

HIV/AIDS

More than 25 years after the virus first emerged, HIV/AIDS has caused more than 25 million deaths. An estimated 40.3 million people are now living with the virus, and 4 million people are newly infected each year (UNAIDS 2005, 2006). Despite improved access to antiretroviral treatment and care, HIV/AIDS remains the leading cause of death among those ages 15 to 59 worldwide (The Henry J. Kaiser Family Foundation 2006a). Developing nations experience increasing and staggering prevalence. Sub-Saharan Africa, home to nearly two-thirds of people living with HIV/AIDS, has been the hardest hit region, but other areas such as Latin America and the Caribbean experience high prevalence rates among adults (The Henry J. Kaiser Family Foundation 2006a). Over the past 25 years, the epidemic has exposed weaknesses in the financing and delivery systems, disparities in treatment and prevalence, the effects of stigma, and the need for evidence-based prevention efforts

The Early Years

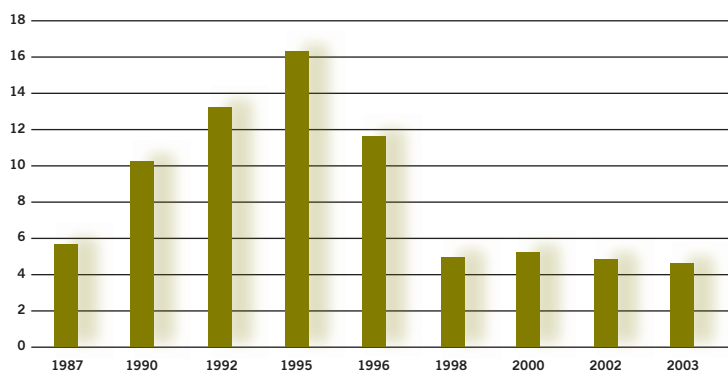
The emergence of HIV in the early 1980s brought fear and uncertainty.

The Centers for Disease Control and Prevention (CDC) first reported the virus in 1981, and it was not until 1983 that the U.S. Public Health Service issued recommendations of preventing transmission through sexual contact and blood transfusions. By this point, the virus was increasing rapidly but had not been isolated. In 1984, scientists Robert Gallo and Luc Montagnier identified Human Immunodeficiency Virus (HIV) as the causative agent of AIDS.

Because of wide misperception of how the virus spread, many individuals with HIV/AIDS faced serious discrimination: eviction, unemployment, and social humiliation. There was considerable confusion and fear as to how the virus could be transmitted; many people believed that the virus could be spread through casual contact, such as shaking hands or sharing a telephone. A public icon of the era, Ryan White, was noted for his struggle after he was banned from school when school officials discovered he had contracted HIV through blood products used to treat his hemophilia. With the help of AIDS advocates, he won the case against his school, but his family was forced to move to a new town because of threats of violence.

By the middle of the decade, years of inaction had caught up, and the government's slow response had cost thousands of lives. The peak of new HIV infections occurred around 1985, at an estimated 160,000 (The Henry J. Kaiser Family Foundation 2006b). President Reagan finally publicly addressed HIV/AIDS in 1986, the same year Dr. C. Everett Koop released the

Figure 1. Mortality from HIV, 1987–2003, (deaths per 100,000)



Source: The Henry J. Kaiser Family Foundation, *AIDS at 25: An Overview of Major Trends in the U.S. Epidemic*, Chartpack, Menlo Park, CA 2006)

Surgeon General's Report on HIV/AIDS, calling for condom use and improved AIDS education.

After it became clear that the virus was not an isolated event and thanks to increasing advocacy, monitoring and treatment efforts improved. In 1985, the U.S. Food and Drug Administration (FDA) approved the first test to detect antibodies to HIV

compelled to pass the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to provide funding for primary care and support services for individuals living with HIV disease who lack health insurance and financial resources for their care. Congress also enacted the Housing Opportunities for People with AIDS (HOPWA) Act of 1991 to provide housing assistance to people living with AIDS. In 1993, President Clinton established the White House Office of National AIDS Policy to focus on coordinating domestic efforts to reduce the number of new infections in the U.S., particularly in segments of the population that experiencing new or renewed increases in the rate of infection.

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in the bloodstream. One year later, azidothymidine (AZT), the first antiretroviral drug for HIV/AIDS, began clinical trials and was FDA-approved in 1987. The AIDS Coalition to Unleash Power, or ACT UP, was established in 1987 to oppose the high price of AZT and the slow pace of FDA approval. The drug price was subsequently lowered. Despite incredible medical and scientific gains, access to treatment is still limited to those without significant financial resources or public assistance.

A tumultuous decade left a nation afraid, bereaved, and inspired to act. Activists throughout the country voiced opinions about discrimination of people with HIV/AIDS, prices of lifesaving drug treatment, and the search for a cure.

The Nineties

The 1990s saw several developments in policy and treatment. By 1990, there were 150,000 reported AIDS cases in the U.S. (The Henry J. Kaiser Family Foundation 2006c). In response to the enormity of this statistic, the U.S. Congress was

As more well-known individuals made their HIV status public, the public perception of the illness shifted. In 1991, Magic Johnson shocked sports fans by retiring from professional basketball because of his HIV status. Johnson's announcement changed the perception that AIDS was a disease affecting only gay men and started a national discussion about how privilege can buy access to expensive, lifesaving therapy.

By the mid-1990s, AIDS was no longer considered a death sentence. In 1995, the new age of highly active antiretroviral therapy (HAART) emerged with the FDA approval of the first protease inhibitors, saquinavir. In part because of HAART, by 1997, AIDS-related deaths in the U.S. declined by more than 40 percent (Figure 1) (CDC 2001).

With the introduction of HAART, the 1996 reauthorization of the CARE Act specifically earmarked

funding for AIDS Drug Assistance Programs (ADAPs) to provide HIV-related treatment medications to low-income people with HIV/AIDS who have limited or no prescription drug coverage. Amendments to the CARE Act in the 2000 reauthorization allow states to use ADAP funds to pay for services that enhance access, adherence, and monitoring of drug treatments.

As individuals with HIV/AIDS lived longer because of new therapies, there was growing recognition of comorbidities faced by vulnerable populations. Mental health and drug abuse disorders and infectious diseases such as Hepatitis C and tuberculosis disproportionately affect people with HIV/AIDS. Other conditions, referred to as social comorbidities, such as homelessness and poverty, present challenges to finding appropriate housing, medical care, and adequate food (IOM 2005).

As the virus increasingly ravaged developing countries, researchers and policymakers began to turn their focus abroad. In 2000, the CDC formed the Global AIDS Program, which has collaborated with governments, the World Health Organization, universities, and nongovernmental organizations to help combat the spread of HIV/AIDS. It adheres to a three-pronged strategy: prevention, treatment, and information and capacity building.

2000 and Beyond

Recent years have seen an increased commitment to global funding. In 2003, the Bush Administration asked Congress to commit \$15 billion over five years to combat AIDS in Africa and the Caribbean.

Just as with other health conditions such as diabetes and cardiovascular disease, HIV reflects a set of racial, ethnic, and class inequalities.

The President's Emergency Plan for AIDS Relief (PEPFAR) nearly tripled the U.S. commitment to international AIDS assistance, aiming to prevent 7 million new infections, provide antiretroviral treatment for 2 million people living with AIDS, and support 10 million people living with AIDS, including AIDS orphans (Office of the Press Secretary 2003). While PEPFAR is on track to fulfill its \$15 billion plan to fight HIV/AIDS, some critics point out that the funding lacks adequate focus on prevention and has unrealistic strings, such as a requirement for recipients to promote abstinence-only programs.

In 2003, UNAIDS and the World Health Organization announced the 3 by 5 initiative, aimed at treating 3 million people with antiretroviral treatment by 2005. The initiative was a step towards the goal of making universal HIV/AIDS prevention and treatment accessible for all who need them. The initiative fell short of its target by about 700,000 people, but it was instrumental in creating support for the expansion of universal HIV treatment.

During this decade, attention has been paid to the shifting demographics of the disease. Just as with other health conditions such as diabetes and cardiovascular disease, HIV reflects a set of racial, ethnic, and class inequalities. Racial and ethnic minorities, the poor, and the uninsured are more likely to con-

tract HIV (Parada 2000). Although African Americans and Hispanics accounted for nearly 70 percent of all new U.S. HIV/AIDS cases in 2004, these groups made up only 27 percent of the total U.S. population (The Henry J. Kaiser Family Foundation 2005). African Americans have not seen equal benefits from treatment and prevention initiatives. The CDC has set a goal to eliminate disparities in HIV by 2010. Strategies to reduce rates of infection among minority populations include early diagnosis, more effective services, increased access to treatment, and medical provider education.

HIV also increasingly affects women. From 1981 to 1987, men accounted for 92 percent of the cases, compared with 74 percent from 1996 to 2000 (CDC 2001). The disease once believed to be exclusive to gay men is now affecting women at an alarming pace. Between 1999 and 2003, the number of AIDS diagnoses increased 15 percent among women and 1 percent among men (CDC 2004). In 2000, the number of women dying from AIDS exceeded the number of men.

Future programs must consider the implications of an aging HIV-infected population. Most individuals face the typical ailments that increase with age – higher rates of heart disease and diabetes, for instance – but for those living with HIV, the challenge of treating more than one chronic disease can be overwhelming. Medication management

becomes more important than ever, as patients are more likely to be taking a wide variety of drugs to treat their conditions.

The statistics are still shocking. While the overall rate of new HIV cases has decreased since the 1980s, HIV/AIDS prevalence is at its highest rate ever and continues to increase each year. In 2005, 4.1 million people were newly infected with HIV worldwide, including 540,000 children (The Henry J. Kaiser Family Foundation 2006a). The epidemic is considered a threat not only to individuals and their families but also to the stability of entire nations.

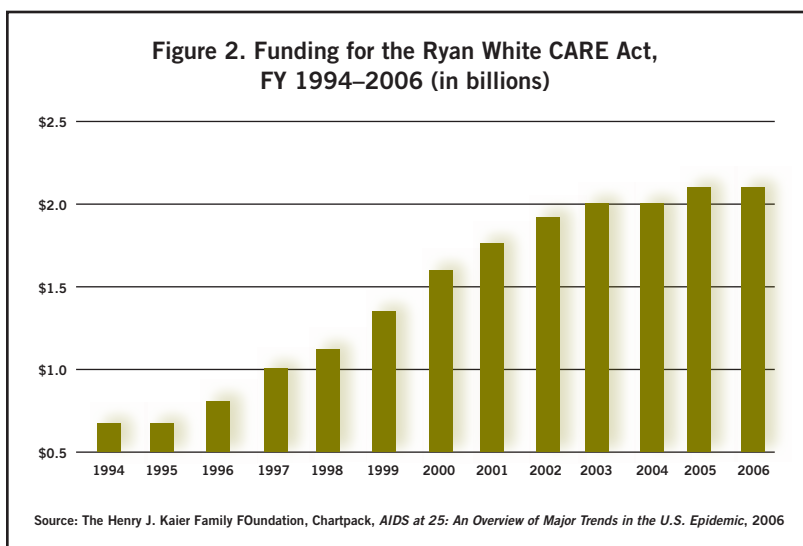
Challenges

Treatment presents challenges, even among those who opt to follow a regimen. While the impact of HAART has been significant, its use is complicated. Treatment regimens can require several pills taken throughout the day, and high rates of adherence are necessary to avoid the development of drug-resistant strains of the virus. Treatment should not be confused with a cure.

HAART may reduce the perceived seriousness of the epidemic; in the U.S. and elsewhere, new therapies can lead some to reengage in risky behaviors. While treatment has reduced the number of deaths, the rate of new infections has not decreased.

Flaws in the financing and delivery system persist. The existing delivery system has not accounted for the shift from treating HIV as an acute condition to a chronic illness (IOM 2005). As a result of HAART, more people are living with HIV/AIDS than ever before, over 1.1 million in the U.S. alone (The Henry J. Kaiser Family Foundation 2006b). The system of care has shifted as well. In the past, most care was provided on an inpatient or hospice basis; now, two-thirds of HIV care occurs in physician offices, community health centers, and clinics. Lessons from managing chronic conditions such as diabetes may apply to HIV as well; effective treatment relies on provider coordination and training.

As with any discretionary federal grant program, the futures of PEPFAR and CARE are uncertain. Funding for PEPFAR is scheduled to run out in 2008, and it will be up to the next president to sustain the commitment. After over a year of debate in Congress, the Ryan White CARE ACT was reauthorized in 2006. The new law, The Ryan White HIV/AIDS Treatment Modernization Act, is authorized for 3 years. Funding for CARE has been relatively stable for the past several years (Figure 2), even though demand for HIV/AIDS therapy has increased. To assure ample funding for metropolitan areas and newly emerging affected rural areas, overall funding has been increased.



It is imperative to devote more attention and funding to prevention efforts. In 2006, just 4 percent of federal funding for HIV/AIDS was devoted to domestic prevention efforts. The current focus on testing and treatment fails to address the most significant means of stopping the spread of the virus; without a vaccine, the only way to slow the spread of HIV is to prevent new cases. Prevention is more important than ever and requires a multi-dimensional approach that could encompass needle exchange, male circumcision, condom distribution, microbicides, and improved education.

In the absence of a vaccine, testing has emerged as a means to controlling the spread of the virus. In 2006, the CDC issued recommendations for mandatory testing, including:

- screening for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening);
- annual screening for persons at high risk for HIV; and
- routine screening for all pregnant women.

Controversy swirls around these recommendations. Many advocates fear that providers will not offer the education and counseling that should come with HIV testing. Instead, testing should be seen as an opportunity to educate the public about risk prevention and healthy behaviors.

Globally, the epidemic has yet to peak. Estimates of new infections still exceed deaths by millions per

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year. In many regions, most individuals with HIV do not know their status and have little or no access to treatment (Curran 2006).

After 25 years, there is still no cure. Even with treatment and increased funding, the only way to fight the epidemic is to reduce the incidence.

Grantmaker Activity

Philanthropy has played a critical role in addressing the AIDS crisis. Very early on, the lack of government recognition or funding diminished any sense of urgency by other funders. In 1983, however, two years after the first identified case of HIV, several foundations, including The New York Community Trust, and The San Francisco Foundation, acted by funding existing social services organizations that were responding to the epidemic (Funders Concerned About AIDS 2003). Funding declined in the mid-1990s, a result of what some observers call AIDS fatigue. In recent years, U.S. funders have funneled more money to the global epidemic. In 2004, U.S. philanthropy provided nearly \$346 million to HIV/AIDS-related causes (Funders Concerned About AIDS 2006). Despite this level of commitment, many funders remain reluctant to get involved in HIV/AIDS philanthropy, perhaps because it involves dealing with uncomfortable issues of sex, drugs, politics, and other charged issues.

Overall, as the epidemic has changed, funding strategies have evolved as well. As people live longer, funders are directing more money toward services for individuals living with HIV/AIDS, such as food programs, housing assistance, and needle exchange. Instead of helping people die comfortably, services are now geared toward enhancing quality of life. Illustrative examples of grantmaking practices follow.

EARLY FUNDING

Robert Wood Johnson Foundation (RWJF) was one of the first philanthropies to take on HIV/AIDS. In 1986, in response to the growing urgency of the situation, RWJF announced its first program focused on HIV/AIDS. This move marked a striking departure from the foundation's typical resistance to fund a single disease. In particular, foundation staff stirred up controversy among its conservative board of directors. But by the mid-1980s, the foundation felt the growing public urgency and decided to act. Identifying a promising service delivery model from San Francisco, foundation staff tested it in communities throughout the country. The AIDS Health Services Program adopted a community-based case management approach to caring for patients as opposed to providing inpatient treatment. The federal government stepped forward to provide matching emergency funding for the

program, and eventually enacted the Ryan White CARE Act, based on the RWJF model. With the introduction of support from the federal government, the foundation decided to end the program in 1991.

COLLABORATIVE EFFORTS

Because AIDS involves a combination of conditions, the most effective grantmaking initiatives involve case management, nutrition support, housing and transportation support, emergency financial assistance, emotional support, and emergency medical expenses.

The National AIDS Fund (NAF) is one of the largest philanthropic organizations focused on HIV/AIDS. Developed in 1988 by the Ford Foundation, NAF's purpose is to direct critical resources to community-based organizations to fight HIV/AIDS at the local level. Through 29 state and local funding collaboratives, or community partners, the fund provides grants and other support to over 400 community-based organizations annually, principally for prevention efforts. With its community partners, NAF has committed over \$134 million for AIDS funding.

The San Diego HIV Funding Collaborative, a NAF community partner, was formed in 1990 by several local funders, including Alliance Healthcare Foundation, and concerned community members. Since its inception, the collaborative has raised nearly \$4 million (\$1.3 million from Alliance Healthcare Foundation) for a wide array of HIV/AIDS services, including medical services, prevention and education services for homeless and runaway youth,

culturally and ethnically appropriate education services, hospice care, and harm reduction services and materials. The collaborative makes the majority of its grants through a request for proposals process and sets aside funds for special projects, discretionary grants, and emergencies.

One challenge the collaborative faces, which is common to many AIDS organizations, is donor fatigue. As the public increasingly considers HIV a chronic disease, some of the urgency of previous years has disappeared. The collaborative hopes to shift the perception that HIV is no longer a serious public health threat and inform people that young people and people of color are infected at higher rates.

Through its involvement with the collaborative, Alliance Healthcare Foundation has learned the power of leveraging. The foundation provides approximately \$100,000 per year to the collaborative: a \$15,000 grant as well as approximately \$85,000 in in-kind services. The foundation's strong support allows the collaborative to exist and raise money from other donors.

SUPPORTING ADVOCACY

Many foundations understand that advocacy can be a powerful tool in combating the challenges of the HIV/AIDS epidemic. The New York Community Trust, for example, has been a pioneer in supporting HIV/AIDS advocacy. As one of the first foundations to enter HIV/AIDS philanthropy, the trust continues to support the cause by administering the New York City AIDS Fund, a community partner of NAF, founded in 1988. Despite gains in

knowledge about HIV prevention, with the advent of HAART, young people are frequently not protecting themselves against infection. After studies revealed a shocking percentage of young people of color in the New York City area were infected, the trust provided a grant to the Legal Action Center of the City of New York to support prevention programs for at-risk populations. The center educates the public by organizing community forums about HIV infection; helps agencies that serve poor women to start HIV-prevention programs; performs media outreach; and works with the State AIDS Institute, community groups, government, foundations, and businesses to fund creative HIV prevention approaches for women of color.

The San Francisco AIDS Foundation was instrumental in the passage of the CARE Act as well as the enactment of HOPWA. To continue its commitment to influencing HIV/AIDS policy, the foundation organized its HIV Advocacy Network (HAN) to engage members to work with decisionmakers. To assist advocates in their work, HAN holds periodic briefings on the latest issues in HIV/AIDS, circulates an e-newsletter, provides training on advocacy skills, and organizes members to make lobbying trips to Washington, DC and Sacramento. Similarly, The New York AIDS Coalition, with funding from The New York Community Trust, has advocated to increase overall funding for the CARE Act rather than changing how the money is distributed, and to stop proposed cuts in Medicaid. The coalition also will offer workshops to teach New Yorkers with AIDS about

the CARE and Medicaid proposals and encourage them to meet with their elected officials to protest the cuts.

REACHING OUT

One of the New York Community Trust's top priorities is supporting the development of HIV prevention programs, and it has funded programs such as the Street-based Employment Empowerment Team (STREET) Project that provides outreach to street-based sex workers in the Bronx. STREET works with individuals to encourage HIV prevention education, counseling, and testing. In 2003, in response to the rising rates of HIV infection in communities of color, the trust worked to increase awareness of AIDS and to encourage testing among African Americans and Latinos. The trust worked with the Federation of Protestant Welfare Agencies to launch a bilingual media campaign that will provide information on services.

Many foundations are supporting evidence-based prevention efforts that the government may be reluctant to fund. Needle exchange programs, which provide sterile needles to injection drug users who turn in their used syringes, have been shown to help prevent the transmission of HIV. Such programs are controversial, however, because many believe they promote drug use. Public Welfare Foundation has funded needle exchange programs since 1996 when it received a funding proposal from Prevention Point Philadelphia, a comprehensive harm reduction program that provides needle exchange, street outreach, and basic medical care. From the foundation's point of view, harm

reduction programs are a way of sustaining life. Harm reduction programs can reach a marginalized population that traditional social services may not have reached. Because of the success of Prevention Point and despite the continued controversy, the foundation has gone on to provide over \$2 million in grants to support this life-saving work.

AIDS is likely to be with us for a very long time, but how far it spreads and how much damage it does is entirely up to us.

—PETER PIOT

FUNDING THE SCIENCE

The International AIDS Vaccine Initiative (IAVI) is a public-private partnership started by the Rockefeller Foundation in 1996 to fund clinical research. IAVI advocates for a vaccine to be a global priority and works to assure that a future vaccine will be accessible to all who need it. Operational in 23 countries, IAVI has invested more than \$100 million in vaccine research and development. Other funders of the IAVI include The New York Community Trust, the Bill and Melinda Gates Foundation, the Starr Foundation, and Broadway Cares/Equity Fights AIDS. Despite the number of unanswered questions surrounding the development of a vaccine, IAVI has helped double the number of vaccine candidates between 2000 and 2005.

GlaxoSmithKline (GSK) supports a variety of scientific initiatives, including improving the convenience of delivering HAART, addressing drug-resistant strains of HIV, and researching a vaccine against HIV

infection. To augment this work, GSK has recognized the importance of community-based responses to HIV/AIDS. In 1992, GSK launched the Positive Action program to provide community organizations across the world with prevention education, fundraising assistance, direct counseling and medical services, and outreach strategies. Positive Action has provided training for health care workers in East Africa, assisted community clinics in Kenya with improving antiretroviral provision, and helped disseminate prevention messages to women and families in rural India.

A GLOBAL EFFORT

The Henry J. Kaiser Family Foundation launched loveLife in 1999 to reduce HIV infection among South African adolescents. Half of South Africa's new HIV infections occur in people before reaching the age of 25. The foundation found that modest changes in adolescent sexual behavior could substantially curtail the HIV epidemic. loveLife's target group is 12- to 17-year-olds, but special programs focusing on children 6 to 12 years of age are also part of the campaign. The initiative was developed through a two-year process of investigation, consultation, and planning, including a review of international HIV prevention programs, an evaluation of existing HIV education efforts, and extensive focus group research among young South Africans. The initiative uses popular culture to promote sexual responsibility and healthy living, while at the same time developing frontline services that are more responsive to the sexual health concerns and needs of adolescents. Beyond HIV prevention, loveLife

aims to prevent other concerns related to sexual health, such as teenage pregnancy and sexually transmitted infections, and to address gender disparities that have impeded progress in the fight against AIDS. Kaiser has also designed several other media campaigns abroad, including India's Heroes Project, in conjunction with the Gates Foundation, and Russia's STOP SPID, which uses PSAs, television and radio programming, and print editorial content.

In the 1998, the Bill and Melinda Gates Foundation entered the field of HIV/AIDS philanthropy, awarding substantial grants to the Population Council to develop microbicides and to IAVI. The Gates' presence has boosted the overall level of giving to HIV/AIDS efforts as well as international media attention. The foundation's focus is to help significantly slow the global spread of HIV. The foundation seeks to fund in areas that maximize use of existing prevention tools or develop effective preventive technologies. Among the foundation's most notable initiatives are its work to prevent HIV in African youth, its support of the Global Fund for AIDS and Health, and its funding for a third-phase trial of a microbicide.

While we have come a long way since the birth of HIV/AIDS, there is still a long road ahead. As Peter Piot, the executive director of UNAIDS, said in the 2004 Report on the Global AIDS Epidemic, "AIDS is likely to be with us for a very long time, but how far it spreads and how much damage it does is entirely up to us" (UNAIDS 2004). With over 40 million individuals infected and

countless lives affected, there is no time to spare.

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Fast Facts

The Worldwide Effects of HIV/AIDS

Since the beginning of the epidemic, HIV/AIDS has claimed more than 25 million lives (The Henry J. Kaiser Family Foundation 2006).

Worldwide, 39 million people are currently living with HIV/AIDS (The Henry J. Kaiser Family Foundation 2006).

During 2005, 4.1 million people were newly infected with HIV, including 540,000 children (The Henry J. Kaiser Family Foundation 2006).

In West Africa, only 1 percent of children and pregnant women with HIV receive antiretroviral treatment (UNICEF 2006).

Without increased action to prevent the spread of the pandemic, more than 18 million children in Africa will have lost one or both parents to AIDS-related illness by 2010 (UNICEF 2006).

Young people, ages 15 to 24, account for over 40 percent of new adult HIV infections (The Henry J. Kaiser Family Foundation 2006).



The Effects of HIV/AIDS on the United States

Over 500,000 people have died from HIV/AIDS since the beginning of the epidemic (The Henry J. Kaiser Family Foundation 2005).

In 2003, an estimated 1.1 million people were living with HIV/AIDS (The Henry J. Kaiser Family Foundation 2005).

Approximately 24 percent to 27 percent of those infected with HIV do not know it (The Henry J. Kaiser Family Foundation 2005).

The Centers for Disease Control and Prevention (CDC) estimates that between 40 percent and 60 percent of the infected population does not receive regular treatment (Taylor 2005).

Racial and ethnic minorities account for over 70 percent of new AIDS cases (The Henry J. Kaiser Family Foundation 2005).

In 2002, HIV was the leading cause of death for African-American women ages 25 to 34 (The Henry J. Kaiser Family Foundation 2005).

In 2004, 27 percent of new HIV/AIDS cases were among women (CDC 2005).

Approximately half of individuals in treatment for HIV have a comorbid mental illness (IOM 2004).



Building the Case for Improved Prevention Efforts

Circumcised men are 60 percent less likely than uncircumcised men to become infected with HIV from female partners (Global HIV Prevention Working Group 2006).

Antiretroviral therapy can cut the risk that an HIV-infected pregnant woman will transmit HIV to her child by nearly 50 percent (Global HIV Prevention Working Group 2006).

Fewer than one in five individuals at high risk for HIV infection have access to effective prevention (Global HIV Prevention Working Group 2006).

By 2008, \$11.4 billion will be needed annually for HIV prevention—two-and-a-half times current spending (Global HIV Prevention Working Group 2006).



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Recommended Reading

Bronner, Ethan, "The Foundation and AIDS: Behind the Curve but Learning the Way," in Stephen L. Isaacs, and James R. Knickman, eds., *To Improve Health and Health Care: Volume V: The Robert Wood Johnson Foundation Anthology* (San Francisco, CA: Jossey-Bass, 2002).

In this essay, Ethan Bronner chronicles how the Robert Wood Johnson Foundation addressed the AIDS crisis in the United States. The story recollects the high level of sensitivity surrounding the topic and how the foundation overcame stigma to make an important contribution to a deadly epidemic.



Funders Concerned About AIDS, *U.S. Philanthropic Commitments for HIV/AIDS 2004* (New York, NY: 2006).

This annual resource tracking report compiles information about the activity of U.S.-based grantmakers in the field of HIV/AIDS. The report separates domestic and international grantmaking, and provides a list of the top HIV/AIDS grantmakers in the U.S.



The Henry J. Kaiser Family Foundation
<http://kff.org/hivaids/index.cfm>

The Henry J. Kaiser Family Foundation is a source of independent and current information on HIV/AIDS. The Web site provides policy reports, fact sheets, and survey data, as well as information on the foundation's media partnerships, journalist training programs, and HIV/AIDS initiatives in South Africa.

Institute of Medicine, *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White* (Washington, DC: National Academies Press, 2004).

This IOM report examines the current standard of care for HIV patients and assesses the system currently used for financing and delivering care. The book recommends expanded federal funding for the treatment of individuals with HIV through a program that would provide timely access and consistent benefits with a strong focus on comprehensive and continuous care and access to antiretroviral therapy.



Shilts, Randy and William Greider, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: St. Martin's Press, 1987).

In the first major book on AIDS, *San Francisco Chronicle* reporter Randy Shilts examines the making of an epidemic. Shilts researched and reported the book exhaustively, chronicling almost day-by-day the first five years of AIDS. The author challenges all aspects of society: the medical and scientific communities; the massmedia; the gay community; and the Reagan Administration who he claims cut funding, ignored calls for action, and deliberately misled Congress.



UNAIDS, *Report on the Global AIDS Epidemic* (Geneva, Switzerland: 2006).

This report includes country, regional and global estimates for the HIV/AIDS epidemic at the end of 2005 and 2003. It also describes the evidence, the success stories, and the challenges that confront countries and the international community in responding to the epidemic.

