Spotlight: Alabama

HIV/AIDS, AIDS Organizations, and Private Foundation Support in Alabama, 2000-2005

Funders Concerned About AIDS

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Letter from FCAA's Executive Director

Dear Colleague,

Since 1987, Funders Concerned About AIDS (FCAA) has worked to mobilize philanthropic leadership, ideas, and resources in the fight against AIDS. As the epidemic has grown and changed, we have adapted our programming to fit the needs of those affected by HIV/AIDS and to reveal key opportunities for private philanthropy. One trend uncovered in recent research by FCAA is the growing internationalization of AIDS philanthropy, and we look forward to serving the field with internationally focused programming. However, we also remain firmly committed to focusing all funders on the domestic epidemic that continues to ravage the most disadvantaged in our own nation.

This year, FCAA is proud to introduce the **Spotlight** series, a new programming initiative dedicated to building awareness around specific regions, communities, and issues. Alabama is the first of these **Spotlight** regions.

Why Alabama? The U.S. South is home to over 40% of all people living with AIDS in the United States—a higher concentration than any other U.S. region. From 2001 to 2005, the estimated number of people living with AIDS in the South increased by 33%—a higher percentage increase than in any other U.S. region. The Deep South, comprised of Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina, faces broad public health challenges which exacerbate the spread of HIV and complicate the plight of those living with AIDS. And yet in 2006, only 19% of U.S. philanthropic commitments for HIV/AIDS went to the South. Alabama is one state that has experienced both the epidemiological challenges and funding shortfalls common to the region. Additionally, and encouragingly, Alabama is the site of a new National AIDS Fund (NAF) Community Partnership: the Alabama Community AIDS Fund. FCAA is focusing on Alabama as an entry-point into the Deep South. Working on the state level provides a microcosm for detailed research and allows us to highlight specific challenges, as well as opportunities for additional private philanthropic investment.

This report synthesizes three main sources of information: epidemiological research provided by the UCLA Program in Global Health; resource tracking data generated by FCAA; and qualitative, front-line perspectives from both foundation and AIDS service executives. It seeks to present a multi-layered portrait of HIV/AIDS in Alabama, the past philanthropic response, and key opportunities for funders. This approach underscores FCAA's commitment to data-driven research, as reflected in our yearly publication, *U.S. Philanthropic Commitments for HIV/AIDS,* and our dedication to movement-building across broad constituencies. ***Spotlight: Alabama*** is FCAA's first in-depth report of this kind, and we hope it serves as a starting place—for further research on philanthropy, for greater awareness of the crisis of AIDS in Alabama and the South, and for new philanthropic initiatives in the fight against AIDS.

The local focus of the **Spotlight** series also speaks to FCAA's mission of inclusion. Our mantra at FCAA in recent years as been "every grant counts." Whether your grantmaking focuses exclusively on HIV/AIDS or provides critical HIV/AIDS grants within far broader portfolios, we consider you an AIDS funder; FCAA is your affinity group. We hope the **Spotlight** series expands the range of AIDS funders, and look forward to continued service and collaboration in this essential effort.

Sincerely,

Sunita Mehta

Executive Summary

Like much of the Deep South, Alabama faces a growing HIV/AIDS epidemic in the context of broader health care challenges. Alabama is among the three poorest states in the nation and ranks 45th among all states in overall population health.[1] The AIDS case rate in Alabama was estimated at 11.4 per 100,000 people in 2005.[2] Moreover, by 2004, all of the states within the Deep South were among the 15 with the highest HIV death rates, with Alabama's at 4.3 per 100,000.[3] The key epidemiological challenges of HIV/AIDS in Alabama include elevated risks for and impacts on vulnerable populations, including African-Americans, women, men who have sex with men (MSM), and youth; the rural geographical dispersion of at-risk and people living with HIV/AIDS (PLWHA) populations; late HIV and AIDS diagnoses; delayed access and poor adherence to care; and high rates of associated health problems, including poor general health, high rates of sexually transmitted infections (STIs), and potential for mental health difficulties.

U.S. Philanthropic Commitments for HIV/AIDS: 2005 & 2006, the most recent edition of FCAA's signature annual publication, found that "as in previous years, the Northeast of the U.S. received a considerable share of all domestic funding … the regional distribution of domestic HIV/AIDS-related philanthropy contrasts with the epidemiology of the U.S. epidemic, as Southern states continue to account for the greatest number of new AIDS diagnoses and the largest number of people living with AIDS."[4] The CDC reports that the South has a higher concentration of people living with AIDS than any other U.S. region, and yet in 2006, only 19% of U.S. philanthropic commitments for HIV/AIDS were directed to the South.[5]

Alabama's AIDS service organizations (ASOs) and related clinics represent an important point of service for PLWHA in Alabama. Though Ryan White Program funding to Alabama has increased, certain funding-gaps remain, and ASOs still face difficulties providing services sufficient to the problem of HIV/AIDS in the state. Private philanthropy has the potential to profoundly improve the ability of service organizations to deliver services effectively, to support programs tailored to local needs, and to strengthen the institutions necessary for a sustained response to HIV/AIDS.

Private philanthropic support to Alabama's ASOs increased significantly between 2001 and 2005. While this growth is encouraging, it was fueled by trends that present unique development challenges to ASOs. Generally, large grants from a few non-Alabama foundations drove growth in dollar amounts, while an increasing number of small grants from Alabama foundations drove growth in numbers of funders and grants per year. To be used strategically, large grants must be maintained as dependable, long-term sources of revenue. Small grants indicate valuable potential, but may not represent an easily managed revenue stream or good value for time spent on development. In the past, private funders have not always sustained their support of Alabama ASOs consistently from year to year. This has created uncertainty in planning programs, and strain on the often-meager development resources of ASOs.

To help address these challenges, funders can:

- Support secondary services, including prevention education, outreach, and transportation.
- Provide increased support for operating and infrastructural costs.
- Work to foster sustained funding relationships with grantees.
- Support tailored, targeted prevention efforts.
- Fund programs to increase early detection of HIV infection and improve access to treatment.

Organizations Included in this Report

FCAA's mission is to mobilize the ideas, leadership, and resources of private philanthropy in the fight against HIV/AIDS. Additionally, one goal for this report was to provide a precise year-to-year comparison of grantmaking activity between specific organizations. Tax reporting conventions mean that these data are only readily available for private foundations registered as 501(c)3 organizations. For these reasons, this report focuses on grants made by private foundations *directly to* AIDS service organizations in Alabama, and does not examine individual or corporate giving[i] or grants made by federated fundraising agencies.[ii] Government granting programs dedicated to HIV/AIDS are not the primary focus of this report, but constitute the backbone of financing for the recipient organizations, and so are discussed briefly in relation to the challenges relevant to private philanthropy.

People living with HIV/AIDS (PLWHA) in Alabama rely on a wide range of community-based organizations (CBOs) and other non-AIDS-specific organizations. However, the design of this project and methodological constraints dictated a focus on a consistently determinable group of foundations and organizations. We chose to limit our research to the AIDS-specific service organizations in the state, and the foundations that directly supported them between 2000 and 2005.[iii] A detailed discussion of methodology can be found in Appendix 1.

Private Foundations Supporting Alabama's AIDS Service Organizations[iv]

FOUNDATION	LOCATION	TOTAL GRANTED TO ALABAMA ASOs, 2000-2005
Broadway Cares/Equity Fights AIDS	New York, NY	$225,000
The Pfizer Foundation, Inc.	New York, NY	$150,000
Wayne and Ida Bowman Foundation	Chattanooga, TN	$139,000
Gill Foundation	Denver, CO	$107,800
M•A•C AIDS Fund	New York, NY	$78,387
Liz Claiborne Foundation	New York, NY	$56,440
Caring Foundation	Birmingham, AL	$54,200
Protective Life Foundation	Birmingham, AL	$45,500
The Community Foundation of Greater Birmingham	Birmingham, AL	$44,350
Alabama Power Foundation	Birmingham, AL	$35,050
Robert R. Meyer Foundation	Tuscaloosa, AL	$27,500
Children Affected by AIDS Foundation	Los Angeles, CA	$23,176
Community Foundation of Greater Memphis	Memphis, TN	$18,000
Daniel Foundation of Alabama	Birmingham, AL	$17,500
Saks Inc. Foundation	Birmingham, AL	$16,500
Hess Foundation, Inc.	Birmingham, AL	$15,000
UPS Foundation, Inc.	Atlanta, GA	$11,000
Amsouth Bancorporation Foundation	Birmingham, AL	$10,021
National AIDS Fund	Washington, DC	$10,000
The Joseph S. Bruno Charitable Foundation	Birmingham, AL	$10,000
Until There's A Cure Foundation	Redwood City, CA	$10,000
The Claude Bennett Family Foundation	Birmingham, AL	$8,220

Private Foundations Supporting Alabama's AIDS Service Organizations[iv] (cont'd)

FOUNDATION	LOCATION	TOTAL GRANTED TO ALABAMA ASOs, 2000-2005
The Campbell Foundation	Ft. Lauderdale, FL	$6,000
Boehringer Ingelheim Cares Foundation, Inc.	Ridgefield, CT	$5,000
DaimlerChrysler Corporation Fund	Auburn Hills, MI	$5,000
Carol W. & Myron J. Rothschild Fund	Montgomery, AL	$4,500
Abahac, Inc.	Birmingham, AL	$4,000
Federated Department Stores Foundation	Cincinnati, OH	$4,000
The Community Foundation of South Alabama	Mobile, AL	$3,300
Berman Charitable Foundation	Anniston, AL	$3,000
The Ronne & Donald Hess Foundation	Birmingham, AL	$2,000
Joy M. & James Grodnick Charitable Foundation	Mobile, AL	$1,100
Citation Charitable Foundation	Birmingham, AL	$1,000
James I. Harrison Family Foundation	Tuscaloosa, AL	$1,000
Reese Phifer, Jr. Memorial Foundation	Tuscaloosa, AL	$400
Gordy-Mead-Britton Foundation	Montgomery, AL	$350
The Aaron Aronov Family Foundation	Montgomery, AL	$250
Mayer and Arlene Mitchell Charitable Foundation	Mobile, AL	$200

AIDS SERVICE ORGANIZATIONS[v]	
AIDS Action Coalition of Huntsville	Huntsville, AL
AIDS Alabama (formerly, AIDS Taskforce of Alabama)	Birmingham, AL
AIDS Outreach of East Alabama Medical Center (EAMC)	Auburn, AL
Birmingham AIDS Outreach	Birmingham, AL
Health Services Center, Inc. (formerly, AIDS Services Center, Inc.)	Anniston, AL
Jefferson County AIDS in Minorities (AIM)	Birmingham, AL
Montgomery AIDS Outreach	Montgomery, AL
Selma AIR	Selma, AL
South Alabama CARES (formerly, Mobile AIDS Support Services)	Mobile, AL
West Alabama AIDS Outreach	Tuscaloosa, AL

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[i] The report does include grants made by foundations affiliated with corporations but registered as separate, 501(c)3 organizations.

[ii] Additionally, to avoid double-counting grants, the report may exclude some support to national organizations that support HIV/AIDS services in Alabama. For instance, the National AIDS Fund (NAF) recently began a new initiative, Southern REACH, which was supported by substantial grants from Ford Foundation and the Elton John AIDS Foundation. However, Southern REACH is directed towards organizations across several Deep South states, and the precise allocations to the ASOs considered here could not be determined.

[iii] At the time of this report's preparation, 2005 was the latest year for which at least 95% of relevant grantmaking data was available, based on estimates from FoundationSearch.com. Due to the small size of the data sets and the need to provide comparable figures year-to-year, years with partial data sets could not be included. However, there has undoubtedly been grantmaking activity in the interval, and if the trends in this report were extended, it could be assumed that significant numbers of new grantmakers had joined the fight against AIDS.

[iv] Due to the unavailability of certain tax records, two foundations supporting Alabama ASOs were identified after portions of this report went to press. These grantmakers, Children Affected by AIDS Foundation (CAAF) and Until There's A Cure Foundation (UTAC), are included in the table to recognize their commitments, but their grants were not integrated into database analyzed in the data sections of this report. These grants were made as follows: In 2001, UTAC made one $10,000 grant to AIDS Alabama. In 2004, CAAF made one $13,176 grant to AIDS Outreach of EAMC. In 2005, CAAF made one $5,000 grant to Birmingham AIDS Outreach and one $5,000 grant to Jefferson County AIDS in Minorities.

[v] Though it is a vital source of HIV/AIDS-related care, the 1917 Clinic at the University of Alabama at Birmingham is not included as a grantee in this report, for several reasons. While the UAB Center for AIDS Research, which houses the 1917 Clinic, receives support from private philanthropy, these grants are often institutional in scale and support a much broader range of activities than the Clinic alone (including research, clinical trials, and broader programs affiliated with other parts of the university). Furthermore, the nature of tax reporting on these grants makes it nearly impossible to tell which part of the funds support work like that of the other ASOs in this report, making meaningful comparisons impossible. Finally, the location of the 1917 Clinic within a much larger organization may well mean that the relevant funding issues are quite different from those faced by smaller, independent organizations.

Part 1
The Context for Private Philanthropy

"Sadly, poverty is a great friend to AIDS/HIV, fuelling infection rates and decreasing the quality and length of lives of those living with the virus who are poor. At the M•A•C AIDS Fund, we have focused a great deal of our funding in the South on alleviating poverty-related issues such as food insecurity and lack of stable housing. One of the greatest challenges over the next few years will be to educate other private and public donors that, just as in Africa and the Caribbean, we cannot truly address AIDS/HIV in the U.S. without addressing poverty."

Nancy Mahon, Esq.,
Executive Director, M•A•C AIDS Fund

General Health and HIV/AIDS in Alabama and the South

At the end of 2005, 40% of people living with AIDS resided in the South, a higher concentration than any other region in the country.[6] From 2001 to 2005, the estimated number of people living with AIDS in the South increased by 33%, a higher percentage increase than any other region.[7] In the same period, the South was the only U.S. region in which the number of deaths among PLWHA increased.[8]

The alarming public health profile of the 21st century South reflects, in part, the continuing legacy of historical and demographic factors, including slavery, mass migration, segregation, the loss of a highly agrarian economy, and a geographically dispersed population.

Health and Poverty in Alabama and the South

Alabama is the 30th largest state in the United States and is bordered by Tennessee, Georgia, Mississippi, and Florida and the Gulf of Mexico. In the 2007 report from the United Health Foundation, which ranks the overall health of each U.S. state, five of the six states of the Deep South fell within the ten worst health profiles in the nation. Alabama ranked 45th in overall health.[9]

On other indicators of general health, Alabama scores near the bottom, with the second highest preterm birth rate (16.1%), the fourth highest low birth weight rate (10.4%) and the sixth highest infant mortality rate (9.1 per 1,000 population) in the country. For Alabama's African-American residents, these figures are dramatically worse.[10]

Alabama is among the three poorest states in the country, with 22% of its residents living beneath the Federal Poverty Level ($15,577 for a family of three in 2005) and 44% designated "low income" (with an annual income less than 200% of FPL).[11]

HIV/AIDS in Alabama and the Deep South

The Deep South as a region (defined as Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) experiences broad public health challenges that complicate the specific problems of HIV/AIDS. Additionally, this region has experienced the greatest proportional increases in HIV/AIDS rates each year since 1990.[12]

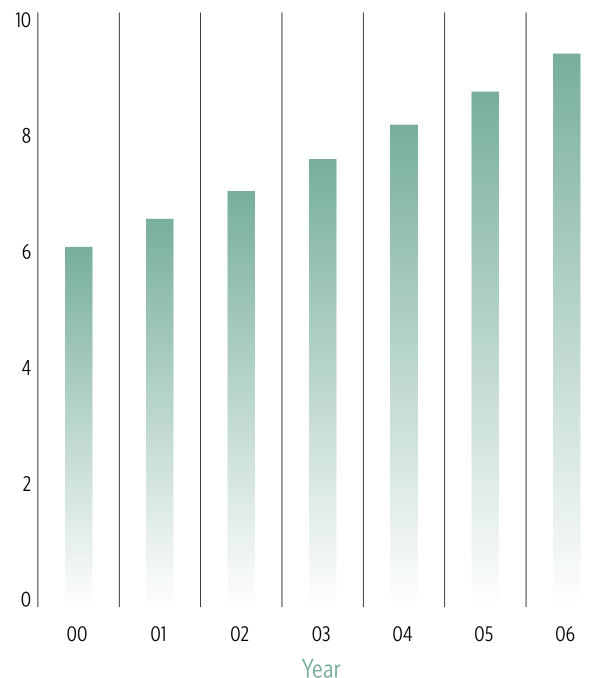
As one report found, "from 2000 to 2003, the number of newly reported AIDS cases increased 35.6% in the U.S. Deep South, while increasing 4.0%

in other Southern states and 5.2% nationally, excluding the Deep South states." This report characterized the HIV/AIDS epidemic in the Deep South as "more similar to the epidemic in less wealthy nations than to other areas of the U.S."[13]

By 2003, all of the states within the Deep South were among the 15 with the highest HIV death rates, with Alabama having a death rate of 4.3 per 100,000 population.

As of 2005, Alabama had an 11.4 per 100,000 incidence rate of reported AIDS cases,[14] and the combined number of Alabama PLWHA in 2005 was 8,252.[15]

Figure 1: HIV/AIDS Prevalence in Alabama by Year, 2000-2006
in thousands



Source: HIV/AIDS Surveillance, HIV Incidence, and HIV Prevalence Studies: Annual Progress Report; January 1-December 31, 2006. Alabama Department of Public Health, Bureau of Communicable Disease, Division of HIV/AIDS Prevention Control.

"We're seeing growth in younger ages—13, 14, 15. A lot of 18 year-olds, and a lot of those 18, 17 year-olds are also African-American gay men. We're seeing a really significant growth... among those very young and very old. It's been real noticeable over the past four, five years."

Mike Murphree, Executive Director,
Montgomery AIDS Outreach

HIV Transmission Risk in Alabama

Among all Alabama residents, the highest HIV transmission risk category continues to be sex between men who have sex with men (MSM), which accounted for 52% of all HIV/AIDS diagnoses in 2006. High-risk heterosexual sex (36%) and intravenous drug use (10%) rank second and third.[16] These figures are comparable to national transmission risk statistics; for HIV/AIDS cases diagnosed in 2005, the CDC reports the following transmission figures: MSM (49%); high-risk heterosexual sex (32%); IDU (14%).[17]

By gender and across racial groups, the Alabama risk behavior profile differs significantly.

For all females, the highest risk behavior was heterosexual sex. Notably, African-American women had a significantly higher risk of HIV infection from heterosexual sex, accounting for 91% of all reported HIV/AIDS diagnoses in 2005 versus 66% for white women.[18]

Among males, MSM accounted for the majority of newly diagnosed infections in 2006 for both African-American (64%) and white (82%) men. Similar to the disparity between African-American and white

"About 68% of our population is from communities of color. We have five counties that we've been designated to serve ... that covers about 3,060 square miles. The majority of people we serve are indigent, low-income. Two counties in our service area are in the top ten for highest rate of infection in the state—that's Macon and Russell county."

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

females, there was a higher percentage of reported cases due to heterosexual sex for African-American men (23%) than white men (5%).[19]

Across all categories, the risk of HIV transmission is increased and complicated by Alabama's high rate of sexually transmitted infections (STIs).[20,21] Among all states, Alabama ranks fourth for gonorrhea, ninth for primary and secondary syphilis, and 28th for chlamydia.[22]

Key Epidemiological Challenges

Alabama faces an array of epidemiological challenges related to HIV/AIDS, some which mirror those on a national scale, and others which reflect specific characteristics of the Deep South. Poor general health indicators and poverty exacerbate each of these and demand innovative approaches to address them.

Impact on Vulnerable Populations

Increasingly, Alabama's HIV/AIDS epidemic is concentrated in its most vulnerable populations, including African-Americans (particularly women and youth), Latino migrant workers, and rural residents.

African-Americans shoulder the greatest burden of the HIV/AIDS epidemic. Among African-American females, this impact is particularly severe, as the number of new HIV/AIDS cases diagnosed has exceeded those among white males for eight consecutive years. There has also been an alarming 89% increase in diagnoses of HIV/AIDS among young African-American males (ages 13 to 24) between 2001 and 2005.[23] At the end of 2005, African-Americans made up 26% of Alabama's total population, but 43% of those living under FPL, 64% of persons estimated to be living with AIDS, and 71% of new AIDS cases.[24]

Latinos have the second highest case rate in Alabama, despite accounting for a small number of total HIV/AIDS diagnoses.[25] Alabama's Latino population grew 208% between 1990 and 2000,[26] a trend linked to the increasing number of migrant workers in the state. Migrant and undocumented workers are presenting new challenges to surveillance that are proving elusive to a public health infrastructure developed for a domestic population. Many and complex factors are at play, including the cyclical movement of migrant men between Mexico and the U.S., limited data on the risk indicators associated with migrant workers in the South, and the relationship (not fully captured by research) between male Latino immigrants and sex workers.

Based on 2000 U.S. Census data, 45% of Alabama's population is considered **rural**. PLWHA in rural areas must often travel considerable distances to medical centers for care. (The University of Alabama at Birmingham outpatient HIV/AIDS clinic reports that 33.7% of patients traveled 50 miles or more to receive HIV care.[27]) Increasing distance from home to clinic is predictive of less frequent access to HIV outpatient services.[28]

Care Issues

In Alabama and throughout the Deep South, delayed access to treatment and suboptimal frequency of

"The disproportionate impact of HIV/AIDS in the South—especially among women, African-Americans and Latinos—prompted the Pfizer Foundation to invest in prevention programs as the best defense against further spread of HIV in the region. The Foundation funded 23 HIV/AIDS services organizations in nine southern states to support targeted programs to prevent new infections in those populations most at risk."

Caroline Roan, Executive Director,
Pfizer Foundation
Senior Director WW Philanthropy, Pfizer Inc.

care are pervasive. Poverty and low-income status are predictors of late diagnosis of HIV/AIDS and may also be one explanation for delayed access to care.[29] In 2005, less than half of newly diagnosed Alabama residents received care in compliance with current federal guidelines (a minimum of three care visits annually for measurement of CD4+ T-cell counts and viral load levels).[30,31]

Mental health services for PLWHA in the South do not appear to be meeting the demonstrated needs of the population, especially for rural residents. Nationally, approximately 50% of HIV-infected patients are afflicted with mental illness.[32] Studies have demonstrated that unmanaged mental illness in HIV-positive individuals is positively correlated with a wide range of risks, including not seeking care, poor adherence to antiretrovirals (ARVs), and a more rapid progression to AIDS.[33,34,35] One study revealed a lower likelihood of mental health service utilization by HIV-positive individuals in the South versus other U.S. regions.[36] Other research indicated that rural participants were less likely to seek mental health services and those that did reported fewer visits.[37]

PLWHA are aging. As the overall distribution of PLWHA in Alabama among age groups has remained stable, the number of residents living with HIV or AIDS has steadily increased while the death rate has dropped by approximately 60% since its high in 1995. This is creating a growing population of older men and women with HIV/AIDS,[38] which could in turn have an impact on the state's ability to provide care, especially when combined with the challenges identified above.

AIDS Service Organizations

Many of the most vulnerable PLWHA in Alabama rely on the state's network of AIDS service organizations (ASOs) for medical and support services. There are both clinical and non-clinical ASOs in Alabama, as well as a group of community-based organizations (CBOs) that often support PLWHA directly or indirectly, but do not identify solely as HIV/AIDS organizations.

Nationally and in Alabama, ASOs often face funding challenges that make it difficult to meet the need for services. Secondary services and prevention education are less often emphasized by government funding programs, making them important areas for philanthropic support.

A recent report from the AIDS Taskforce of Greater Cleveland (ATGC) that sampled 100 ASOs nationwide over a four-year period indicated that the number of ASOs with a budget surplus decreased from 66% in 2001 to 44% in 2005. Across the national sample, "ASOs rely heavily on government grants and contracts, followed by public support. However, between 2001 and 2005, the organizations in our sample increased their reliance on program revenue and special events."[39]

Regionally, the South "had fewer organizations with a budget surplus and relied more heavily on program revenue and special events than other regions. The Northeast had the greatest number of organizations with a budget surplus."[40] FCAA research indicates that philanthropic commitments to HIV/AIDS organizations in the Northeast increased from 34% of total domestic commitments in 2005 to 48% in 2006. As discussed above, the South is the U.S. region with the highest proportional figures for HIV/AIDS, but received only 19% of all U.S. philanthropic commitments for HIV/AIDS.[41]

Private philanthropic support has played a proportionally small role in most organizations' overall budgets; in keeping with national trends, most ASOs in Alabama get the bulk of their revenue from government grants and contracts. For large Alabama ASOs that do extensive government contracting, private philanthropic support can represent less than one percent of total revenue, but generally the grants identified in our research combined to contribute between 1% and 10% of annual revenue per year, with the percentage often changing dramatically from year to year.[vi] The consistency of philanthropic support as a revenue stream is explored further in Part 2.

Despite their modest proportional contribution, however, philanthropic grants nevertheless represent an essential source of support, because of the general need for funds, and restrictions built in to government programs. In Alabama, many of the broader epidemiological challenges—including geographic dispersion, poor access to and adherence to care, and the need for prevention education tailored for vulnerable populations—call out for flexible, long-term solutions. In interviews with FCAA, ASO executives emphasized the need for sustained philanthropic support, especially for areas unfunded or underfunded by government

"We are heavily, heavily dependent on federal funds, particularly Ryan White Part C, and immediately after that, Ryan White Part B."

Mike Murphree, Executive Director
Montgomery AIDS Outreach

"80% of our money is government ... the other 20% is a combination of United Way, special event fundraising, donors, or other non-government grants."

Associate Director
AIDS Alabama

[vi] FCAA obtained the 990 tax forms for the ten ASOs considered in this report and compared the grants made to each organization with their overall revenue figures.

Federal Funding Support

"We could make our clinics even better—the money is there in Ryan White Part B. But it's a reimbursement-based program in Alabama, and we have to front these costs first in order to be reimbursed. As an agency with limited financial streams, incurring these costs to cover salaries and services is difficult. We could do so much more if we had a nest egg to cover these outlays."

Mike Murphree
Executive Director, Montgomery AIDS Outreach

programs, such as the Ryan White Program.

The following table presents the total federal funding directed to Alabama in fiscal year 2006. State and local funding is not included.

Ryan White Program Funding	$19,367,328
CDC	
HIV Prevention	$2,268,498
HIV/AIDS Surveillance	$900,852
CBO/CBA	$438,499
DASH	$246,311
Miscellaneous	$324,442
Total	$4,178,602
SAMHSA	
Center for Mental Health Services	$0
Center for Substance Abuse Prevention	$754,320
Center for Substance Abuse Treatment	$2,655,157
Total	$2,655,157
Housing Opportunities for People with AIDS (HOPWA)	
Total	$1,656,000
Office of Minority Health Funding	$0
Grand Total	**$27,857,087**

Source: Henry J. Kaiser Family Foundation. Statehealthfacts.org. Accessed March 18, 2007.

It is important to note that Medicaid is the largest source of financing for HIV/AIDS care in the nation; over half of all adults and 90% of children with AIDS are enrolled in the program. However, as it is not an HIV-specific program, its role in financing the operations of the ASOs discussed here is outside the purview of this report. The following section explores the Ryan White Program in more detail, as the largest federal grant program specifically for HIV/AIDS, and the majority of HIV-specific federal funding for Alabama's ASOs.

The Ryan White Program

The Ryan White Program (formerly known as the Ryan White CARE Act) is the largest federal grant program designed specifically for people with HIV/AIDS and it provides the majority of financing for many HIV/AIDS organizations. Funding is organized under Parts (previously, Titles), which distribute grants to different types of recipients and programs. Appendix 2 describes the structure of the Ryan White Program in greater detail.

The 2006 reauthorization of the Program changed several aspects of its funding mechanism, including a promise of larger grants to states without "eligible metropolitan areas," (the urban centers that had historically borne the brunt of HIV/AIDS and had received proportionally greater shares of federal funds).[42] The reauthorization also introduced the requirement that

"Ryan White grants are reimbursement in nature, and therefore providers and community-based organizations (CBOs) must normally incur expenses in order to request reimbursement. Reimbursement is usually requested in one of two ways: through a line item or unit cost reimbursement. Because these are both reimbursement mechanisms after expenditures are incurred, many providers and CBOs struggle with cash flow and sometimes ensuring that most expenses are covered by these grants. Some expenses are not allowable under Ryan White grants, including construction and capital purchases. This makes it doubly difficult for small organizations in particular to keep services flowing so that client needs are met adequately."

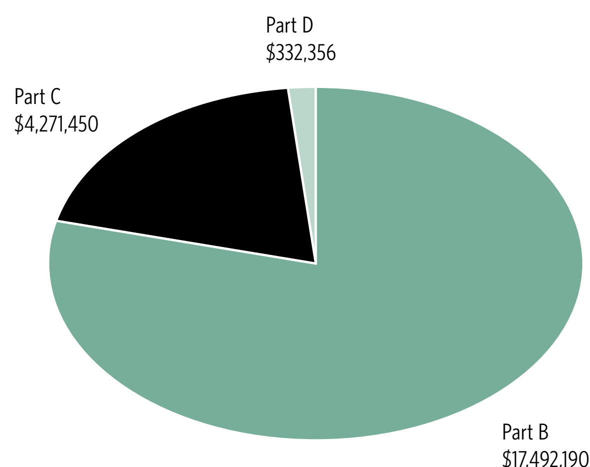
Murray Penner, Deputy Executive Director of Domestic Programs,
National Alliance of State and Territorial AIDS Directors (NASTAD)

75% of funding from Parts B and C be spent on "core medical services" (see Appendix 2).

Ryan White in Alabama

The state received more money overall as a result of the 2006 reauthorization, with Part B funding increasing from approximately $12.4 million, a typical annual sum since 2004, to about $17.5 million in fiscal year 2006.[43,44] Parts B and C together constitute 98.5% of Ryan White funding to Alabama. The remainder is Part D (formerly Title IV), which covers family and community-based services to children, youth and women living with HIV. Figure 2 shows the proportional distribution of Ryan White Program funding for fiscal year 2007.[45]

Figure 2: FY 2007 Ryan White Program Support to Alabama by Part



Source: Henry J. Kaiser Family Foundation. Statehealthfacts.org. Accessed March 18, 2007.

In Alabama, as discussed in more detail above, delayed initiation of and/or inconsistent adherence to HIV/AIDS treatment is pervasive in both urban and rural areas. The Ryan White Program's emphasis on core medical services would seem to take for

granted that services are established and reaching those that need them. Several of the ASO executives surveyed expressed a need for funding for non-medical support services. Additionally, Program funds are reimbursement-based, meaning that ASOs must incur the costs of providing services before receiving funding. This can make it difficult for organizations to maintain or expand programs in the context of growing client load.

As noted above, Ryan White Program funding constitutes the vast majority of HIV-specific program funding for many of the ASOs discussed in this report. Government grants in general represent the main funding stream for most ASOs nationally. So, where the structure of these grants does not align fully with the needs faced by the PLWHA and service communities, it is imperative that private philanthropy recognizes the opportunity to provide uniquely targeted assistance.

"We are not a clinic, and the trend has been for supportive services to take cuts statewide."

Anonymous survey respondent

"The scarcity of HIV prevention education funding in Alabama is shameful. People wonder why HIV rates are exploding in the South, yet neither the federal nor state government provides enough dollars to do the work. We have five or six projects funded at about $60,000 each from the Centers for Disease Control and another $300,000 that the Alabama Legislature provides. And that's pretty much all of the prevention funding for the whole state."

Kathie M. Hiers, CEO
AIDS Alabama

Part 2
Private Philanthropic Support

"We fund in the Deep South because it is home to disproportionately impacted populations, but it is where efforts are least developed. In more rural areas, that lack of programming capacity is often coupled with a lack of development capacity and an inability to pursue and report on private grants. However, turning our back is not an option."

Patrick Flaherty, Deputy National Director
Gill Foundation

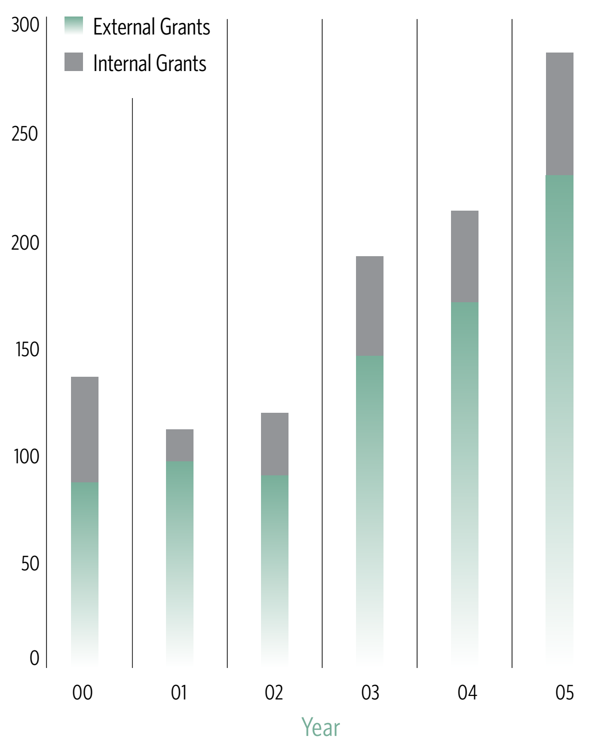
Given the epidemiological profile and public funding challenges discussed above, it is evident that private philanthropy can play a key role the response to HIV/AIDS in Alabama. This section presents data on the recent activity of private funders supporting ASOs in Alabama and explores the degree to which philanthropy has met the needs of these organizations.

Overall, private philanthropic support to Alabama ASOs more than doubled from 2000 to 2005, mainly due to increases in large grants from foundations based outside the state. Support from Alabama-based foundations stayed relatively consistent over that period. The number of unique funders making grants to Alabama ASOs also increased nearly every year both within and outside Alabama. However, most of the grants made are proportionally small: an average of 73% of grants made per year are under $4,000. A pattern of small, numerous grants may raise unique challenges for AIDS service organizations. The following section explores these trends and their ramifications in greater detail.

Trends in Support from Private Philanthropy to Alabama ASOs, 2000-2005

The total philanthropic support to Alabama's ASOs more than doubled between 2000 and 2005. Much of this growth was due to an increase in the number of large grants (generally, $20,000 to $50,000) from foundations based outside Alabama. Support from

Figure 3: Total Grant Amounts from Private Foundations to Alabama ASOs by Year, 2000-2005
in thousands ($)



Note: Figure 2 omits grants below $4,000.
Source: FCAA calculations of data from FoundationSearch.com

grantmakers within Alabama has remained relatively consistent, with a developing pattern of more numerous, but smaller, grants, as evidenced by the drop in the size of average and median grants since 2003. While overall support has grown, the largest grants come from outside Alabama. Inside Alabama, and among smaller grantmakers, growth is less significant.

- From 2000 through 2005, total yearly grantmaking (above $4,000) increased by 112%.
- External grantmaking increased by 166%.
- Internal grantmaking increased by 16%.
- From 2000 through 2005, the average grant from an external funder increased by 77%, from $8,624 to $15,267.
- The average grant from an internal funder increased in 2003, but over all five years decreased from $9,800 to $8,150, a decrease of 17%.
- The recent decrease of the external median, in the context of a rising average, indicates an increase in the proportional contribution of larger grants to the total granted by non-Alabama foundations.

Small Grants

Between 2000 and 2005, individual grants under $4,000 accounted for 23% on average of the yearly total dollar amount given to Alabama ASOs by Alabama grantmakers.[vii,viii] However, these grants represented an average of 73% of the total *number of grants* made. Thus, while consistently providing only a modest share of dollar amounts, small grants represent the majority of activity by Alabama grantmakers.

Grants below $1,000 make up 34% of the total number of grants made from 2000 through 2005, but only 2% of total grant dollars (59 grants out of 175, and $27,441 out of $1,120,568).

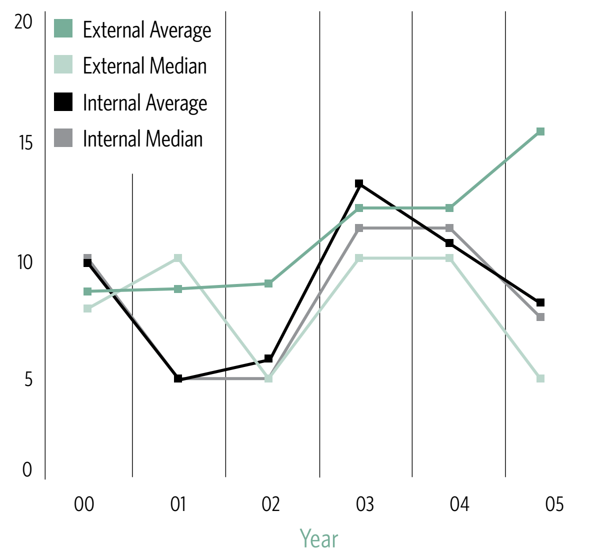
Regarding external (outside Alabama) grantmakers, a similar dynamic exists, when small and larger grants are reviewed together. In 2005, there were 15 grants from external funders for a total of $229,000. Ten of these grants (68%) were $5,000 or less, and represented only 21% of the total dollars sent to Alabama. For each year from 2000 through 2005, the bottom half of each year's grants from non-Alabama funders represented an average of 26% of the total amount granted to Alabama's ASOs.

Figure 5 displays grant counts by year for external grants and internal grants above and below $4,000.

In other words, the majority of grant activity represents a minority of resources. From the perspective of a grantseeker, a greater volume of smaller grants may not represent a dependable or coordinated financial stream, and may involve proportionally greater transaction costs and development effort.

Asked what his organization would do with a grant between $500 and $1,000, one survey respondent answered, "That would not really make a difference in our issues right now. In fact, if I were going after grants, I would not waste a whole lot of energy, because I

Figure 4: Averages and Medians for Grants Over $4,000 by Year
in thousands ($)

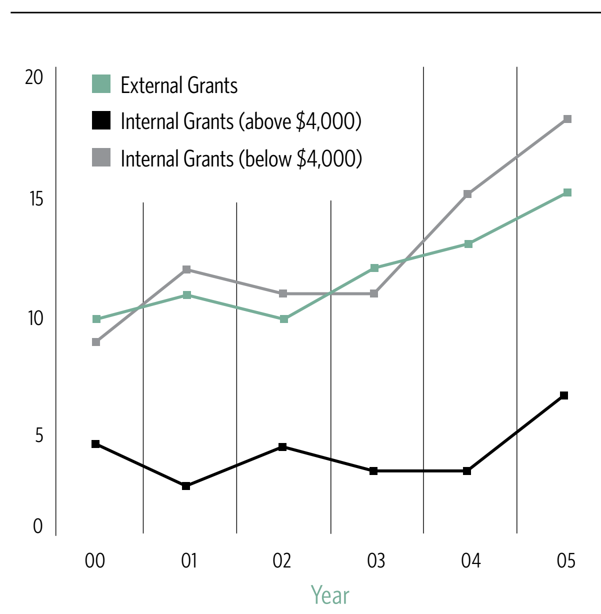


Source: FCAA calculations of data from FoundationSearch.com

"My problem is I don't have anybody to work with me on [pursuing private philanthropy]. If I had a grantwriter, it would be so easy, because I could handle the overseeing of the agency... but unfortunately a lot of programs in our state, a lot of the agencies like ours, and certainly smaller ones, we do not have grantwriters on staff, and that makes it harder."

Mike Murphree, Executive Director,
Montgomery AIDS Outreach

Figure 5: Number of Grants from Private Philanthropy to Alabama ASOs by Year, 2000-2005



Source: FCAA calculations of data from FoundationSearch.com

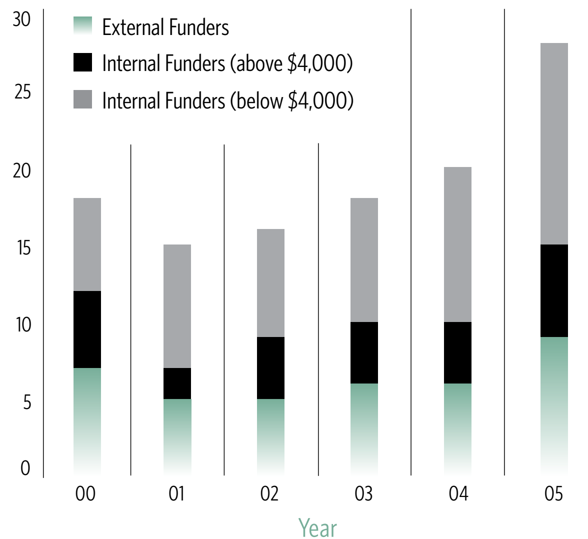
don't have the time and I don't have a grantwriter, going after a series of thousand dollar grants." For a grant between $1,000 and $5,000: "That's a little better ... but... unless it's a one-pager... it would not be worth that time." (Mike Murphree, Executive Director, Montgomery AIDS Outreach)

This pattern is even more pronounced on a national scale. FCAA's recent publication, *U.S. Philanthropic Commitments for HIV/AIDS: 2005 & 2006,* revealed that in 2005, only ten funders contributed 71% of all HIV/AIDS funding by U.S.-based funders. In 2006, the top ten were responsible for 90%, with the Bill & Melinda Gates Foundation alone accounting for 75% of all HIV/AIDS funding by U.S.-based funders.

"And since Katrina, we really got slammed. There's only a certain amount of money you can raise, and it basically went towards that. We would catch whatever was left over."

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

Figure 6: Number of Unique Funders Supporting Alabama ASOs by Year, 2000—2005



Source: FCAA calculations of data from FoundationSearch.com

The Funder Population

From 2001 to 2005, more funders made grants to Alabama's ASOs each year. Figure 6 shows the growth in unique funders per year between 2000 and 2005. While figures are unavailable for external grantmakers funding below $4,000, small Alabama grantmakers represent the largest and fastest growing segment of the funder population.

The general growth in unique funders is an encouraging development. However, a key challenge for grantees, especially those with limited development capacity, remains the cultivation of funders to the point where their grants enable the growth of sustained programs.

[vii] FoundationSearch.com, the database drawn upon to create this report, does not include grants below $4,000. A more detailed discussion of FoundationSearch.com and the $4,000 cut-off is found in Appendix 1. FoundationSearch.com does create a list of giving interests for each foundation, however, based off all the keywords found in the process of digitizing the 990 tax information that makes up the database.

[viii] FCAA manually searched the tax-forms of Alabama foundations that had listed "HIV/AIDS" as a giving interest to uncover grants below $4,000. A similar search of national funders was deemed unfeasible due to the great number of "HIV/AIDS"-interested foundations nationwide. However, the findings for Alabama grants below $4,000 are quite relevant to the claims of this study.

"HIV/AIDS in the Deep South involves public health challenges that require innovative, long-term responses. Recognizing this, Broadway Cares/ Equity Fights AIDS makes it a priority to fund our grantees sustainably. Regular grants allow organizations to maintain programs year-to-year and maximize their effectiveness. Additionally, we work to streamline the grant application process, freeing grantees to spend more energy on the essential work of fighting HIV/AIDS."

Tom Viola, Executive Director,
Broadway Cares/Equity Fights AIDS

- There is potential for "growing" funder support levels, but many ASOs cannot afford dedicated development staff, indicating a potential vicious cycle in funding shortfalls.
- From 2001 through 2005, more unique funders made grants each year.
- However, most of these new funders made grants below $4,000.

Continuity of Private Philanthropic Support within Recipient Organizations

Figures 7a through 7f show the private philantropic support received by individual ASOs[ix] both as an annual total and by individual grant. Each broad green column shows the total amount received in a given year. Within the broad bars, each grant making up that total is depicted with its own column, to scale. Any foundation that made at least one grant from 2000—2005 to the recipient in question is consistently coded with a letter identifying its grants (or lack thereof) from year to year. These letter codes are consistent between figures. Please note that the scale of the vertical axis changes between figures.

Figures 7a-f: Private Philanthropic Support to Individual ASOs by Grant, 2000—2005

Figure 7a: AIDS Alabama

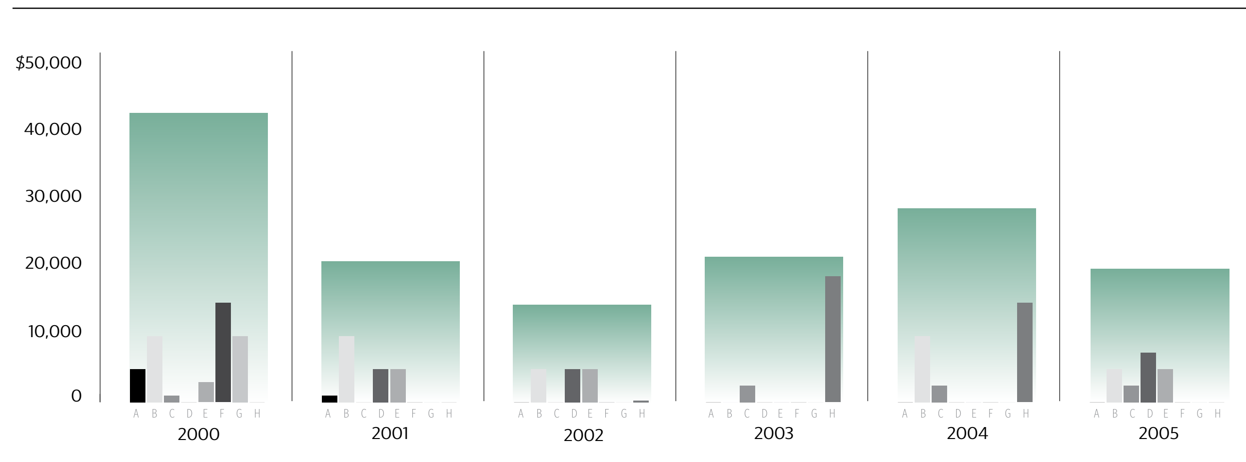


Figure 7b: Birmingham AIDS Outreach

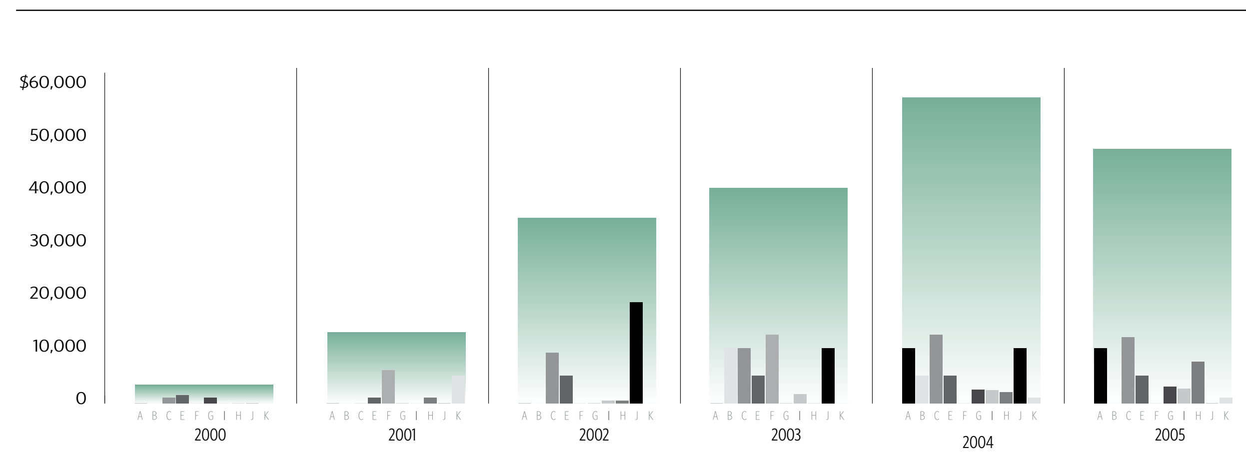


Figure 7c: Health Services Center, Inc.

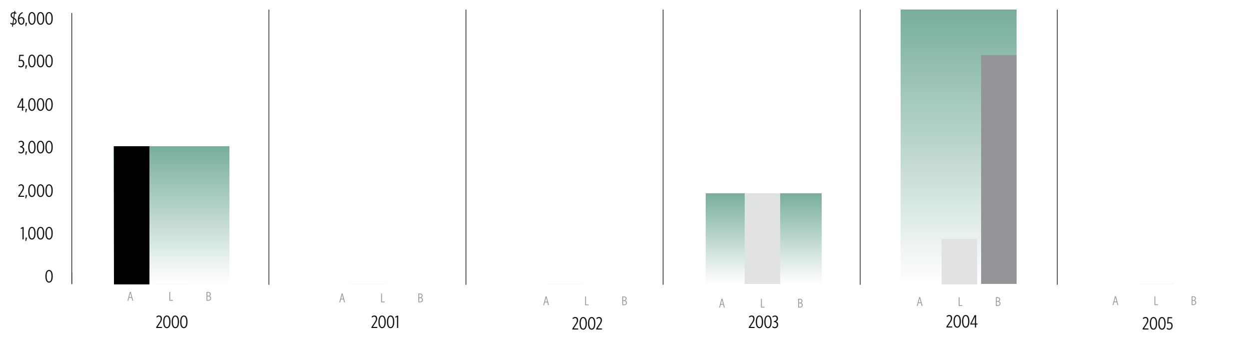


Figure 7d: Mobile AIDS Support Services

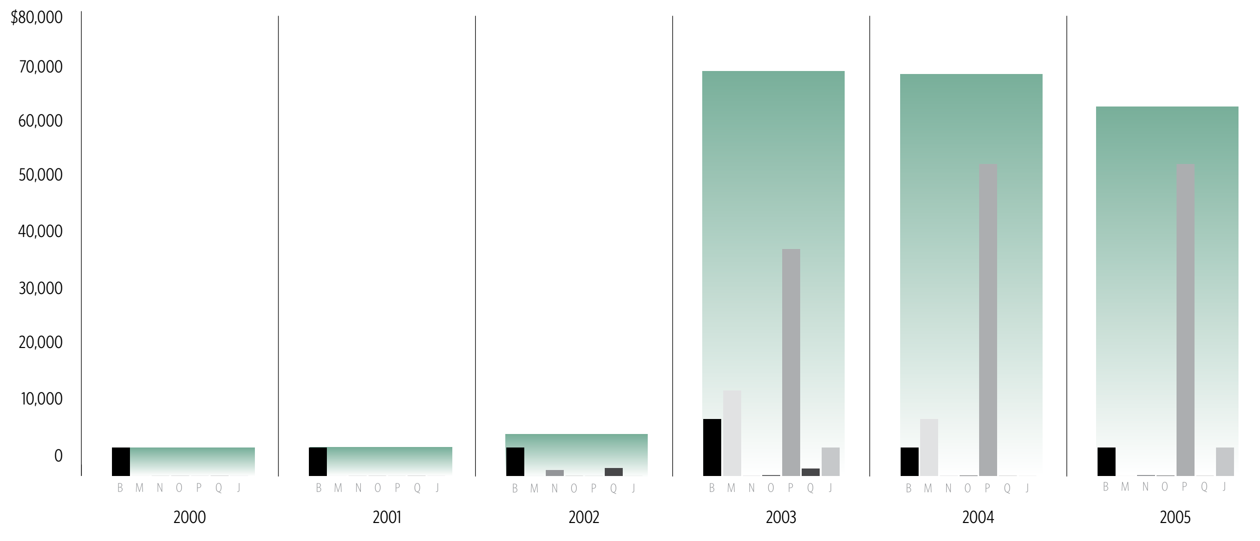


Figure 7e: Montgomery AIDS Outreach

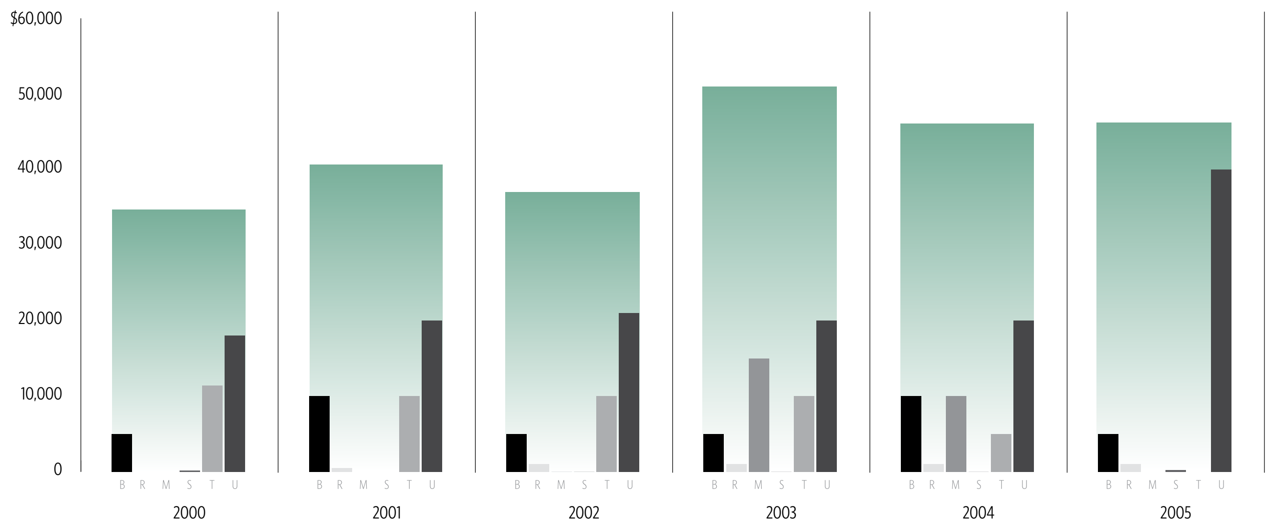
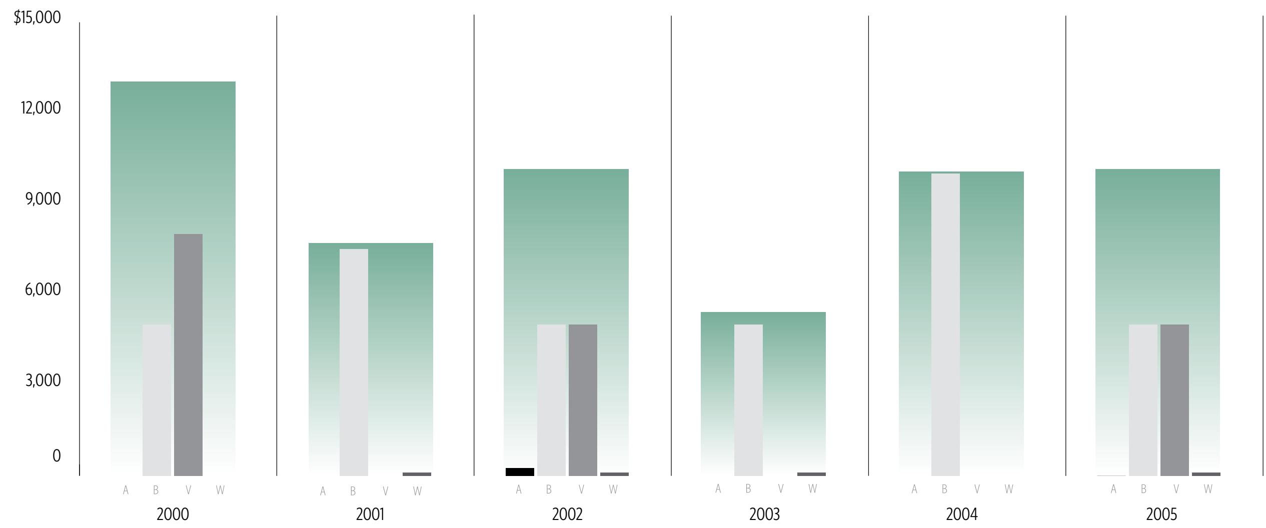


Figure 7f: West Alabama AIDS Outreach



ix Of the ten ASOs considered in this report, only the six depicted received philanthropic support from more than one foundation in the six-year period studied.

Part 3
Conclusions

"One of the concerns many people have about foundations is how foundations often will not give to operating expenses or to the kind of day-to-day work of delivering services that have to be carried out. And I think that's another thing I would like the foundation community to rethink."[54]

Sen. Hillary Rodham Clinton
1999 White House Conference on Philanthropy

The key epidemiological challenges of HIV/AIDS in Alabama include specific risks for and impacts on vulnerable populations, the geographical dispersion of at-risk and PLWHA populations, late HIV and AIDS diagnoses, delayed access and poor adherence to care, and high rates of associated health problems, including poor general health, high rates of STIs, and potential for mental health difficulties. These problems are related to broad geographic and demographic factors, and require long-term, structurally appropriate responses. Though both public and private financial support has increased, growth has not been sufficient to tackle increases in HIV prevalence, or to fully meet financial needs.

What Funders Can Do:

Support secondary services, including prevention education, outreach, and transportation.
As discussed in detail in Part 1, a successful long-term response to the epidemic will almost certainly require greater support to secondary services, including work to connect PLWHA to steady medical attention, and prevention education for those most at-risk for HIV. The present need in Alabama may not be drugs and medical services, but outreach, transportation, prevention education, and infrastructure improvements tailored to the state's rural geography. Additionally, funders can help facilitate access to confidential mental health services and integrate them with HIV care, particularly in rural communities, and support efforts to link existing rural and urban services and facilitate housing, employment, and health care for migrating residents. Funders should consider increased support to non-medical services, a key funding-gap under major government programs.

Provide increased support for operating and infrastructure costs.
Several executives surveyed by FCAA stressed the difficulty of covering basic infrastructure costs for their organizations, including rent, utilities, and technology. Private philanthropic support is rarely approved for these costs, and while some government funding is available, reimbursement-based funding and restrictions on construction and capital expenditures make consistent coverage difficult. These costs are not "extra;" failure to cover them strains service provision, human resources, and long-term organizational viability. Funders should consider increased operating support to ASOs to enable the effective implementation of necessary programs.

Work to foster sustained funding relationships with grantees.
In an environment of generally poor health and structural barriers to prevention and care, programs need to be sustained year-to-year to make an impact. Regardless of grant size, philanthropic funding that is regular and predictable can be used more effectively by grantees to support long-term programs and to form an authentic revenue stream within a larger budget. This is even more critical when government funding programs do not prioritize the programs most needed in Alabama.

Funders should consider ways to make their support to individual grantees sustainable over the long-term, and to reduce costs and bureaucracy around applications for small grants. The grant application process costs grantseekers time, money, and energy. Especially for grants below $5,000, funders should consider streamlining the application process so that recipients get the maximum net value from the grant.

Support tailored, targeted prevention efforts.
Greater resources are needed for prevention, due to the heightened vulnerability of specific populations and risk groups, including African-Americans, women, youth, and migrant workers, and a relative shortfall of public prevention funding. Additionally, from 1999 to 2003, just seven of Alabama's 67 counties (Baldwin, Houston, Jefferson, Madison, Mobile, Montgomery, and Tuscaloosa) accounted for 65% of HIV/AIDS diagnoses.[46] Funders should consider supporting prevention efforts targeted at these groups and areas.

Fund programs to increase early detection of HIV infection and improve access to treatment.
For people already infected with HIV, early detection and steady access to medication can help delay progression to AIDS. Alabama's rural geography is only one factor that distances PLWHA from care centers, and public funding is less readily available for transportation and outreach programs. Funders should consider supporting these programs to improve the prospects of those living with HIV and AIDS.

"We're still running a deficit, and that deficit comes from overhead costs. As you know, in writing grants, the majority of your grants are program-specific and it's restricted funds ... Only one grant gives us the ability to pay towards our phones, our computers, things like that, our copiers, the basic stuff you use every day that people don't realize. As a result of that, we struggle."

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

"We had to let go of a paid provider who was here a half day a week. We had to discontinue our nutrition program and have our nurses do it—we had a dedicated registered dietitian that we paid ... to come work with new clients and clients that were at risk. We had to lay her off. We had to do away with all our emergency financial assistance."

Mary Elizabeth Marr, Executive Director
AIDS Action Coalition of Huntsville

In Closing

This report focused solely on private philanthropic support to AIDS service organizations in Alabama. Other recent research reveals a broader national context for the grantmaking trends identified in this report.

A 2006 report from the Center for Effective Philanthropy (CEP), *In Search of Impact,* which surveyed both foundation CEOs and grantees, found that "the typical grant made by the large foundations in our study is program restricted, small, and short-term."[47] Half of the foundation CEOs surveyed preferred program grants to operating grants, while only 16% of CEOs indicated a preference for operating grants. 60% of these cited "responsiveness to grantee needs" as the motivation.[48] However, the report also found that "there is agreement among [foundation] CEOs on at least one thing: Operating support is viewed as being most effective—and more effective than program support—in creating impact on and encouraging sustainability of grantee organizations."[49,50]

The CEP report also found that grantees, however, "are as likely to suggest larger grants or multi-year grants—or bundle these attributes—as they are to suggest more operating support grants."[51] The report concluded that "there is a tension…between these leaders' views of what is best for their foundations—and even what they believe creates the most positive social impact—and what might best serve the organizational interests of their grant recipients." And among grantees, there exist distinct preferences for operating support, and sustained support of any kind. The report found that "grantees are as likely to suggest larger grants or multi-year grants—or bundle these attributes—as they are to suggest more operating support grants."[52] *Daring to Lead,* a 2006 report by CompassPoint Nonprofit Services, surveyed a national sample of nonprofit executive directors and asked them to "rank six potential actions by funders in terms of what would be most helpful to them in their work. The largest number of executives ranked the provision of more general operating support as the most helpful. The provision of multi-year support was the second most highly ranked action."[53]

Spotlight: Alabama represents one starting place for further exploration of philanthropy's essential role in fighting HIV/AIDS. However, it is clearly evident that the question of *how* funders make grants is just as important as that of what they support. In the fight against AIDS, in Alabama and the world over, grantmakers have the unique opportunity to express philanthropy's independence, both by innovating in areas of dire need, and by responding to the voices of those closest to the fight—their recipients.

Appendix I: Methodology

FCAA designed this project with an emphasis on interdisciplinary research. Scientific literature was identified using electronic databases. Data on foundation grantmaking was generated in FoundationSearch.com, an online grant database. FoundationSearch.com receives forms 990 from the Internal Revenue Service, scans, and digitizes them. Grants above $4,000 are entered in a searchable database tagged with various identifiers, including Granting Foundation, Year, Grant Amount, Recipient, and Grant Description, as well as address fields for both grantmaking and recipient organizations. FCAA identified the population of grant recipients via initial internet and FoundationSearch.com searches, and through conversations with key staff of identified organizations in Alabama.

To identify grants to Alabama ASOs below $4,000, FCAA manually searched the tax forms for 2000 through 2005 of all foundations based in Alabama that listed HIV/AIDS as a giving interest in their FoundationSearch.com profiles. FCAA elected not to perform similar searches on a national scale due to the vastly greater numbers of foundations giving to HIV/AIDS and of recipient organizations. However, our findings for small grants in Alabama revealed significant trends for understanding HIV/AIDS philanthropy, and this is a population of grantmakers that should not be ignored.

To ensure that we did not miss grants, FCAA also relied on prior research (our annual resource tracking document) to identify a population of foundations that had made grants to AIDS organizations based in the South. We examined the giving history of these foundations as revealed by FoundationSearch.com and the foundations' annual reports to identify grants to our selected population of ASOs. Only in one case was a foundation identified via this process that had not been found via database searches.

Following scientific literature review and initial research on foundation giving, FCAA distributed a survey on challenges in financing AIDS work in Alabama to the executive directors of Alabama's ASOs and collected responses via written submissions and phone interviews. Interviewees could elect the level of anonymity they preferred. All quotes attributed to ASO directors and key staff are verbatim extractions from these surveys and interviews. Three ASO executives did not complete the survey following repeated requests for contact.

Appendix 2: Funding under the Ryan White Program

Structure of the Ryan White Program [55,56]

Part A: Funds "eligible metropolitan areas" (EMAs), defined by a cumulative total of more than 2,000 reported AIDS cases over the most recent 5-year period, and "transitional grant areas" (TGAs), those with 1,000-1,999 reported AIDS cases over the most recent 5-year period. At least 75% of Part A funds must be spent on core medical services. Part A represented 29% of Ryan White Program funding in fiscal year (FY) 2007. Alabama has no EMAs or TGAs and did not receive Part A funds.

Part B: Funds all U.S. states and territories. Also includes ADAP and Emerging Communities (ECs) grants. At least 75% of funds must be spent on core medical services. Part B grants are made directly to states or to "consortia" of service organizations. Part B represented 57% of total Ryan White Program funding in FY 2007 and approximately 79% of funding to Alabama.

Part C: Funds public and private organizations for Early Intervention Services (EIS) and Capacity Development & Planning. 75% of funds must be spent on core medical services. Part C represented 9% of Ryan White Program funding in FY 2007 and approximately 19% of funding to Alabama.

Part D: Funds public and private organizations directly to provide family-centered and community-based services to children, youth, and women living with HIV and their families. Part D grants do not carry a core medical earmark. Part D represented 3% of total Ryan White Program funding in FY 2007 and approximately 2% of funding to Alabama.

Part F: Funds dental, educational, minority-related, and other special projects. Part F represented 3% of

total Ryan White Program funding in FY 2007. Alabama did not receive any direct Part F funding.

Core medical services are defined below. The remainder of Part B grants can be used for support services, defined as "services, subject to the approval of the secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services)."[57]

"Core medical services" include:[58]

- Outpatient and ambulatory health services
- AIDS Drug Assistance Program treatments
- AIDS pharmaceutical assistance
- Oral health care
- Health insurance premium and cost sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services (defined under section 2614(c))
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence services

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