



## Dear Allies and Colleagues:

Since the first case of HIV/AIDS was identified in 1981, the disease has been surrounded by myths and misconceptions. Some of the earliest leadership and action was catalyzed in the United States. However, despite mounting numbers of new infections and ominous predictions of the potential spread of the disease across the globe, unified leadership and action developed slowly. Over the past 25 years HIV/AIDS has been allowed to become the largest and most devastating public health pandemic and social justice issue of our time.

Over the years, the impact of HIV/AIDS in the developing world grew so large that it could no longer be ignored. Simultaneously, HIV prevention successes resulted in significant decreases in new HIV infections and the availability of new anti-retroviral treatments caused HIV-related death rates in the U.S. to fall. These factors have led the media, the general public and funders to conclude that there are two epidemics: the **international epidemic**, which needs immediate and significant attention and the **domestic or U.S. epidemic**, which is “under control.”

The primary purpose of this paper is to dispel this myth. **HIV/AIDS is ONE Epidemic** that is fueled by a universal set of social and structural inequities. The HIV/AIDS pandemic is neither inevitable nor unsolvable, but the choice is ours.

It is my sincere hope that this paper serves as a catalyst for positive action by individuals, service organizations, communities, private sector leaders, celebrities, foundations and governments. Together, we can change the course of the epidemic and create a healthier future for all people.

I invite your leadership, collaboration and action!

Respectfully,



Kandy Ferree  
President & CEO

The National AIDS Fund is proud to present this publication in collaboration with the Samarathopia Fund of The New York Community Trust.




Around the world, the number of people living with HIV or AIDS is now an estimated 40.3 million people, up from 37.5 million in 2003. Five million people will become newly infected with HIV in 2006 and, during that same time period, more than three million people will likely die of AIDS-related illnesses.

On average, people with HIV/AIDS in the United States have far better access to health care, education, and resources than people elsewhere in the world

# HOWEVER,

*the determinants of who becomes infected and ill from HIV/AIDS are much the same in the United States as in the rest of the world.*



 <b>NEW YORK CITY</b> <b>neighborhoods compared to selected countries</b>		
	Data about HIV/AIDS in New York City and selected neighborhoods <sup>5</sup>	Data about HIV/AIDS in selected countries <sup>6</sup>
<b>HIV/AIDS prevalence (# of total cases per 100 people)</b>	<b>4.0</b> (all men ages 40-49, New York City, 2001) <b>4.0</b> (adult population, Chelsea/Clinton, 2001) <b>2.8</b> (adult population, Bedford-Stuyvesant/Crown Heights, 2001) <b>2.3</b> (adult population, Central Harlem/Morningside Heights, 2001) <b>1.5</b> (adult population, High Bridge/Morissania, Croton/Tremont, Hunts Point/Motthaven, 2001)	<b>3.2</b> (adult population, Trinidad & Tobago, 2001) <b>3.0</b> (adult population, Bahamas, 2001) <sup>7</sup> <b>2.6</b> (adult population, Cambodia, 2001) <b>1.9</b> (adult population, Benin, 2001) <b>1.5</b> (adult population, Barbados, 2001)

## THE “U.S. EPIDEMIC” MIRRORS THE “GLOBAL EPIDEMIC”

In the United States, those working for an effective HIV/AIDS response have much to be proud of. Due to strong community-level work, HIV infection rates have fallen precipitously from their peak levels in the 1980s from over 160,000 to 40,000 per year. The nation’s investment in biomedical research has produced powerful HIV treatments, and those who have access to AIDS treatment in the United States can receive some of the best AIDS-related care in the world. And, due to focused efforts of many advocates, the U.S. government dedicated more than \$17 billion to address the domestic epidemic in fiscal year 2005.

However, the HIV/AIDS epidemic persists at extremely high levels in key populations in the U.S., and continues to spread. The U.S. Centers for Disease Control (CDC) estimates that approximately 40,000 people in the United States are newly infected with HIV each year. Although estimated incidence did plummet from its peak of more than 160,000 annual infections in the mid-1980s, the number of newly infected has remained at the current annual incidence since 1990. The CDC estimates that between 1.039 million and 1.185 million people were living with HIV/AIDS in the U.S. in 2003, with 405,926 people living with AIDS. **Furthermore, approximately one in three people living with HIV – 350,000 individuals – don’t know their status.**<sup>3,4</sup>



	Data about HIV/AIDS in populations outside the U.S.	Data about HIV/AIDS in U.S. populations		
		Men who have sex with men (MSM)	Injection drug users (IDU)	Women at risk through sexual transmission
HIV/AIDS prevalence (# of total cases per 100 people)	16 (general population, South Africa, 2005) <sup>12</sup>	46 (444 African-American MSM, 2003-4) <sup>14</sup>	26 (531 men and women entering Odyssey House, NYC, 2003) <sup>16</sup>	7 (160 non-IDU women entering Odyssey House, NYC, 2003) <sup>18</sup>
	16 (women aged 15-24, Lesotho, 2004) <sup>13</sup>	14 (young African-American MSM ages 15-22) <sup>15</sup>	26 (154 IDU MSM recruited and tested, seven U.S. cities, 2003-2004) <sup>17</sup>	0.6 (all Black women in 29 states with HIV reporting, 2002) <sup>19</sup>
HIV incidence (# of new infections per 100 uninfected people per year)	2.7 (all adults, general population, 2005)	2.8 (4,697 MSM in VaxGen trial, multiple cities, 1998-99) <sup>21</sup>	1.8 (1,870 IDU, Baltimore, 1995-98) <sup>23</sup>	1.5 (308 women in VaxGen trial, multiple cities, 1998-99)
	1.8 (all urban adults, Ethiopia, 2005) <sup>20</sup>	2.1 (4,295 MSM in HIVNET 015 Explore study, multiple cities, 1999-2003) <sup>22</sup>	1.7 (622 IDU, Bronx, 1985-present)	1.2 (511 women in HIVNET, multiple cities, 1995-99)

The factors that concentrate the HIV/AIDS epidemic in specific populations around the world are the same. HIV/AIDS affects growing numbers of individuals who are poor, without private health insurance, and who are dependent on a functioning public system for prevention information and lifesaving care. In short, HIV infections and poor HIV-related health outcomes are concentrated among those who are unable to negotiate or access quality health because of poverty, homelessness, recent incarceration, drug use, sexuality, and ethnic, racial, or national identity.<sup>24</sup>

The concentration of HIV and AIDS into high prevalence networks is self-reinforcing. Once a large proportion of people in a sexual/drug use network are already infected, those at risk are more likely to be exposed.<sup>25</sup> In the United States, one reason that HIV/AIDS is at such high rates among selected African-American populations and among men who have sex with men (MSM) and injection drug users (IDU) is that these rates have been allowed to persist and gradually increase for decades. The same is true about HIV/AIDS rates among MSM, IDU, and other marginalized populations throughout the world.

**As with the overall HIV/AIDS epidemic, these concentrated sub-epidemics are neither inevitable nor unsolvable. A great deal is known about how to prevent and treat HIV/AIDS.** Many organizations around the world have documented “best-practice” interventions that can guide strategic investments into HIV/AIDS programming. And, finally, the United States and other countries have developed and ratified many international health and human rights standards that, if applied, would address the factors that fuel HIV/AIDS. The course of the HIV/AIDS epidemic can be changed locally and globally, and the time to accelerate efforts is now.









**WHILE PROGRESS HAS BEEN MADE AGAINST HIV/AIDS, MUCH IS YET TO BE DONE.**

It is possible to prevent, treat, and ultimately curb the impact of the HIV/AIDS epidemic. Countries such as Australia have shown that early investment in several core interventions - safe blood supplies, risk reduction education and support, access to male and female condoms, testing and treatment for HIV and other sexually-transmitted infections (STIs), comprehensive sexual health education, and accessible HIV treatment and basic health care - can allow communities to reduce and avoid epidemics of HIV and other STIs.

**However, in the United States at the current level of effort, HIV/AIDS continues to deepen its hold.**

Both the private sector and the public sector - federal, state, and local governments - are showing an unwillingness to acknowledge the data and act upon the priority interventions that could end HIV/AIDS. For example:

**SEXUAL AND REPRODUCTIVE HEALTH PROGRAMS FOR YOUTH CAN BE IMPROVED.**

An array of individual studies and meta-analyses (a systematic review of all relevant studies) have determined that comprehensive sex education and condom promotion programs that include information about abstinence, condom use and reproductive health can be effective at helping young people to reduce their number of sexual partners, increase condom use when they do have sex, and delay the onset of sexual intercourse.<sup>43</sup> A multitude of studies and program evaluations have concluded that abstinence-only programs are not effective.<sup>44</sup>

# IN THE UNITED STATES,

AS IN OTHER COUNTRIES, THE HIV/AIDS EPIDEMIC IS DRIVEN PARTLY OUT OF A SOCIETAL RELUCTANCE TO PROPERLY EDUCATE THE NEXT GENERATION ABOUT PREVENTION OF SEXUALLY-TRANSMITTED HIV AND OTHER INFECTIONS.







## FUNDING FOR HEALTH SERVICES HAS BEEN GIVEN GREATER PRIORITY IN NATIONAL, STATE AND LOCAL POLITICS AND POLICIES

At a national level, although spending through mandatory health programs like Medicare and Medicaid has increased, U.S. federal government support for most discretionary health efforts, including HIV prevention, housing, mental health and substance abuse programs, has been declining for years. For example, the Housing Opportunities for People with AIDS (HOPWA) program fell from \$295 million in FY 2004 to \$282 million in FY 2005 and a further reduction is proposed for 2006. In another example, federally-funded AIDS Drug Assistance Programs served approximately 136,000 people in 2003, but by early 2004, budget shortfalls at state levels resulted in a **waiting list of 1263 individuals who are unable to access services and must, therefore, go without life-saving medications.**<sup>52</sup>

HIV prevention has also been affected. Of the \$18.5 billion that the U.S. government spent on HIV/AIDS funding in 2004,

# ONLY 5%

WENT TOWARD PREVENTION EDUCATION PROGRAMS.<sup>53</sup>

Funding for HIV prevention at the U.S. Centers for Disease Control and Prevention (CDC) declined from \$738 million to \$731.7 million from FY 2004 to 2005. The President's 2006 budget proposal requests a further reduction of \$4.7 million.

At a state and municipal level, even the mandated Medicaid and Medicare programs are under pressure. Many state governments are responding to fiscal pressures by reducing or restricting Medicaid benefits, imposing cost sharing requirements (including increasing Medicaid co-payments), and implementing controls on pharmacy costs. For example, in October 2005, the federal government gave approval for Florida to make significant changes to its Medicaid program that included placing absolute limits on spending and allowing private insurers more room to limit benefits. These measures, combined with delayed eligibility for both the Medicaid and Medicare programs, create structural barriers to appropriate care by discouraging providers from treating poor individuals with HIV. The result: fewer than half of the people in many regions who meet government criteria for use of antiretroviral treatment for HIV are likely to be receiving these drugs, and a significant share of people who have HIV and AIDS will be tested too late in the course of disease to benefit from early care.



# NATIONAL AIDS FUND

*A National Catalyst for Local Action*

The National AIDS Fund was founded in 1988 with a clear mission: to reduce the incidence and impact of HIV/AIDS by promoting leadership and generating resources for effective community responses to the epidemic. Through an expanding network of **Community Partnerships** the Fund promotes collaborative local planning and provides strategic grants and technical support to nearly 400 direct service organizations annually. Community Partnerships are consortia of concerned business, philanthropic, and community leaders dedicated to supporting HIV/AIDS prevention and care in their communities and regions. The **Community Partnerships** use the leverage of our national grants to raise support locally, and make community-level decisions about how and where funds should be spent to meet the most pressing local needs.

The National AIDS Fund is positioned at the center of a critical crossroads - connecting national and local funders, public and private sector leaders, scientists, and community-based organizations. Over the past 18 years we have marshaled and invested over \$134 million to combat the AIDS epidemic.

**TOGETHER, WE ARE MAKING A DIFFERENCE!**





NATIONAL AIDS FUND

*A National Catalyst for Local Action*

729 15th Street, NW  
9th Floor  
Washington, DC  
20005

202-408-4848  
www.aidsfund.org