specific immunoglobulin G antibodies in African sera by using recombinant gG2, Western Blotting, and gG2 inhibition, *J Clin Microbiol* 2002;40:3635-3640.

169. Watson-Jones D et al., Effect of Herpes Simplex Suppression on Incidence of HIV among Women in Tanzania, *New Eng J Med* 2008;358:1560-1571.

170. Levine RS et al., Black-White Mortality From HIV in the United States Before and After Introduction of Highly Active Antiretroviral Therapy in 1996, *Am J Pub Health* 2007;97:1884-1892.

171. New York City Department of Health and Mental Hygiene, *HIV Epidemiology Program—1st Semiannual Report*, April 2006.

172. New York City Department of Health and Mental Hygiene, October 2007.

173. District of Columbia Department of Health, 2007.

174. UNAIDS, 2008.

175. Antiretroviral Therapy in Lower Income Countries Collaboration, ART Cohort Collaboration Groups, Mortality of HIV-1-infected patients in the first year of antiretroviral therapy: comparison between low-income and high-income countries, *Lancet* 2006;367:817-824.

176. Beck E, Walensky RP, The Outcome and Impact of Ten Years of HAART, in *A Decade of HAART* (Zuniga JM et al., eds.), Oxford University Press, Oxford, UK, 2008.

177. Bergier EM et al., *New York City's HIV-Related Health Disparities: Surveillance Data Guides Public Health Action*, New York City Department of Health and Mental Hygiene, XVI International AIDS Conference, Toronto, 2006, accessed 16 June 2008 at www.nyc.gov/html/doh/downloads/pdf/dires/epi-presentation-iac2006-HIVhealthdisp.pdf.

178. New York City Departments of Health and Mental Hygiene and Homeless Services, *The Health of Homeless Adults in New York City*, December 2005, accessed 16 June 2008 at http://home2.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf.

179. UNAIDS, 2008.

180. For a history of the Minority AIDS Initiative, *see* Aragón R, Kates J, *The Minority AIDS Initiative*, Henry J. Kaiser Family Foundation, 2004, accessed 9 June 2008 at www.kff.org/hivaids/upload/Minority-AIDS-Initiative-Policy-Brief.pdf.

181. *See* Henry J. Kaiser Family Foundation, *U.S. Federal Funding for HIV/AIDS: The FY2009 Budget Request*, April 2008 (Kaiser 2008 Funding Report); Summers T, Kates J, *Trends in U.S. Government Funding for HIV/AIDS: Fiscal Years 1981 to 2004*, March 2004.

182. Kaiser 2008 Funding Report; Summers T, Kates J, March 2004; Henry J. Kaiser Family Foundation, *Federal Funding for HIV/AIDS: The FY2005 Budget Request*, February 2004.

183. Summers T, Kates J, March 2004.

184. Kaiser 2008 Funding Report.

185. Since national goals were established for Health People 2010, the federal government added

an indicator tracking the number of HIV/AIDS cases in adolescents and adults, relying on surveillance data from 33 states with mature reporting systems. Trends in new diagnoses, however, do not necessarily reflect actual HIV incidence and do not constitute an estimate of the number of HIV infections prevented as a result of federally-financed prevention programs. As of August 2007, no national target had been established for the indicator on HIV/AIDS diagnoses. (U.S. Department of Health and Human Services, Public Health Service, *Progress Review—HIV—Healthy People 2010*, 30 August 2007, accessed 9 June 2008 at www.healthypeople.gov/data/2010prog/focus13/.

186. *See* UNAIDS, *HIV Prevention Needs and Successes: A Tale of Three Countries*, 2001.

187. Piot, 2008.

188. *See* Henry J. Kaiser Family Foundation, *U.S. Federal Funding for HIV/AIDS: The FY2009 Budget Request*, 2008 (Kaiser Funding Report).

189. Kaiser Funding Report, 2008.

190. Schackman B, Lifetime Cost of Current HIV Care in the United States, *Medical Care* 2006;44:990-997.

191. Funders Concerned About AIDS, *U.S. Philanthropic Commitments for HIV/AIDS 2005 & 2006*, 2007.

192. *See* UNAIDS, 2008.

193. United Nations Development Program, *Thailand's Response to HIV/AIDS: Progress and Challenges*, 2004, accessed 10 June 2008 at www.undp.or.th/download/HIV_AIDS_FullReport_ENG.pdf.

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."

■ The **African American HIV University,** the Institute's flagship training program, is a fellowship program designed to increase the quantity and quality of HIV education in Black communities by training and supporting peer educators of African descent. AAHU's treatment and science college trains Black people in the science of HIV/AIDS. We believe when people understand the science of AIDS, they are better equipped to protect themselves from the virus, less likely to stigmatize those living with the disease or at risk of infection, better able to adhere to

treatment and advocate for care, and better positioned to influence public and private HIV/AIDS polices. The Prevention and Mobilization College prepares Black AIDS workers to engage and mobilize traditional Black institutions in efforts to confront HIV/AIDS and increase utilization of HIV prevention services in their communities.

- The **International Community Treatment and Science Workshop** is a training and mentoring program to help people who are living with HIV/AIDS or who are working with community-based and non-governmental AIDS organizations to meaningfully access information presented at scientific meetings.
- The **Drum Beat** is the Institute's Black media project designed to train Black media on how to report accurately on HIV/AIDS and tell the stories of those infected and affected. The **Black Media Task Force on AIDS,** a component of the Drum Beat Project, currently has over 1500 Black media members.
- The Institute publishes original editorial materials on the Black AIDS epidemic. Our flagship publication is our **"State of AIDS in Black America"** series. In the past few years, the institute has published reports on Black women, Black youth, Black gay and bisexual men and treatment in Black America. Our website **www.BlackAIDS.org** attracts nearly 100,000 hits a month. And our weekly AIDS updates currently have over 35,000 subscribers. The ***Drum Beat*** newspaper is a semi-annual tabloid with a distribution of 300,000. It is distributed to Black conventions, barbershops, beauty parlors, bookstores and doctors' offices. The Institute's newest publication is ***Ledge,*** a magazine produced by and for Black college students and distributed on the campuses of historically Black colleges and universities around the country.
- **Heroes in the Struggle** is a photographic tribute to the work of Black warriors in the fight against AIDS. Featuring elected officials and other policy makers, leading Black clergy, celebrities and entertainers, journalists, caregivers, advocates and people living with HIV/AIDS, HITS travels to Black universities, museums and community-based organizations throughout the United States, providing information on HIV/AIDS, raising awareness and generating community dialogues about what Black people are doing and what we need to do to end the AIDS epidemic in our communities.
- The Black AIDS Institute and BET, in association with the Kaiser Family Foundation, also sponsors the **Rap-It-Up Black AIDS Short-Subject Film Competition** to highlight the issue of AIDS and HIV infection within the African American community. By showcasing examples of heroism from within Black communities, we can galvanize African Americans to refocus and recommit to overcoming this epidemic.
- The Institute provides **technical assistance** to traditional African American institutions, elected officials and churches who are interested in developing effective HIV/AIDS programs, and to AIDS organizations that would like to work more effectively with traditional African American institutions.

Finally, nearly 30,000 people participated in AIDS updates, town hall meetings or community organizing forums sponsored by the Institute annually.

- **Leaders in the Fight to Eradicate AIDS (LifeAIDS)** is a national Black student membership organization created to mobilize Black college students around HIV/AIDS. LifeAIDS sponsors a national **Black Student Teach-In** and publishes *Ledge,* the only national AIDS magazine written, edited and published by Black students. Founded in 2004, LifeAIDS is

Black leaders gather at XVI International AIDS Conference in Toronto in August 2006.

the nation's only AIDS organization created by Black college students to mobilize Black college students to end the AIDS epidemic in Black communities. LifeAIDS has a presence on more than 70 college campuses nationwide.

■ The **National Black AIDS Mobilization** is an unprecedented five year multi-sector collaboration between all three national Black AIDS organizations in the United States (The Balm in Gilead, the National Black Leadership Commission on AIDS and the Black AIDS Institute) with a goal of ending the AIDS epidemic in Black America by 2012.

BAM seeks to build a new sense of urgency in Black America, so that no one accepts the idea that the presence of HIV and AIDS is inevitable. The campaign calls on traditional Black institutions, leaders and individuals to actions toward ending the AIDS epidemic in Black America.

The project has four key objectives: cut HIV rates in Black America, increase the percentage of Black Americans who know their HIV status, increase Black utilization of HIV treatment and care, and decrease HIV/AIDS stigma in Black communities.

BAM does this in two ways: identifying and recruiting traditional Black institutions and leaders, and providing Black leaders and institutions with the skills and capacity to develop strategic action plans for themselves and/or their organizations.

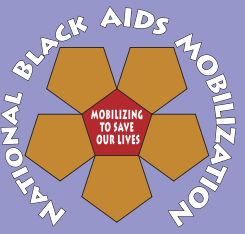
■ The **Test 1 Million** campaign is a two-year effort to screen one million people for HIV by December 1, 2008. The campaign began with a celebrity-studded press conference in collaboration with SAG and AFTRA at the Screen Actors Guild. Other events include an Oakland-to-Los Angeles run where people will be tested along the California coast run route and a national "get free concert tickets in return for taking an HIV test" program in partnership with leading R&B and hip-hop artists.

About the Authors

PHILL WILSON is founder and Chief Executive Officer of the Black AIDS Institute. Prior to founding the Institute, he served as Director of Policy and Planning at AIDS Project Los Angeles. Wilson was a member of the U.S. delegation to the 1994 World AIDS Summit in Paris, and has worked extensively on HIV/AIDS policy, research, prevention and treatment issues in Russia, Latvia, the Ukraine, the UK, Holland, Germany, France, Mexico, South Africa, Zimbabwe, Zambia, Tanzania, India and Botswana. Mr. Wilson graduated with a Bachelors Degree in Fine Arts in 1977 from Illinois Wesleyan University. He currently lives in Los Angeles with his partner.

KAI WRIGHT is publications editor for the Black AIDS Institute. As a writer and editor in Brooklyn, N.Y., his work explores the politics of sex, race and health. Wright has reported from all over the world for leading independent and community-based publications, ranging from *Mother Jones* to *Essence* magazines, and has received several awards and fellowships for his AIDS writing. Wright is author of *Drifting Toward Love: Black, Brown, Gay and Coming of Age on the Streets of New York*, as well as two books of African-American history. He is a native of Indianapolis, Indiana. To check out more of Kai's work, visit Kaiwright.com.

MICHAEL T. ISBELL is a graduate of Harvard Law School who has worked for two decades in the AIDS field. He was formerly director of the AIDS Litigation Project of the Lambda Legal Defense and Education Fund, director of public policy at Gay Men's Health Crisis, and a member of the Presidential Advisory Council on HIV/AIDS during the Clinton administration. For the past 10 years, he has been a consultant in the public health field on public policy, advocacy-related communications, and organizational development. He lives in New York City.



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

Black AIDS Institute

1833 West Eighth Street #200
Los Angeles, California 90057-4257
213-353-3610 ▪ 213-989-0181 fax ▪ info@BlackAIDS.org
www.BlackAIDS.org