

The White House AIDS Strategy: A policy solution to address racial disparities of HIV/AIDS in African Americans living in New York City

Briana L. Cartwright
Profs. Shamasunder and Matsuoka
Urban and Environmental Policy
Occidental College

Table of Contents

Executive Summary	3
Introduction.....	5
Methodology	10
Gaps in Topical Literature	11
Primary Data	13
Secondary Data	15
Background	17
<i>Demographics of the Disease</i>	17
<i>Social, Political, and Economic Context</i>	18
<i>The African American HIV incidence in New York City</i>	21
<i>The Funding Issue as a National Priority</i>	23
<i>The National HIV/AIDS Strategy</i>	26
Findings and Analysis	28
<i>How we can end HIV/AIDS in America</i>	30
<i>Trends in the Reduction of HIV/AIDS in New York</i>	31
Causes of the Disparity	32
<i>The Significance of Black Church</i>	33
Funding.....	39
<i>Perception of National HIV/AIDS Strategy</i>	43
Recommendations	46
<i>Holistic Approach</i>	48
<i>Policy Recommendations</i>	53
Laws	53
<i>Collaborative Program Funding</i>	54
<i>Culturally Competent Staff Training</i>	55
<i>Local Self-Sustained Funding</i>	56
<i>Local Church Involvement</i>	56
<i>Local Media Campaigns</i>	56
<i>Streamlined Monitoring and Evaluation</i>	57
<i>Long Term Federal Funding</i>	58
Conclusions.....	58
Bibliography	61

Executive Summary

Topic: The National HIV / AIDS Strategy: A policy solution to address racial disparities of African Americans living with AIDS in New York City

Problem: African Americans account for 13% of our population but account for 47% of HIV infections. New York City represents the epicenter of this epidemic with the largest - over 110,000 - cumulatively reported HIV – Infected African Americans. The scale of the problem indicates a basic failure of HIV/AIDS policies and programs in African American communities in New York City.

Research Question: Why is there a significantly higher incidence of HIV / AIDS among African Americans and can the new National HIV / AIDS Strategy reduce it?

Methodology: After reviewing literature on African American HIV disparities and New York City as the largest example, I interviewed a cross – section of academic, government and community experts in the field of African American HIV / AIDS programs. I focused the interviews on gaps between the literature and a complete explanation of the causes of the disparity and potential policy solutions supported by the National HIV / AIDS Strategy. Comparing the explanations of the disparity to the stated intent and features of the National Strategy, I prepared recommendations that applied the National Strategy to the specific requirements of African American HIV / AIDS prevention and treatment in New York City and by extension to other areas of high African American population density.

Key Findings: Topical literature shows that African American cultural and religious institutions identified the topic of HIV with conditions of social stigma. A less educated population, association of HIV with homosexuality, distrust of government health programs rooted within

the African American historical experience and fear of unstable public health funding impede African American participation in prevention, testing and treatment programs. These factors accelerated the spread of HIV and the development of full-blown AIDS among African Americans. The National HIV strategy supports and funds a new and effective collaboration among between federal, state and local government in support of community based organizations that gain the trust of African Americans. New York laws requiring the offer of HIV testing to all residents over age 13 also removed barriers to increased participation in HIV programs. The combination of locally trusted prevention and testing programs with holistically individualized treatment regimens, culturally sensitive staff, increased public awareness and churches addressing stigma has begun to reverse the HIV epidemic in New York.

Recommendations: The findings revealed initial successes of the new National HIV / AIDS Strategy but also highlighted lingering disparities in funding, staff training requirements, need for fund raising assistance for community organizations and persistent distrust of government agencies and health care policies that can change with new political regimes. Recommended supplements to the National Strategy include long term national commitment to the current strategy, required inclusion of local community organizations in federal HIV program funding formulas, expanded culturally competency training for all front-line staff, inclusion of churches in HIV prevention and testing programs and expanded public media campaigns. Long term federal funding of flexible local programs is critical.

Introduction

A global audience of hundreds of millions watched the Green Bay Packers win the 2011 Superbowl. If, on the night of their victory, our government announced that the entire population of Green Bay was HIV positive, the shock would be felt around the world. Within America's largest city, enough African Americans to populate Green Bay have lived silently under the influence of HIV since it was first detected. Fortunately, the disease can be prevented and the epidemic can be reversed with effectively implemented policies that target unique social and cultural challenges within the urban African American communities. African Americans living in New York City represent a disproportionate incidence of HIV/AIDS, with the rate of AIDS for African Americans approximating nine times that of Whites (Kaiser, 2006). In New York City, current statistics indicate that over 110,000 historical cases and 80% of all new cases of HIV/AIDS have been represented by African Americans. Forty percent of all cases in America are reported among African Americans, although this group only represents 12% of the population. This epidemic appears at its most virulent in urban areas with highest concentrations of African Americans. (CDC,2011) The escalating rate of HIV/AIDS in the African American community now compares to some of the world's greatest historical catastrophes. (Black AIDS Institute, 2012) Key factors including the scale of the epidemic coupled with the disparity of its prevalence in the African American community and the high concentration of the epidemic in New York City call for a federal policy response with new levels of cultural sensitivity and local public and private collaboration.

The HIV epidemic in New York

Conditions of HIV/AIDS for African Americans living in New York depict an epidemic in full bloom with New York City representing the epicenter of a national African American HIV disparity. (Freiden, 2004) At each stage of the HIV continuum, from initial HIV infection to contraction of full-blown AIDS, outcomes are worse for African American people than for other racial or ethnic groups. (Black AIDS Institute, 2012). In the case of HIV testing, for example, the rate of undiagnosed infection is higher in African Americans than for other ethnic groups, with an estimated 116,750 African American Americans living with undiagnosed HIV infection. (Black AIDS Institute, 2012). Lack of diagnosis not only prevents people from receiving much need treatment but it also leads to substantial exposure of the virus to their sexual partners. The disparity between African Americans and all other American populations offers a topic of analysis and a focus for an improved national policy response. Unlike traditional diseases such as polio or even more common sexually transmitted diseases, the HIV/AIDS epidemic involves forms of transmission that defy typical government health program approaches because of the often hidden nature of the infection and culturally reinforced resistance to testing, treatment and prevention measures.

The new National HIV Strategy

Fortunately, a recently implemented 2010 White House HIV policy targets the causes and conditions of the African American HIV population in New York City. The National HIV / AIDS Strategy (NHAS) features new approaches to HIV prevention, testing and treatment that involve collaboration with local community based organizations (CBOs) as well as state and local government health care agencies. The NHAS targets program resources to the needs of areas of highest concentration of HIV. This strategy recognizes the fact that the epidemic

spreads fastest in areas of highest concentration of and therefore proximity to HIV – infected residents. The NHAS therefore identifies high-density African American communities that present a high incidence of HIV infection as targets for resources and technical assistance. Not a social program, this data-driven approach is purely focused on measurable medical results and not social justice per se. The next NHAS breakthrough involves recognition that HIV / AIDS is a unique and highly socially stigmatized disease. The NHAS acknowledges that, because African American culture often strongly disapproves of homosexuality and wrongfully associates HIV with homosexual behavior, the fastest growing cohort of heterosexual females and the general African American population fear often violent and life-affecting repercussions of participating in any level of prevention, testing or treatment. The NHAS also recognizes historically rooted African American distrust of government agencies and programs. Most importantly, it specifically for the first time acknowledges the dramatic disparity in the African American community and targets its reduction as a national priority.

The NHAS creatively addresses these causes of the disparity by encouraging and funding a collaborative model that empowers local and trusted community based organizations that break through the stigma with locally and culturally specific tactics that attract both infected and non-infected African Americans to prevention, testing and treatment efforts. The NHAS represents a departure from traditional health care programs in that the primary point of service delivery is community – based, education focused and a multi-disciplinary effort to promote prevention measures introduces non-medical program partners, projects and activities. The economic and social impact of reduced HIV incidence in high-density African American populations such as New York City and Washington DC provides cost-justified outcomes and promotes self-sustained and locally managed prevention programs for future success. Finally, the NHAS

signals HIV prevention, testing and treatment as a national priority – a key requirement of community confidence needed to attract African Americans to participate in local programs.

Why new national strategy emphasizes African Americans

Unlike other STDs, the commonly held association with homosexuality places added stigma, denial and repression against HIV – related information and prevention practices in the African American community compared to all others. Lacking a universal cure or inoculation, HIV/AIDS also requires prevention, testing and treatment programs that involve a degree of education that many African and African American communities lack. Due to a 31% illiteracy in the African American community, television and musical media need to inform a growing urban audience (NAAL, 2003). Written materials go unread. If education is only administered within a clinic, then it fails to deliver prevention methods to the broader audience and creates a barrier to participation in the form of a social and cultural stigma that African American Americans resist. Social media and smartphones have become widely accepted within the younger African American communities and offer low-cost channels to communicate prevention related messages and appeals to get tested. The combination of stigma and lack of education create a syndrome of denial of the existence of the disease itself coupled with a rejection of the existence of the infected population as well as self-identification of infected individuals with the infected population. As opposed to other diseases and STDs, HIV is believed by African Americans to be the only disease linked to homosexuality that is strongly stigmatized by African and African American religion and culture. (Black AIDS Institute 2012) This unique aspect of the disease and the stigma attached to the disease explains the dramatic statistical disparity evidenced in all major research studies on the subject. The HIV/AIDS epidemic in the African American

community is therefore significantly more pronounced than others because of a unique socially reinforced resistance to information, identification and treatment solutions.

The policy solution

Despite advances in the therapeutic management of HIV-infected individuals, the solution to such a problem in the African American community requires a coordinated policy response with social and cultural components. (Black AIDS Institute, 2012) In the case of such socially propagated misunderstanding and resistance, traditional government programs based on patients voluntarily presenting themselves for treatment have extremely limited efficacy other than distributing medicine or attempting to administer treatment. Overseas, more effective HIV/AIDS policies empower community organizations with more culturally sensitive program management techniques that overcome the social stigma and relieve people from the fear of social consequences for participating in testing, prevention or treatment programs. For example, in South Africa, the LoveLife program uses government funding to sponsor radio and television commercials aimed at young people ages 13-24. The LoveLife program incorporates music and dance to attract and inform their audience about the dangers of risky sexual behaviors. The program is publicly promoted with billboards and creative advertising campaigns that deliver messages on health and sex education and promoting positive life affirming behaviors. They connect good health with a good life and offer examples of career success. The Obama administration has recently introduced policies and programs that similarly engage and empower local community organizations such as the Black AIDS Institute, The Balm at Gilead and others that I interviewed and summarized in the literature review to address this epidemic. This paper seeks to explore the effectiveness of the new National HIV / AIDS Strategy in terms of its

cultural relevance and program level impact on reducing the incidence of HIV / AIDS in African Americans in New York City.

Research focus: national strategy applied in New York City

My research seeks to better understand HIV/AIDS prevention programs in New York City. I evaluated the integration of the National HIV/AIDS Strategy as it reaches and addresses the specific needs of this community to cause them to engage in testing, treatment and prevention efforts that effectively reverse the epidemic. A recent body of evidence indicates that the current policies attack false beliefs, engage otherwise hostile community and church groups and encourage the same level of awareness and active prevention that other communities adopted in the past. By correlating these best practices with reduction in the incidence of HIV/AIDS in New York City, I identified a policy framework that can be replicated in other communities with high African American population. I also analyzed international best practices, compared successful media awareness approaches implemented in South Africa to our current national policy and programs, and applied them to a potential solution for African Americans living in New York City.

Methodology

This social analysis aims to gain a better understanding of and to evaluate the National AIDS Strategy in terms of its implementation in New York. I interviewed key officials at the AIDS Institute, Gay Men of African Descent, Gay Men Health Crisis, and Brooklyn AIDS Task Force. I also targeted key subjects to interview including Dr. Daniel O’Connell, Deputy Director of the State of New York AIDS Institute, Dr. Leo Wilton and Dr. Robert Miller. Primary data was collected mainly through answers to questions asked to experts in the field of HIV/AIDS prevention as well as African American community leaders. Building positive relationships with

the community members was essential to the study due to the limited time period and their busy schedules.

Gaps in Topical Literature

One gap in the literature is the need for more local information on media strategies for HIV prevention and to encourage testing and treatment. Many HIV/AIDS organizations are trying their best to address the stigma surrounding HIV within the African American community. However, some have more effective ideas on how to approach the situation than others do. One evaluates the idea based on how successful was the outcome. For example, Justin Thompson from Gay Men of African Descent explained that their organization has conducted a campaign called “HIV is My Reality.” This campaign took pictures of fifteen HIV-positive African American men and placed their stories underneath their pictures. They then used them in presentations and conferences around the United States. Thompson described the approach as “people who are basically being out about their HIV status and publicly sharing their story.” They also included these pictures on bus shelters, movie theaters, and buses.



This approach uses mass media to invoke a dialogue within the community that attempts to help the public to understand the life of a person with HIV. It appears as if this approach has

encouraged HIV positive people to feel free to disclose their status; however, it does not as effectively address the need for prevention. A distinct campaign such as the Lovelife campaigns in South Africa needs to appeal to non-HIV positive heterosexual African Americans to inform them of the need for condom use, testing and other healthy lifestyle choices.

A coordinated local social and public media campaign could generate measurable results in terms of testing or indications that girls are learning health behaviors. This research has not found enough examples of local coordination with national HIV/AIDS awareness campaigns or effective local radio, music or other forms of artistic communication targeted at African Americans. This does not mean that such media campaigns do not exist, it simply means that I was unable to gather enough data on them at this time. However, media campaigns have proven effective in South Africa and other communities of color and holds promise to deliver and reinforce culturally sensitive messages to prevent HIV or to encourage testing and treatment.

Another key gap in my findings is the lack of an HIV-positive person to interview. Constraints of time and distance, as well as the ever-present stigma of self-identification have limited access to this population for this research. Further research will attempt to include input from this population and explore options to discreetly gather input on all related topics of discussion. New York City is not only large and complex, it consists of many African American communities that cut across a spectrum of socio-economic strata. The fact that HIV positive subjects avoided interviews speaks to the enduring fear of hostility and stigma if the subject's condition is exposed. The very stigma that blocked interviews also blocks participation in HIV prevention, testing and treatment programs. This is not as much of a gap as a self-fulfilling and self-perpetuating condition of the African American community applied to the topic of HIV / AIDS,

Primary Data

My research therefore indicates that the solution for this disparity logically originates from within the core set of cultural influences that contribute to its cause. Even as the number of new HIV infections in New York has fallen, the proportional disparity between African Americans and whites has not. Overall, African Americans in general suffer from a historical lack of information, education and communication that becomes magnified when a scientific subject such as HIV collides with an often-inappropriate association with homosexuality that is further condemned by the African American church (Wiley, 2010). As a centerpiece of African American culture, my interviews noted that the Black Church holds one of the keys to the solution, but also contributes disproportionately to the stigma that creates barriers for both treatment and prevention. A lack of equitable distribution of medicines along with a lack of funding also exists in greater proportion within the African American community of New York City. Although difficult to explain and measure, this inequity also partially explains at least some of the past statistically proven disparities. Finally, the lack of a national acceptance of HIV and the need for a coordinated umbrella of leadership to unite the comparatively large number of independent local organizations in New York served to further widen the disparities of HIV between African American New Yorkers. The findings indicate that success may originate within the cultural centers of the African American community in New York, but will also require national leadership with increased funding, targeted media campaigns and coordinated oversight of agencies and community organizations.

The key design of my project identifies gaps between stated policies as defined in the NHAS guidelines and the actual results as recorded in their reports. Direct interviews with Dr. Wilton, Dr. Miller, Ms. Stone, Dr. O'Connell, Mr. Thompson, and Dr. Fenton will reveal

qualitative aspects of program service delivery and activity performance. Primary sources of information will identify remaining gaps and barriers within the New York African American community that require further investigation. The interviews will reveal the presence or absence of effective, culturally sensitive management and community outreach techniques.

I asked both open and closed-ended questions during formal interviews of a cohort of executive, administrative, management and operations staff and client subjects. My open-ended questions revealed subjective opinions of the programs while more objective closed-ended questions established a factual frame of reference. The in-depth interviews were digitally recorded and then transcribed. I detected and analyzed salient themes in the transcribed interviews and attempted a final quantitative analysis of the responses in the form of charts and graphs that correlate effective techniques with measured results. With a focus on the subject's efforts independently of and in conjunction with collaboration with other entities, I attempted to assess the efficacy of the recent NHAS collaborative strategy measured in terms of its application to the efforts of each interviewee. If the subject has found another effective approach that diverges from the national strategy, that was noted and the subject was probed to explain the causes of its effectiveness as well as the likelihood that the approach is replicable in other settings or can be introduced to the national strategy. Comparing the national strategy with local programs, projects and activities uncovered local techniques that reach and address the local African American community while conforming to a national program with a national funding, operational and reporting structure. Direct interviews provided examples of such local project and activity – level success and challenges to illustrate the relative effectiveness of the strategy or to further explain the unique disparity revealed by the secondary data.

Secondary Data

A portion of the data used to support this paper was collected from secondary sources. To find this data, I conducted extensive Internet and literature searches. I limited the use of secondary data to sources that specialize in the HIV/AIDS field including Centers for Disease Control, New York City Department of Health and Mental Hygiene, The Kaiser Family Foundation, Black AIDS Institute, academic institutions, health care professionals, government agencies, NGOs, and journals. I have discovered information on current national prevention programs and on HIV/AIDS prevention programs in New York. Maintaining this focus on authoritative sources, I am able to support interviews with direct sources as the result of my advance literature review. A common theme among these substantial research findings emerges from the basic need for collaboration between federal and community-based agencies to deliver prevention and treatment that addresses the specific needs of African Americans. The primary data is organized to affirm or deny the secondary data which will determine the validity in the proposition that policies that empower local community organizations offer a more effective solution for African American HIV/AIDS prevention and reduction.

The importance of the African American HIV battle in New York

I chose this topic because of the opportunity that it presents for urban policy development that can achieve measurable results in a large, highly dangerous and culturally relevant public health challenge. This topic represents one of the most difficult policy challenges because of the social and cultural roots of it that limit the efficacy of government to directly address it. The social stigma connected to HIV includes common misperceptions of the disease, homophobia and sometimes violent reactions to even the potential discussion of the topic among the very

population that it is killing daily. For this reason, it has been difficult for me and others to collect information from direct interviews with infected subjects that could shed light on effective solutions. In fact, many of my attempts to schedule such interviews were unsuccessful for a variety of ostensible reasons other than simple fear or shame on the part of the subject. The biases of the researcher infiltrate all methods of data collection and interpretation. My personal passion for trying to eradicate HIV/AIDS might have influenced conclusions drawn from the evidence provided. My passion started at fifteen years of age when I watched a BBC documentary on the HIV/AIDS epidemic in South Africa and learned that 25 million people had succumbed to the disease. Another bias that may be inherent in my work is due to my limitations in gaining access to HIV positive people due to patient confidentiality and protection. Also, due to community organizations having to present positive images to their funding sources, subjects may hesitate to express negative opinions.

The hesitance of government officials to discuss the subject coupled with the highly sensitive nature of the topic further fueled with the consequences of a breach in privacy conceal the true barriers to HIV / AIDS program success in the African American community. This study reflects information that I was able to gather within the time constraints of two semesters. The NHAS is still a work in progress. I focused on the fact that the implementation of a coordinated program in the United States is new. Without having years of data on the progress of the new White House policy, I had to focus on the potential contribution that the coordinated programs could make based on experience elsewhere and primary research input from local experts in the field.

Background

Demographics of the Disease

Compared with members of other races and ethnicities, African Americans account for a higher proportion of HIV infections at all stages of disease—from new infections to death. (Black AIDS Institute, 2012). In 2009, African American men accounted for 70% of the estimated new HIV infections among all African Americans. The estimated rate of new HIV infection for African American men was more than six and a half times as high as that of white men, and two and a half times as high as that of Latino men or African American women. (Kaiser, 2006) In 2009, African American men who have sex with men (MSM) represented an estimated 73% of new infections among all African American men, and 37% among all MSM. (CDC, 2011) More new HIV infections occurred among young African American MSM (aged 13–29) than any other age and racial group of MSM. In addition, new HIV infections among young African American MSM increased by 48% from 2006–2009. (Prejean et al, 2011) In 2009, African American women accounted for 30% of the estimated new HIV infections among all African Americans (CDC, 2011). Most (85%) African American women with HIV acquired HIV through heterosexual sex. (CDC, 2011). The estimated rate of new HIV infections for African American women was more than 15 times as high as the rate for white women, and more than three times as high as that of Latina women. (CDC, 2011)

The November 2011 Centers for Disease Control report provides a detailed analysis of the subject. At some point of in their lifetimes, an estimated 1 in 16 African American men and 1 in 32 African American women will be diagnosed with HIV infection (CDC, 2011) In 2009, an estimated 160,741 African Americans were diagnosed with AIDS in the United States, while by the end of 2008 an estimated 240,627 African Americans with an AIDS diagnosis had died in the

United States. (CDC, 2011). In 2007, HIV was the ninth leading cause of death for all African Americans and the third leading cause of death for African American women and African American men aged 35–44. (CDC, 2011)

In the next section, I will explore the disparity between African Americans and the general population. The disparity indicates clear cultural and social factors that have inhibited prevention and treatment methods that have worked in non African-American communities. Plumbing the depths of this problem presents a national challenge, but on a regional or local level, statistics appear to correlate with the national cohort. A review of this problem in New York, for instance, and specific areas of New York, reveal similar disparities which indicates similar if not common causes of the problem across racially concentrated African American populations.

The Social, Political, and Economic Context of the African American HIV Disparity

The 2011 Centers for Disease Control report defines the causes of this condition clearly. (CDC, 2011) African Americans face a number of challenges that contribute to the higher rates of HIV infection. (CDC, 2011) The greater number of people living with HIV in African American communities and the fact that African Americans tend to have sex with partners of the same race/ethnicity means that they face a greater risk of HIV infection with each new sexual encounter. (CDC, 2011). African American communities continue to experience higher rates of other sexually transmitted infections (STIs) compared with other racial/ethnic communities in the United States. (CDC, 2011) The presence of certain STIs can significantly increase the chance of contracting HIV. (CDC. 2011)

Additionally, a person who has both HIV and certain Sexually Transmitted Infections has a greater chance of infecting others with HIV.” (CDC, 2011). The CDC has within the past

ninety days issued a targeted study of HIV among African Americans and singled out New York City to monitor and evaluate programs that are attempting to fight this disease. (CDC, 2011) The report reinforced the need to concentrate on the scope of the problem in New York City to get a better understanding of the national epicenter of this epidemic.

Beyond the government and academic reports that attempt to explain this disparity, a far deeper source of conflict within Black America surrounds perceptions of homosexuality and topics such as HIV that relate to them. Recent reactions to President Obama's May 2012 new endorsement of Gay marriage expose long – standing beliefs that Gay sex is not only a biblical sin but that HIV is the consequence of it. As major Black religious leaders have just this weekend denounced President Obama, a media counter – attack against their prejudice and ignorance has exposed the depth of misunderstanding, lack of education and high level of animosity surrounding these topics. Amidst such open conflict, the quiet desperation of African Americans living with HIV for the past thirty years begins to make more sense. They could not expose their condition or even partake of information that could help prevent it without fear of being ostracized socially or even physically abused.

In *Black Sexual Politics*, Patricia Hill Collins explains the disproportionate impact of HIV as well as many other critical threats against African Americans as, “Poverty, unemployment, rape, HIV / AIDS, incarceration, substance abuse, adolescent pregnancy, high rates of Black children in foster care, interracial violence (especially by young Black males as both victims and perpetrators), and similar issues have a disproportionate impact on African Americans. All of these social problems take gender specific forms, and none will be solved without serious attention to the politics of gender and sexuality.” (Collins 2004, intro) If the HIV epidemic alone represented a study in disparity, then the government, academic and medical

research alone could explain it. African Americans uniquely face other related challenges and HIV is simply one of them. However, the religious furor surrounding the homophobic attacks on Gay marriage pin-point a far deeper internal attitude surrounding HIV that makes it stand even higher in the hierarchy of uniquely African American cultural and social problems.

The combination of the power of the Black church (explained further in this paper) and the already complex perceptions of Black masculinity threatened by centuries of slavery, laws that made Black men 3/5 of a “real man” and lingering direct threats to Black manhood that were only legally addressed in the mid-1960’s make homosexuality and the perception that HIV is a homosexual disease the equivalent of another direct threat to the relevance, power and even existence of the Black man. Collins explored these deep and complex relationships as they relate to Black men and women and the conflicts between them as they navigate the larger American society. In the vacuum of communication, darkness of ignorance and sheer terror at the idea of the disease itself, the deafening silence of the Black church on this matter all but relegated it to the category of a taboo sin. Therefore, the statistics that indicate that Black heterosexual women have become the fastest growing segment contracting HIV clearly directly derives from this silence and ignorance. The other major segment, men having sex with men, is the “traditional” source of HIV and, in a purely biblical context, the Black church even today defines these relationships as a sin and therefore “they” should suffer HIV as a consequence. In isolation, without a national strategy or leadership this logic has condemned African Americans to suffer in silence. Compounded by Collins’ broader context of many other disparities that single out the African American community, the HIV / AIDS disparity in New York City becomes immediately far more understandable within this social and cultural context.

The African American HIV incidence in New York City

Armed with a social and cultural explanation of the problem, we can now interpret the sheer scale of it to realize the need for national leadership and resources. The Centers for Disease Control report illustrates the scale of the problem as, “ NYS Population (overall): 19,541,453, Percentage of Population (U.S. / NYS): 12.9% / 17.2%, People living with HIV/AIDS: 55,429, New HIV infections / new AIDS cases: 2,168 / 1,920.” The statistics are staggering, African American New Yorkers living with HIV/AIDS comprise 44% of all cases, though they only represent 17.2% of the statewide population. (CDC, 2011). African American New Yorkers have the highest prevalence rate of HIV/AIDS in the State, with nearly 1,876 cases per 100,000 people; nearly 9 times the prevalence among whites. (CDC, 2011). The prevalence rate of AIDS diagnoses among African Americans is approximately 61 per 100,000 throughout the U.S. That figure rises to 95 in New York State. (CDC, 2011). The prevalence rate of African American New Yorkers living with HIV/AIDS increased 7% between 2005 and 2008. (CDC, 2011). With over 33,000 cases, New York has the highest number of African American residents living with HIV than any other state; about 10,000 more than Florida, the state with the second highest number. (Kaiser, 2006). New York contains more African American HIV cases than 36 other states combined. (Kaiser, 2006). There are more African American Americans living with AIDS in New York than California, Texas, and Illinois combined. (CDC, 2011). Additionally, there are greater than 10 times the number of African Americans living with AIDS in New York than Ohio, a state with two major cities – Cleveland and Cincinnati – having populations of African American residents as high as 47%. (CDC, 2011). New York City represents the massive epicenter of the urban African American HIV population.

Of people who have recently tested HIV positive, African Americans account for 49.2% of all late diagnoses (either concurrently or within one year being diagnosed with AIDS).

(Blackaids.org, 2009) Whites account for only 15.8% of late diagnoses. (Blackaids.org, 2009) A late diagnosis is one that is made after the HIV virus has progressed to the point of causing AIDS. Caught in earlier stages, medication has a greater chance of preventing the onset of AIDS. Approximately 34.3% of all new diagnoses among African Americans are late – higher than whites (28.2%) and lower than Hispanics (35.4%) and Asian/Pacific Islanders (36.6%) African American New Yorkers accounted for 2,168 new HIV diagnoses in 2009, which is more than new HIV infections among whites and Hispanics combined. (BlackAids.org, 2009)

Throughout New York State African Americans comprise 43% of accumulative AIDS cases and 49% of new AIDS cases, while among New York City residents, that figure is 44% and 51% respectively. (Blackaids.org, 2009). In New York City, approximately 45.6% of people living with HIV/AIDS are African American, slightly higher than the state average. (CDC, 2011). Nearly 52% of those concurrently diagnosed with HIV and AIDS are African American. (CDC, 2011). African American men comprise approximately 40% of New York City men living with HIV/AIDS, while African American women comprise nearly 59% of all women living with HIV/AIDS in New York City. (CDC, 2011). Among new AIDS diagnoses in New York City, African American men comprise approximately 46% of all new cases among men, while African American women comprise 63% of all new AIDS cases among New York City women. (Blackaids.org, 2009) . Similarly, throughout the rest of the state outside New York City, African American men account for 32% of new AIDS diagnoses among men, while African American women account for just over 50% of new AIDS cases among women. (CDC, 2011). Approximately, 44% of prisoners throughout New York State (outside New York City) living with HIV/AIDS are African American, while a similar number are Hispanic. (CDC, 2011) This is more than 5 times greater than white prisoners are. (NYAC, 2011). More than 65% of new

HIV diagnoses among prisoners in New York State (outside NYC) in 2008 were among African American prisoners.” (NYAC, 2011).

The statistics indicate a dramatically higher incidence of HIV among African Americans across America, but New York demonstrates an even greater incidence compared to other areas. If a national policy can address the uniquely African American causes of this disparity, the local New York implementation of that policy will require even greater sensitivity to local causal factors. Also, if a solution can succeed in New York City, such a solution may work as well or better in other areas of African American population density.

The Funding Issue as a National Priority

Before addressing the current White House policy as a potential solution to the African American HIV disparity in New York City, the issue of resources that led to the need for a White House policy response must be understood. The need to combat HIV / AIDS within a narrow segment of the population and in a highly specific location creates a strain on even the most robust state or local government budget. Similar to a natural disaster that befalls a limited area but harms a disproportionate number of people, a federal response with federal funding must supplement state and local resources. When a national policy effectively targets a limited number of locations and ethnic groups, this rationale helps to explain the primary financial purpose of federal involvement. Current NHAS policy defines a clear mission, but unlike typical health policy that can allocate a per capita cost for treatment, testing, education, treatment, and prevention have no upper cost limit and also have complex control requirements. The tendency of many leaders is to simply avoid the problem because they cannot fund it with certainty of a specific result. A federal response is therefore required as state and local resources alone cannot address the unique requirement of African American HIV cases in New York City.

On a global level, America has provided HIV program assistance to foreign nations. The African American AIDS Institute says it is not criticizing the federal government for helping poorer countries cope with the AIDS epidemic, but it prefers that federal funds go to the areas of greatest domestic need first. The AIDS Institute says, "AIDS epidemic [in the U.S.] is not getting the kind of attention that it merits. We understand the needs of black folk in Johannesburg (South Africa), why can't we understand the needs of them in Jackson, Mississippi? We understand the needs in Nigeria or Botswana, why not understand the needs of Los Angeles or Oakland?" (Left Behind, 2008). Although the resources existed to fight HIV overseas, cash-strapped local governments facing disproportionate HIV epidemics like New York City had not received these funds as a priority and the epidemic spiraled as a result. Due to pressure from entities such as the Black AIDS Institute, new policies with new funding targeting African American – specific programs in urban areas became a national priority. NHAS points to the scale of federal assistance to this effort saying, "The United States investment in responding to the domestic HIV epidemic has risen to more than \$19 billion per year." They connect the impact of this large national spending to the effectiveness of the local programs and in order to achieve that connection, they advocate a model of "seamless" collaboration among local agencies coordinated by the national programs such as those controlled by the Centers for Disease Control that are studied in New York City. (*Left Behind*. 2008)

However, some have argued that directing the CDC's entire HIV budget towards the African American AIDS epidemic would not be sufficient. What could be improved, therefore, is the size and the targeting of the HIV budget itself. If a funding formula required local community organization participation in public awareness, prevention and testing the demand for treatment would be lower. Balancing outreach, education, prevention and testing funding with

the more immediately pressing need for treatment and medication presents an ongoing challenge. For the 2009 financial year the CDC said \$1.6bn was needed for HIV prevention, far in excess of the \$753 million allocated for 2008, indicating how financial need has so far been greatly unmet (Avert, 2010). Although Obama's 2011 budget shows a 4 percent increase in funding for HIV prevention to the CDC, some leaders from the HIV/AIDS community see the new budget as a setback, stating that ‘With the growing number of new infections and people needing lifesaving treatment and services, we are disappointed in the level of spending proposed by the government.’ (Avert, 2010) *Carl Schmid, deputy executive director of the AIDS Institute* ‘The CDC currently funds several projects around the United States that address the epidemic in African Americans. (Avert, 2010) These include rapid HIV testing programs in traditionally African American universities and colleges across the country, a variety of epidemiological research programs, and the ‘Minority AIDS Initiative’, which aims to address health disparities and provide prevention programs to ethnic minority groups at high risk of HIV. The CDC also runs a variety of social marketing and advertising campaigns, many of which target Black churches - the focal points of many African American communities (around 80 percent of African Americans are thought to belong to a church). (Avert, 2010). In 2007, they provided \$35 million to facilitate HIV testing and improve early HIV diagnoses in areas with high levels of HIV within local African American communities (Avert 2010).

Essentially, a degree of experimentation must be performed within a sustained budget to define the optimal funding level for each program. Working at a community level, local funding sources can supplement public funding for innovative programs and techniques. Examples of similar approaches exist overseas and may provide a heuristic guide for current and future local programs. The New York focus allows lessons learned to apply to other urban areas as well.

The National HIV/AIDS Strategy: What it means for African Americans

Under ideal circumstances, an African American resident of New York City would receive regular health screening including HIV testing. They would also receive education and public information to help them avoid risky behaviors such as unprotected sex or sharing of syringes. In the event that they were detected with HIV, our patient would receive immediate treatment and live a life nearly as long as they would without HIV while not transmitting HIV to any other person. In short, an African American would have the same outcomes of a white person in the same position. However, the fact that our African American patient was seven times more likely to contract HIV/AIDS speaks to a disparity that requires a national solution.

In “Deciding Moment: The State of AIDS in Black America”, the Black AIDS Institute summarized the national strategy goals as:

1. Reducing the number of people with HIV/AIDS
2. Increasing access to care and optimizing outcomes for those diagnosed with HIV/AIDS
3. Reducing HIV Related disparities

The breakthrough in the new strategy is expanded collaboration among state, local and community stakeholders that allows for flexible, locally and culturally specific allocations of resources beyond the traditional health clinic. As the first coordinated strategy, it targets resources at the areas of greatest density of HIV-infected populations., As such, the strategy also represented a solution directly aimed at the African American community. (Black AIDS Institute, 2012) Because of the dynamics of the HIV epidemic, the strategy specifically identified and targeted key urban settings beginning with New York City and Washington, D.C. as focal points for increased funding and technical assistance for state and local agencies and community organizations. (National Strategy p.ix)

The second key element of the national solution is its focus on local implementation specifically through non-governmental entities. The government targeted the African American community with a commitment to, “Reduce HIV-related mortality in communities at high risk for HIV infection and adopt community-level approaches to reduce HIV infection in high-risk communities.” (National Strategy, p. ix) The strategy reaches closest to a unique cause of the African American disparity as it seeks to, “Reduce stigma and discrimination against people living with HIV.” These three elements of the plan adapt it closely to the needs of the African American community.

As a tool to unify federal policies and programs across the Department of Health and Human Services, National Institute of Health, Centers for Disease Control and other agencies, the strategy offers a clear path for state and local government agencies to follow. However, as a tool to reach underserved and practically hidden populations, the plan empowers community-based organizations with funding, monitoring and evaluation resources as well. As an acknowledgement of the disparity between African Americans and whites, the strategy attempts to engage local leaders to attack the cultural and educational sources and causes of the problem.

The strategy also acknowledges the lack of awareness. It states that one in five HIV – infected Americans are not even aware of their status and are likely carriers of the disease. (National Strategy p.1) As a part of community awareness, the strategy focuses on educating the public at large to end the stigma and “ugly” treatment of those with HIV.

More than a health care delivery program, the NHAS offers a holistic, community-based environment to support a variety of locally appropriate solutions. It’s data – driven approach identifies the high-risk groups (African Americans) and targets resources to them. This strategy offers a feasible solution to end HIV / AIDS in the African American community because it

speaks to and specifically seeks to address the disparity. It is feasible because it goes to the root social, cultural and historical causes of the disparity and allows local and trusted organizations to

Interview Findings and Analysis

I interviewed a cross-section of academic, community and institutional experts from New York who have actively focused on reducing the incidence of HIV/AIDS in African American communities in New York City. Their first-hand insights came directly from years of first-hand experience with patients, community activists, government officials and health care practitioners and their collective viewpoint proved surprisingly coherent with little difference of opinion on the causes, conditions and solutions at hand. Some of them have conducted years of highly specialized formal research on this topic.

My interviews indicate that the solution for to address the disproportionate rate of HIV among African Americans originate from within the core set of cultural influences that contribute to its cause. (CDC, 2011). Even as the number of new HIV infections in New York has fallen, the proportional disparity between African Americans and whites has not. (Black AIDS Institute). Overall, African Americans in general suffer from a historical lack of information, education and communication that becomes magnified when a scientific subject such as HIV demands a level of understanding beyond the commonly held belief within the African American community and the African American church that HIV is the result of homosexual activity and is therefore a holy abomination. By avoiding the topic of HIV or by propagating the homophobic myths associated with it, the African American church served to deepen the anti-HIV stigma and accelerate its impact in the community. As a centerpiece of African American culture, the African American church holds one of the keys to the solution as a

trusted and most influential voice with a large African American audience . , Just as it can help, it can also contribute disproportionately to the stigma by its silence or advancement of false information. Because of this role in the community, the African American Church either creates solutions or barriers for both treatment and prevention. (Parsons, 2010).

Due to the depth of the problem and the scale of the population, my interviews, generalized their answers to apply city-wide, gaps remain in the subject matter. Further and further interviews could certainly reveal more details, but the final analysis and solution reflect the input and recommendations of each person that I interviewed. My interviews focused on the following areas of focus within the National HIV Strategy to produce general and specific questions including:

1. How can we end HIV/AIDS in the African American community?
2. What trends do you see in the reduction of HIV/AIDS in New York?
3. What policies, programs, barriers and resources affect those trends?
4. What is your opinion of the new White House national HIV strategy?
5. What causes the disparity in HIV incidence between African Americans and others?
6. What approaches succeed best in the African American community?
7. What is the impact of funding and what issues affect adequate funding?
8. What do you recommend / what relevant questions did we not discuss?

How we can end HIV / AIDS in America

An interview with Daniel O’Connell, Deputy Director of the State of New York AIDS Institute provides an excellent overview of all of the key points outlined above. Additional interview subjects and secondary sources essentially corroborated the findings provided by Dr. O’Connell. As one of the highest ranking state government officials in the field of HIV/AIDS treatment and prevention with over 25 years of experience in this position, Dr. O’Connell provided subject matter expertise with institutional and historical contexts dating to the beginning of the HIV epidemic in America. Dr. O’Connell stressed that the first step toward ending HIV / AIDS in any community is to get all citizens of the age of sexual activity tested. If you cannot test the population, you cannot treat the population. In the African American community, testing is avoided due to the stigma placed on the topic of HIV in general. Therefore, inviting and inducing the African Americans to overcome the stigma and fear of social or relationship repercussions in order to present themselves for testing represents the first challenge. Dr. O’Connell cites significant progress since the early 1980’s not only in reducing the incidence and spread of HIV but more importantly reducing the deaths from AIDS as the result of early testing. This point corroborates a key finding in the literature. In “The State of AIDS in African American America”, The African American AIDS Institute identifies the need for unprecedented marketing of testing programs in the African American community. Echoing Dr. O’Connell, the Institute states, “Testing needs to be effectively marketed through campaigns that take advantage of state-of-the-art learning and techniques from the marketing world.”(Wright, 2009) The outreach to the community is key and the combination of advanced marketing techniques and old-fashioned church leadership may cross enough generations to change attitudes that hinder otherwise effective programs.

Trends in the Reduction of HIV / AIDS in New York

Dr. O'Connell cites significant progress since the early 1980's not only in reducing the incidence and spread of HIV but more importantly reducing the deaths from AIDS. He cited a current population of 1.1 million Americans with HIV, and then noted that twenty years ago that population would have a greater risk of death. He said that ending AIDS in America is today more of a function of ceasing the incidence of new HIV infections, and the average life expectancy of an HIV patient is now within ten years of the non-infected population. These positive trends in the state of New York include a current rate of 4,000 new HIV cases in 2011 compared to 5,100 in 2006. One reason for this success is a \$ 2 billion state Medicaid allocation for HIV/ AIDS and another \$400 million for treatment and \$ 100 million for prevention from the New York City budget.

Dr. O'Connell also points to New York laws that require all health facilities to offer HIV testing. A new law provides this for all patients and an older law provided this for pregnant women. New York State has reduced the transmission of HIV from pregnant mothers their children from 500 cases per year to just 5, a 99 percent decrease. New York Laws enabling needle exchanges also reduced the drug related HIV incidence to five percent. He views the new White House strategy as positive, but notes that it has arrived twenty years later than it should have and the entire collaborative strategy that the White House advocates requires more emphasis on prevention. In "The State of AIDS in Black America", The Black AIDS Institute identifies the need for unprecedented marketing of testing programs in the African American community. Echoing Dr. O'Connell, the Institute states, "Testing needs to be effectively marketed through campaigns that take advantage of state-of-the-art learning and techniques from the marketing world."(Wright, 2009) The outreach to the community is key and the combination

of advanced marketing techniques and old-fashioned church leadership may cross enough generations to change attitudes that hinder otherwise effective programs.

Causes of the Disparity

Dr. O’Connell pointed to the historical fact that a lack of equitable distribution of medicines along with a lack of funding also exists in greater proportion within the African American community of New York City. (Black AIDS Institute, 2012). The NHAS specifically corroborated Dr. O’Connell’s analysis and this basic inequity also partially explains at least some of the past statistically proven disparities. Also, the lack of national acceptance of HIV reduction as a priority and the need for a coordinated umbrella of leadership to unite the comparatively large number of independent local organizations in New York served to further widen the disparities of HIV between African American New Yorkers. (NHAS). My interviews all confirmed the African American distrust of government programs and fear of stigma attached to any aspect of HIV programs including prevention messages that target non-infected people. Although other ethnic groups confronted poverty and discrimination, the African American experience was unique in its legally reinforced and government – sponsored invidious discrimination especially in the areas of health and education. The sense of alienation from government compounded with a generally less educated population allowed myths and misunderstandings to substitute from hard medical facts. Another unexpected key factor that my research and interviews uncovered is the unique role of the African American church in promoting the stigma and negatively influencing the spread of the epidemic. I address this in its own section because it is such a critical element of the cause as well as the solution. Due to a long cultural heritage that relied on the church and music for cohesion, the African American community relies heavily on guidance from local church leaders. This explains the fact that the civil rights movement was led by church leaders like Martin Luther King and also explains to a large extent the role that the church, music and local cultural centers have played in the disparity. Also, African American music including Hip-Hop styles promote risky and often promiscuous sexual behavior that multiplies the partners that an HIV – Positive African American may pursue. Anecdotal evidence from interviewees that sought anonymity explained the fact that, in a highly concentrated population, frequent encounters between strangers resulting in unprotected sex happens daily and on a large scale in New York City. The findings indicate that success in reducing the disparity may originate within the cultural centers of the African American community in New York, but will also require national leadership with increased funding, targeted media campaigns and coordinated oversight of agencies and community organizations.

The Significance of Black Church in Reversing the HIV Epidemic in the African American community

Many interviewees noted the central importance of the Black Church. The Black Church has a long history of leadership, education and advocacy around civil rights, spiritual and physical health. (Seele, 2002) The Black Church continues to be the most important and influential organization in the African American community today. (Id.) Therefore, the

mobilization and involvement of the Black Church in AIDS awareness and prevention is vital to reducing the growing rates of HIV in the African American community. Mr. Justin Thompson, Health Promotion Associate for Gay Men of African Descent (GMAD) states that faith-based institutions have been an integral part of the African American community and they need to play a more active role in providing HIV prevention, care and outreach services to their congregation and surrounding communities.

The Balm in Gilead, Inc. an international non-denominational Non-Governmental Agency located in Richmond, Virginia and New York City, in collaboration with the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau has been in the forefront of identifying successful models for the delivery of HIV/AIDS related services by the Black Church. (Seele, 2002). This collaboration offers an example of the kind of effective working relationship between the federal government and local community based organizations. This delivery model engages a major church in a lead role to educate other churches in the methods and techniques of running an HIV awareness program. Black churches have been one of the lone functioning anchors of African American society, but as Dr. O'Connell stated, the Black Churches tended to view HIV as the result of a holy abomination and therefore tended to avoid the subject and reinforce the stigma. One of the aspects of their mission in the new national strategy is for a church like Balm in Gilead to re-educate the members and other churches to understand and fight the very stigma that they may have originated.

Successful approaches in the African American community

For the HIV prevention message to resonate, the public must absorb and remember it. The Black Church offers the African American community an effective medium for the prevention message. The Black Church plays a major role in shaping the attitudes, opinions, and

behavior of people of all ages. (Rouse, 2000). It seemed that many organizations already thought of this approach but none have devised a way to implement it. Justin Thompson, Health Promotion Associate for Gay Men of African Descent (GMAD) said, “For a long time the faith based institutions have been an integral part of the African American community. They are highly influential politically, socially, and economically within the African American community. Therefore, their messages about HIV prevention and outreach services for people who are living with HIV could be actually very helpful to the community as a whole.” Despite this knowledge, his organization has not initiated a program to reduce the stigma associated with HIV, which would involve the Black Church.

Dr. Leo Wilton, Associate Professor in the Departments of Human Development and Africana Studies at the State University of New York, similarly expressed that they are conducting conversations with HIV/AIDS organizations that are proving effective with institutions. He said, “The institution of the church for example is important. The Black Church relates to the AIDS epidemic in terms of its history and everything. Therefore, I think that there have been important conversations that have happened and that need to continue to happen. The Black Church offers transformative places for people to come. There are some Black Churches like the Balm of Gilead that are very transformative and many have provided leadership so that different African American faith communities more broadly participate, but we need a lot more of that emphasis.” Thus, Dr. Wilton was enthusiastic about the conversations that are recently occurring within HIV organizations but does not seem to be too concerned that not much has materialized from the conversations. Dr. Wilton continued to say, “think about dealing with the Black Church as one institution, imagine all the folks that would be exposed to prevention and intervention within the context of Black Church like 1000 upon 1000 upon 1000. Even within

one church, you can have well over 1000 people. Therefore, that would be good...if you think about it in terms of the history of Black Church, they have been very involved in the civil rights struggle and those sorts of things. The very traditional African American cultural institutions have to be involved.” The high-rise housing of New York packs a high-density population into each square mile. The churches therefore contain large populations compared to other cities and therefore wield significant influence on a large scale. The immediate cultural connection to this population is the Black Church.

The primary cultural distinction between African Americans and other cultures originates from and is propagated by the Black Church. The interviews reveal the fact that the stigma associated with homosexuality and therefore holy abominations have created barriers for both prevention and treatment of HIV within the Black Church. However, the Black Church has served as a uniquely powerful and large-scale vehicle for education and mobilization of African Americans in a manner for which little comparison exists beyond the African American community. Due to the large population of African Americans, and the tendency for African Americans to source sexual partners exclusively within their community, the impact of this stigma and the role of the church is magnified beyond proportion and therefore may at least partially explain the disparity and also offer at least a significant if not partial part of the solution. As the Black Church embraces HIV education for prevention and acceptance of HIV– infected homosexual and heterosexual people, it offers the potentially greatest single positive element of a large-scale solution.

Krishna Stone from Gay Men Health Crisis echoed Dr. Wilton by expressing that faith organizations communicate to the community the importance of the negative impact of stigma on the individual. She indicated, “In many neighborhoods, particularly in the African American

community, the church is a power base. If they are on board to helping de-stigmatize HIV and all the issues they can have, programs about HIV intervention and engaging in safer sex will help push through the stigma.” Given the size of these churches due to the scale and density of the population, they are powerful. Creating awareness among organizations that they need to find creative ways to engage Black Churches is a step forward in trying to remove the stigma within the African American community.

Dr. Robert Miller, an Associate Professor in the School of social work at the University at Albany, raised the issue of the utility of spirituality in the lives of gay African American men living with the HIV disease in his dissertation authored 2000. Through his research, he discovered that even though the drugs were available in the lab they were not for the general population to access. Regardless of the reasons, real barriers existed that severely restricted the treatment options for the public. Many people had to learn how to deal with HIV without access to proper medical treatment. Therefore, many people still had to deal with not only getting access to the medication but also figuring out the meaning of their life. As a researcher, Dr. Miller found out through his research that spirituality did make a difference in people’s lives as they were managing HIV. Dr Miller has been able to challenge churches and other organizations that provide religious support for their members to have a deeper understanding of their personal relationship between the message in church and its impact in the daily lives of their church members. So part of his work critiques homophobic clerical messages in sermons, in addition to encouraging churches to engage members who are impacted by HIV. In essence, the church often drove away the HIV-infected or potential future HIV–infected member with homophobic messages. The church often alienated the very population that needed them the most. According to Dr. Miller, “I think there has to be something said about going to church and listening to a

sermon that is supposed to be uplifting and giving you insight for your own relationship to the divine and instead of hearing about you being an abomination.” As individuals feel disconnected from their primary social institution, the denial and shame associated with this stigma create a powerful inter-generational barrier with few solutions beside transformation of the institution itself from within. This inter-generational barrier persists across generations as the ignorance and prejudice of older generations fails to evolve as new information changes perceptions of HIV as a punishment for homosexual activity. Young people, in the absence of updated information from trusted sources, or in the absence of any source willing to discuss the subject at all, continue to perpetuate the same stigma and ignorance that surrounded HIV when it first emerged as a little-understood epidemic in the early 1980s.

Dr. Miller explored these inter-generational causes of the churches’ negative impact on HIV awareness. He found answers to these questions;

“Part of it is that it is a new challenge to seek out a new or different church particularity if you are in a vulnerable state. There is also something to say about a person who goes to a church whose parents, grandparents, and great-grandparents attended. After multiple generations of your family attend one church, and you decide you are not going to go, that is a major shift and that requires a great deal of courage. It makes more sense to help your own church accept your condition and adjust their ministry accordingly. So, I think my work has allowed people to interrogate some of those church leaders to help determine some clear ways to educate homophobic servants to the fact that they create some unintended consequences that hurt some members. At the same time, I am asking the people who go to these churches and services if that is the best use of your time. Are you actually achieving your intention by going to these places that routinely disenfranchise you or more importantly castigate and cast doubt on your ability to have a relationship with your creator?”

These findings clearly define the central and pivotal role that the Black Church can play especially in an area with such a large and highly concentrated population. The fight to eradicate HIV/AIDS within the African American community of New York City begins within the Black Church as it transforms biblically linked stigma to culturally supported acceptance and positive

reinforcement of the value of all human life including HIV–infected hetero and homosexuals. It is imperative for the Black Church to lead the ground-level initiatives for HIV/ AIDS education and awareness. Once the NHAS engages the African American church as a partner, a sustained funding, training and technical assistance effort must support the partnership.

Funding

Dr. O’Connell indicated that over \$ 2Billion in annual New York State funding and federal funding has been directed at HIV / AIDS programs statewide. This has made medicine and clinical resources available as needed and has contributed to the reduction in the incidence of HIV / AIDS in New York. However, the still- developing implementation of the NHAS is just now identifying the budgetary requirements of new prevention and testing programs and the cost as well as the cost – benefit models are still under development. Dr. O’Connell is involved in these discussions and an ongoing contention for scarce health care resources pits HIV against other diseases and health care delivery requirements.

Dr. O’Connell explained the impact of past funding in terms of reduced national incidence of HIV / AIDS. He cited a current population of 1.1 million Americans with HIV, and then noted that twenty years ago that population would have a greater risk of death. He said that ending AIDS in America is today more of a function of ceasing the incidence of new HIV infections, and the average life expectancy of an HIV patient is now within ten years of the non-infected population. One reason for this success is the \$ 2 billion state Medicaid allocation for HIV/ AIDS and another \$400 million for treatment and \$ 100 million for prevention from the New York City budget.

In spite of the aggressive funding in New York State this year, funding has been the main concern for many years of many HIV/AIDS organizations trying to effectively serve their

community. Krishna Stone from Gay Men Health Crisis perfectly summed up the problem by saying “It is hard to do work if your funding is being cut.” She further explained, “Whenever there are budget cuts from local government to national government grants it has a big impact on expanding and doing the work from a holistic approach.” A representative from Brooklyn AIDS Task Force can testify to Ms. Stone’s comments. Because Brooklyn represents the greatest population of HIV cases within New York City, the Brooklyn Aids Task Force is the leading community-based organization on the front-line fight to prevent, test, and treat HIV in New York. The Brooklyn Task force offered a variety of HIV related services including home visits to ensure that patients followed care regimens. The Brooklyn Aids Task Force representative explained how the Brooklyn AIDS Task force is no longer able to do home visits. They were once able to provide home visits but they lost their funding from the AIDS institute and the new contractor does not allow home visits.

Brooklyn AIDS Task Force is not the only organization that has been faced with this problem. Dr. Dr. Leo Wilton, Associate Professor in the Departments of Human Development and Africana Studies at the State University of New York explained, “There has been a recent trend in terms of defunding these organizations who are working on the ground level ... there has been this new emphasis on organizations using benchmarks and forcing organizations to collect all these evaluation data. So for example, how do you know that your HIV prevention intervention works and why should we continue to fund it? While it is important to have this information, you do not also get the resources and infrastructure within the CBOs. That is setting them up to fail. The infrastructure to do the evaluation is missing.” Dr. Miller also agrees by stating that the funders must provide appropriate technical assistance to the

community-based organizations to sustain these added requirements as they do their work for which they are funded.

Although a critical feature of the new National Strategy is collaboration, the practical aspects of funding and inter-agency coordination require effective management techniques that place a premium on experienced personnel and skill sets. This administrative knowledge gap weakens the delivery of otherwise properly planned services due to lack of skill in requesting, applying and / or documenting the use of funding. An overall “Road Map” is required to help community organizations learn how, where and when to fit into the funding process. Dr. Miller also stated, “What is problematic is that a group of existing programs are no longer funded. Part of that has to do with skill set relating to managing these programs, the other part of it has to do with the appropriate understanding, and coordinated effort between state funding agencies and these community based organizations. So for HIV prevention to happen in communities of color, part of success includes the capacity of the community based organizations to know what the expectations are for the funding and an additional skill of intervention on behalf of the management of the organization.” This is an important issue that needs to be addressed because without proper funding, it is difficult for these organizations to provide the community services that are greatly needed.

Funding of social programs can temporarily address the symptoms of poverty like cold and hunger, but it cannot prevent them. However, in the case of health programs, the economic benefits can last across generations. For instance, one can imagine how important money would be for an organization that is trying to combat not only the symptoms of HIV/AIDS but also working to prevent the long term cultural and inter-generational causes of it. The cost of long-term media campaigns is equal to any advertising campaign and can cost millions of dollars per

year to sustain in a metropolitan area the size of New York City. Mr. Thompson articulated, “What has been very detrimental to services for people’s health has been the lack of funding for these programs. This is a highly problematic issue that we have for people living with HIV in New York.” While this issue is supposed to be addressed through the new National HIV/AIDS strategy, it has not. The National Strategy does attempt to cut through the levels of bureaucracy to help the community-based service providers expand services. One of the greatest challenges of the National Strategy is to address flexible funding for small community groups that produce results in terms of outreach, testing, and prevention. A formula with necessary spending controls, monitoring and evaluation will cut through the layers of bureaucracy that Thompson refers to.

Examples of this multi-level funding formula would have to include the federal, state, city, and community entities with oversight of the spending from each level. Because of the nature of such spending, with AIDS awareness advertising campaigns as an example, traditional unit-of-service cost tracking methods do not apply. The oversight of this kind of spending requires culturally sensitive review committee members and effective methods of planning, organizing and executing funding decisions such as grant requests.

Dr. Miller's interview describes the multi-level impact of coordinated funding as,

"The State of New York is the recipient of \$33 million dollars from the Center of Disease Control and Prevention and those are for services in the State of New York for HIV prevention. There is a community based oversight body called the HIV prevention-planning group, which is mandated by the CDC and implemented by the health department of New York State. There is a body of people from across upstate New York. New York City has its own PPG (prevention planning group). My experience being on the HIV prevention-planning group was understanding in some really extraordinary ways that the State of New York understood that mother-to-child transmission was an extraordinary problem and they were able to focus their priority statement and their funding stream from various programs to engage in actions that provided AZT, anti-HIV drugs, to mothers who were pregnant resulting in a decrease from mother to child transmission to some ungodly number. I think last year there were

six in the entire state of New York that were born to HIV infected mothers. To be involved in that set of work that both had as a priority, restructuring of the priority as well as putting money in place to get the programs access to the drug and then provide it to the mothers at risk.”

The results of this kind of collaborative effort are astounding given the scale and complexity of the task. In my mind, that is an extraordinary story of policy development and how policy relates to practice. Most of these things can affect an outcome that is directed toward the people who are most at risk.” The proper inter-agency coordination can produce measurable results. In the case described by Dr. Miller, the next generation was saved from HIV/AIDS at a fraction of the avoided cost.

Perception of National HIV/AIDS Strategy

Ms. Krishna Stone from Gay Men Health Crisis t explained that the National HIV/AIDS Strategy will “help organizations with writing grants” which would be a step closer in solving the funding problem that many organizations are facing. Many HIV/AIDS advocates like the National HIV/AIDS Strategy for other reasons including the key presence of a President who has made it a national priority. This “sea change” in national attention created a sense of urgency as well as importance for many agencies and organizations engaged in an otherwise lonely and long-term and sometimes seemingly futile fight against a killer disease with devastating economic and social impact. Interviewees feel that a national effort adds a morale boost as well as at least the potential for increased funding and additional resources. Dr. Miller explains, “It will be one of the signature efforts that will help bring the end of AIDS as we understand it.” Dr. Miller points to unprecedented inter-agency cooperation in the formulation of the National Strategy and was glad to see that the White House is addressing the issue of HIV/AIDS domestically. He stressed that, historically, HIV/AIDS was completely ignored as a matter of

U.S. domestic policy. As recently as the George W. Bush administration, the fight against HIV was confined to African and foreign nations while the domestic challenge was neglected.

Dr. Miller explains that “The fact that the President can articulate an end to AIDS is an extraordinary thing and has not been done in the history of the White House in relation to reversing this epidemic. If you’ll remember, President Reagan did not mention the words A-I-D-S or G-A-Y-S in the white house. It wasn’t until Rock Hudson died that he even publically acknowledged that there was something going on. That may have made more sense personally but certainly not from a governmental response.” The top-level awareness of HIV / AIDS and the strong national commitment in itself motivates and focuses efforts across all levels of government but more importantly engages society and community organizations to share the commitment.

This is a new moral “war” backed up with funding and specific visible local support. Mr. Thompson agrees that this response is revolutionary for America by stating, “For a long time since the 80’s there hasn’t been a politician that has done much concerning HIV and AIDS especially on a national level and this is affecting the United States at higher rates than other places in the world. I believe that having a National HIV/AIDS Strategy that accepts the input of communities is one of the crucial steps in reducing HIV in the nation or eradicating HIV in the nation.” Many are just happy that the White House finally addressed HIV and AIDS in America, even if the efficacy of the policy and the strategy has not yet been seen.

Ms. Stone indicates that in addition, “The coordination of the HIV programs within New York is very important and I believe that the HIV National Strategy helped with this. The implementation process is just being started.... It is to enhance their ability to partner with each other and coordinate their efforts.” Due to the implementation process just starting, there are

many unknowns still. However, the concerns circle back around to the funding portion. Dr. Miller mentioned, “While the attention of the President and the Strategy is important if not extraordinary, there is still an issue of how we fund the initiative and strategies that the President has put forward. That is not a critique but a query from observation in that it has to be looked at concurrently.” The national strategy can serve as a catalyst for faith-based and private funding. As the same media campaigns that create awareness of prevention, testing, and treatment gather momentum, they can also solicit direct contributions to local community organizations that exhibit visible results. The win-win of the National Strategy can be found in relieving the taxpayer of the burden of providing for the health care of an unemployed AIDS patient and also enabling funding to prevent and control HIV before it turns into AIDS through privately funded local efforts.

However, a counter-argument against the potential success of the National Strategy emerges once again from the perspective of funding. Mr. Thompson articulated, “What has been very detrimental to services for people’s health has been the lack of funding for these programs. This is a highly problematic issue that we have for people living with HIV in New York.” While this issue is supposed to be addressed through the new National HIV/AIDS strategy, it has not. The National Strategy does attempt to cut through the levels of bureaucracy to help the community-based service providers expand services.

Hopefully, the White House devises a multi-tiered funding approach to fund their Strategy because Brooklyn Aids Task Force would love to see the coordinated programs actually happen. She stated, “It would be better to do it as a community instead of one state doing this thing and another doing another. It would be better for us to come together and have one strong message.” It seems as if many HIV/AIDS organizations feel that it is important to have their

efforts coordinated with other HIV/AIDS organizations. A crucial financial and organizational challenge for local agencies and community organizations is the need to share public awareness, pool resources and eliminate redundancy. In addition, the reporting requirements of foundations and government grantors restricts otherwise highly effective but small local entities. A recently standardized national monitoring effort appears to relieve some of the reporting burden from smaller agencies as larger entities assist them with this aspect of the program. Finally, a large and yet improperly explained disparity in distribution of medicines to the African American population of New York City may become subject to national oversight which may potentially increase the availability of medicines and other treatment options.

Further Recommendations and Unasked Questions

My questions focused on HIV programs, the National Strategy, and ways to apply them in New York City. The interviews revealed some broader sustainability issues that affect New York in a national context. I had not considered the fact that, just as the concentrated local epidemic required a national response, the national will to sustain it may become affected by factors other than local need or success. The National Strategy also faces the challenge of a wide array of local political implications. The breakthrough of the National Strategy in New York City may not translate to other areas of America that still harbor deeply seated cultural resistance to the very subject of HIV / AIDS. This potential resistance also applies to political parties and leaders who hold widely varying understandings of the fundamental medical facts of HIV and who may tend to introduce religious or homophobic interpretations of the disease into political dogma that restricts future support for the strategy.

A change in national leadership could doom the National Strategy just as the Bush administration doomed the successful Needle Exchange program of the Clinton Era. The

Brooklyn AIDS Taskforce asserts, “Some states are more conservative and other states are liberal. With politics, it can depend on which message is being sent out.” Just because this Strategy has been implemented, it does not mean that it is going to be implemented effectively in every state. In addition, Dr. Wilton raises the biggest political issue by asserting that, “If we have a Republican administration, are they going to reverse the policy, the strategy, are they going to make it lukewarm? This is very likely, so this next election is critically important in regards to the domestic fight to reverse the HIV/AIDS epidemic. That is the first thing they go for is undo stuff that is done.” Everyone I interviewed agreed that this national approach is a great start at attempting to address the HIV/AIDS crisis in a holistic way but many are concerned that it will not be carried out due to lack of adequate funding. The cost and management overhead of implicating a national policy with local programs, projects and activities requires sustained funding for a wide variety of agencies and organizations that lack a standardized process to assimilate the funding and monitor and evaluate its impact.

An eventually self-sustaining funding model must evolve as well. In the event that “Obamacare” public health services are repealed, or the National Strategy becomes altered by a change of leadership within or beyond the next four years, each service delivery agency or organization must be able to sustain their efforts in order to also sustain the public trust. African Americans in particular do not trust their government and have seen many public policies and programs come and go that were intended to help them. In the case of HIV, to offer oneself to a public program that may create public awareness of a highly stigmatized disease, only to have that program dissolve, forces that person to live for the rest of their life without the promised support of the program but with the unbearable social stigma. Self-sustained funding is a critical component of achieving the trust of African Americans in American and in New York City.

Beyond the “feel-good” effects, the tools and personnel required of this strategy have yet to appear as a fully funded and coordinated national effort. However, the direction has now been made clear and the benefits of local participation appear to outweigh the costs and risks for local organizations. An aggressive schedule of activity, again with the Black Church as an anchor and a coordinated media campaign, may economically address the cultural roots of the problem and therefore reduce the need for the more expensive treatment options over time. A self-perpetuating fund-raising effort will also be needed for predictable long-term success.

A Holistic Approach

The literature, interviews, and analysis of the National Strategy lead me to recommend the “Holistic Approach” defined by the National Strategy. This approach involves inclusion of all available resources to meet the needs of each individual including education and prevention measures to avoid the risk of HIV and other diseases entirely. As the opposite of the typical “cookie cutter” government approach, the Holistic approach allows an evaluation of the needs of the individual and prescription of a combination of helpful psychological and cultural forms of assistance in addition to medical treatment. The Holistic Approach seeks to include community resources in communicating messages that promote prevention and testing in order to avoid the need for medication or to identify the disease in early, more treatable stages in order to allow the patient to still have an economically productive life. Removing stigma and producing a properly educated community cost infinitely less than treating an HIV patient for life, supporting them and their family with public assistance and also losing an economically productive citizen. The least – cost option, especially in the African American community of high population density of New York City, is the path of cultural transformation through communication and education. The Church and targeted media campaigns therefore play a sustained and low-cost role that

attacks cultural stigma as the root of the problem. Dr. Miller believes that to engage in the adoption of a policy without attending to the other kinds of stresses related to both education, economics, and employment opportunities than the policy is not going to be effective. This seems to be a consensus among people within the field of HIV/AIDS was that the best approach to handle the issue is a holistic approach. A holistic approach means recognizing the emotional, mental, spiritual and physical elements of each person while addressing them having HIV/AIDS. By working with this systems approach the cause of HIV/AIDS is targeted, rather than just the symptoms.

Ms. Stone discusses this approach in more detail by explaining “there are many complex factors that place people at risk for HIV. When they become HIV positive those factors may still be much part of their lives, for example poverty, racism, sexism, domestic violence, and homophobia. Those factors still need to be addressed. That is why programs need to be holistic because in order to help someone who is living with HIV or AIDS stabilize their life there are those components that need to be addressed through counseling, work force development which addresses poverty, housing which addresses poverty, food which again addresses poverty, domestic violence they need counseling. The more their lives are stable the more they can move forward. Right now, we are seeing at GMHC, 77% of our clients live at or below poverty line. So, we are not just talking about the disease we are talking about stabilizing someone medically while working in partnership with medical services but then also stabilizing their life from those factors that I mentioned.” The holistic synergies of this approach not only reduce the cost and risk of local programs, they increase the feasibility for low-income participants to sustain their involvement over time. A key factor to the disparity among African Americans is the logistical and financial barrier to making the long-term commitment to health related activities. This

approach creates a more likely prospect of this kind of personal development that is too often confused with lack of personal responsibility. The success factors are complex. Therefore, the solution is complex but more feasible and resources are more practically applied to individual needs when addressed holistically.

For instance, Ms. Stone continues explaining that “If you have a person who is living with HIV and they are homeless it is going to be harder for them to manage taking medication, if they are hungry they cannot take their medication because then they can’t absorb it, if they have to hide their medication because someone might discover them, they will be physically abused then that is harder for them to move on with their lives. So, the idea is that you are addressing those factors while you are working on making sure they are connecting with medical care.”

Once you can evaluate an individual’s needs upon intake and coordinate resources from multiple providers, you can overcome enough barriers to allow the individual to apply their own motivation to succeed from that point. The individual’s needs do not always meet the institution’s resources, but the holistic coordination of community resources extends the institutional efficacy to meet the need. This is the value of the coordinated national strategy in that it identifies the interests, needs, ideas and resources of all agencies and organizations and creates a channel to holistically apply them to individual needs.

Many organizations want to concentrate on the holistic approach because there is a huge correlation between HIV and poverty. Ms. Stone explains, “When people are dealing with poverty, they do not have that many options. If you are a woman who home life is unstable and you have children, you then have a man that comes along and say that he will take care of you and your children as long as you are providing him unprotected sex. They make decisions based on survival.” In addition, what is important she declares is that “The areas where there is

poverty there is not a lot of access to support services and the medical care needed. They use emergency room as the doctor office. Those kinds of components put people at higher risk.” Ironically, the very coordination and holistic approach that the national strategy uses reduces the cost and risk of health care services in general. Properly applied, the example of reduced emergency room visits in New York City can apply nationally. The key is that low-income patients require options that apply to them. Their life circumstances do not always fit the institutional health service model. In many cases, illiteracy or limited communication options reduce the effectiveness of health care outreach programs and poverty limits their access to the available resources. Even time and transportation options are limited and if a woman has young children, the likelihood that she can attend to her personal health needs further diminishes due to poverty.

Mr. Thompson agrees with Ms. Stone by saying “still socio-economic status plays a big part in how information is being disseminated, how services are offered, and the way that the service organizations target people to receive services.” Thus, there is an importance for as Dr. Wilton says, “Culturally tailored, culturally, relevant, culturally focused programs.” He further goes on to say, “Those are the most promising, but they have to come from communities that live the experiences versus the top down approach from researchers. Some researchers may not be part of that community or may not have the training or multi-cultural competence to try to work on those sort of issues in communities of color right now in relation to HIV. I would think those would be the most promising in order to be able to curtail the HIV epidemic.” Cultural competence provides a measurable capacity to adapt resources to the needs of individuals. Rather than evaluating the cost of cultural competence, the national strategy measures the costs avoided by adapting health services to individual needs. The cost – benefit analysis of culturally

competent and medically relevant programs reveals positive results and sustainable long-term community benefits.

The importance of explaining the holistic approach is as Mr. Miller states, “you got to be able to understand that HIV doesn’t happen in a vacuum. To the extent you can think about what job training, education, employment, and issues of violence in communities, one of many, how all of those different ideas feel like they need to be discrete issues but in fact are highly interconnected and until you see HIV in its holistic place you are not going to be able to do the kind of effective work that needs to be done.” The past policies seemingly promoted the “vacuum” wherein individual programs operated in a “stovepipe” setting with no national umbrella, competition for funding and a largely unknown potential client population that presented itself only after their condition was beyond the point of available treatment options. The holistic approach promoted by the current National Strategy attempts to avoid the incidence of HIV and, if that is not possible, provide treatment options earlier in the onset so as to minimize the impact and attempt to provide lifestyle options that limit the progression of HIV into full-blown AIDS. Many patients, with early intervention, live successful lives with HIV because of this very approach. The opposite of a burden on society, they become productive tax-paying family members that can make a positive contribution to society.

It would be useful for community-based organizations to know that they need to take a holistic approach due to HIV not occurring in a vacuum. Brooklyn AIDS Task Force is trying to use this approach as one of their representatives stated that they “provide broad range of programs where others only do a few programs. Many other organizations don’t have substance abuse management or case management. We have a lot under our umbrella.” This organization is taking the right approach to the extent that they can understand HIV from a holistic

perspective. They have a much more intellectual understanding than other HIV organizations about what the detailed context of the circumstances is around HIV and the African American community, so they can attempt to mount a more efficient response to the struggle.

Policy Recommendations

In any setting, effective HIV solutions require testing, education and treatment in a format that reduces stigma and that attracts participation. Workable solutions must affordably prevent the problem while limiting the spread to larger populations or future generations. To meet constraints of time, money, and geography, culturally and locally specific solutions will require collaboration among many community resources and leadership initiatives. Fortunately, creative collaboration offers a lower cost than traditional government bureaucracy and therefore possibly offers a long-term source of solutions.

Based on an analysis of primary and secondary findings, eight policy recommendations will build on and improve the National Strategy and all HIV / AIDS prevention and treatment programs on a national level. The recommendations build on a record of success achieved in New York and apply to communities of color nationally. The eight recommendations include:

1. Laws requiring availability of testing
2. Collaborative Program Funding
3. Culturally Competent Staff and Management Training
4. Local self-sustained funding
5. Local church involvement
6. Local media campaigns
7. Streamlined Program, project and activity monitoring

8. Long Term Federal Level Commitment

Laws

First, as of September 1, 2010, New York State law requires all health care institutions to offer HIV testing to all patients of age 13 and above should become national law. The New York State “Amended HIV Testing” law states, “HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services with limited exceptions noted in the law. The offering must be made to inpatients, persons seeking services in emergency departments, persons receiving primary care as an outpatient at a clinic or from a physician, physician assistant, nurse practitioner or midwife.” (NYSDOH, 2011) Because one in three cases of HIV turn into AIDS undetected, screening can prevent the onset of AIDS and the transmission of HIV. This provides the greatest return on investment possible. In addition to mandatory testing availability, improved sex education and public awareness programs must target the age groups between 13 and 21. An existing law that enabled free syringe exchange produced dramatic results, but was reversed by our Congress. Re-enacting that law will reproduce proven results. The law should provide cash incentives for local pharmacies to retrieve and dispense syringes.

HIV is preventable using safe sex practices. Unfortunately, significant myths, high-risk sexual behaviors, and misinformation exist in African American communities. An improved sex education policy should mandate health and HIV awareness programs coupled with national and local public information campaigns targeted at young people. A law matching New York State’s requirement for availability of ARV medications for all patients will also provide an early response and limit the spread of HIV while preventing the development of AIDS in each patient.

Collaborative Program Funding

A recommended policy will provide funding formula that requires Community Based Organization participation in federal funding to state and local agencies. All funds dispensed through the program should be tied to performance metrics in order to attract further private and public funding. A key component of culturally competent public policies involve collaboration between public agencies and community-based organizations. CBOs reach underrepresented populations, overcome cultural stigma and resistance, and attract the targeted population to participate in programs. They also attract private funding to leverage public funds for long-term sustainability. A method of measuring “Cultural Competence” should indicate and reward with funding each agency’s or Community Based Organization’s sensitivity to the needs of their local community.

Funding priorities should shift toward prevention as demand for treatment declines. The return on investment in prevention merits a policy to provide long term funding for small community based organizations to invest in staff, infrastructure and training to implement the national HIV / AIDS education policy at the local level. Finally, the funding formula should support prevention programs in the form of challenge and matching grants that encourage creative, culturally competent prevention programs. Program activities should help remove the stigma surrounding HIV and to encourage young people to participate in testing and safe sex, cultural reinforcement of positive sexual behavior. The above requires consistent messages in public media that reach young people of color. State of the art marketing techniques combined with locally administered youth social activities including music and entertainment build positive self-image and affirm the value of the individual and their health.

Culturally Competent Staff Training

All government and CBO staff that meet African Americans should be sensitized to the stigma and potentially fatal consequences of breaches in anonymity and confidence. To encourage maximum participation, staff training and privacy practices should be implemented that encourage and reinforce the benefits of participation in prevention, testing, and treatment activities.

Local Self-Sustained Funding

In addition to the collaborative funding formula, CBO's should receive training and technical assistance to solicit grant funding, conduct public fund-raisers, and provide self-sustaining business presences in the community. In the event that the collaborative funding formula may not deliver required results or economic downturns limit funding, CBOs must have internally operated independent sources of revenue for HIV / AIDS programs.

Local Church Involvement

The African American community, especially in New York City, relies heavily in church involvement. Direct engagement of African American churches, as a moral and operational force for HIV awareness should be an offered to each community by federal mandate. As an extension of the collaborative funding model and local HIV / AIDS awareness campaigns, the local church extension will create a community based center for voluntary citizen participation in prevention and testing in conjunction with or as an alternative to CBO efforts. In addition, as naturally self-sustained and self-funding community institutions, churches survive when CBOs and even government agencies cease to exist. Also, the permanent enlistment of the church as a force against HIV serves to counter the past perception – perpetuated by many African American church leaders – that HIV is a taboo subject and that participation in any HIV – related activity is

a symbol of participation or association with an unholy practice. For the African American, the local church offers the only fully trusted and sustained community resource.

Local Media Campaigns

As an ongoing and culturally sensitive strategy to defeat the stigma and resistance to HIV as a topic and prevention and testing as culturally acceptable and encouraged behaviors, the use of entertainment has been effective in African American culture. As a funded effort, the education processes within such media campaigns provide an extension of government policy but rely on local community organizations, churches and citizens for execution. The collaborative funding strategy coupled with the local church and self-sustainable CBO efforts all intersect in support of the media campaign. Awareness and a stigma-free public sphere of discussion enables the prevention and testing components as well as early intervention for existing HIV-infected cases. A broader, more frequent and publicly reinforced awareness can bridge the gap between African Americans and awareness that is more appropriate and cultural reinforcement levels of whites.

Streamlined Monitoring and Evaluation

On August 4, 2011, New York Mayor Bloomberg launched the “Nation’s most comprehensive effort to tackle disparities between young Black and Latino males and their peers.” As a corollary of the NHAS collaborative model, integration of HIV disparity reduction into overall efforts to reduce other disparities affecting African Americans provides a centralized mechanism to monitor and evaluate performance. Backed by a \$ 127 million budget, the New York Mayor’s effort targets disparities in education and health among African Americans as well as Latinos as contributing to a 90% representation in the violent crimes and 60% unemployment. Small community organizations and churches offer valuable front-line resources for program delivery

but lack the administrative infrastructure to consistently produce the data required by the typical federal program. The New York anti – disparity program, with targeted HIV efforts included, can relieve the local partners of some of this burden and yield valuable data to support their independent fund – raising and self-sustainability campaigns. The August 4 New York City Mayor’s Office press release said, “ New Policies and Practices, Plus City Resources and Private Funding, Will Address Challenges in Key Areas of Education, Employment, Health and Justice.” (NYC.gov Aug 4, 2011) This summarizes the epitome of local leadership within a collaborative model that attracts private funding within an interdisciplinary model. Along with Dr. O’Connel’s robust State level commitment, the local New York City counterpart for the national NHAS is in place. Finally, however, the federal level leadership and funding must complete and support this clearly innovative local effort. ***Long Term Federal Funding***

As in the case of self-sustained funding for local CBOs, the African American must be made to feel that the federal commitment to their health and future is permanent. The National Strategy cannot give way to repeals of “Obamacare”, become perceived as a “pet project” of the current administration or in any way appear or become perceived as a political “football”. The impact of the lives of African Americans, within their community, is permanent once they become involved in a visible way with the subject of HIV. The risk, to them, of the government changing its funding and the community losing its moral and practical support can be literally fatal to some. The National Strategy must be reinforced as a permanent policy with a series of long-term funding and technical support commitments. Likewise, the local commitment to the collaborative funding strategy will require local CBO, church and government agency investments in infrastructure, training and public awareness campaigns. These investments must

be monitored and funding requirements must demand accountability for the use of funds, but in return for accountability, local entities must also be guaranteed long-term federal support.

Conclusion

The African American community in New York City provides a bell-weather for other communities of color in America. Blessed with strong community organizations, dedicated statewide HIV program support, effective testing laws, adequate funding to ensure that medicine is available and the many benefits of a recent federal collaboration strategy, the epidemic is in a state of local decline. However, the proportional disparity between African Americans and remains and the trend can easily reverse itself if economic disruption reduces funding. If individuals, especially young people, fail to receive education, testing and opportunities to pursue health lifestyles, the epidemic can swing back to earlier proportions. Ending HIV/AIDS in the African American community requires individual awareness, leadership sensitivity, public education and significant marketing campaigns. The leadership component of successful HIV / AIDS policies and programs require sustained funding to offer the kind of permanent lifeline needed to attract and gain the trust of African Americans long leery of the government. Religious leaders in particular need to embrace and effect fundamental changes in their personal attitudes about HIV/AIDS. The African American public, led by the church and supported by national and community leadership, must affirm the individual value of each person and end the fear and ignorance that create a uniquely African American stigma that serves as the root cause of the disparity.

HIV is a preventable disease and the effectiveness of its prevention is a matter of attitude, perception and education. In the case of this paper and other research efforts, the subjects of analysis either avoid interviews or remain anonymous. This is one of the most volatile topics

and the strong and frankly unexpected level of emotion behind HIV makes it extremely difficult as the object of a survey. Far more ignorance and avoidance surround this subject than most any other that I have encountered and if not for recent national attention, the problem could continue to spiral out of control in New York City. The national strategy acknowledges this fact and attempts to offer a road map for local communities such as New York City to follow. However, local communities need to provide their own self-sustaining policies and programs with local ideas and resources. There is too much at stake to have politics reverse current progress or for the African American community to lose recent embryonic confidence in government. The timetable to end HIV / AIDS in New York City as well as America remains unclear, but current trends have shifted in the right direction such that the next generation should at least have the option to avoid this disease without undue social stigma or dependence on any particular federal government program or agency. Fortunately, New York has a history of leadership in this area and offers its own positive example of collaboration and culturally competent community based organizations support for the nation.

Bibliography

- “30 Years of HIV in African American Communities: A Timeline.” *CDC*.
https://docs.google.com/a/oxy.edu/viewer?a=v&q=cache:o5q0Z5GGXu8J:www.cdc.gov/nchhstp/newsroom/docs/Timeline-30years-HIV-African-American-Community-508.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESirdh8_IKvjhCky3KkCe32OXOTEib2VhW4mhdaxP74S1M-dXFuyRssai3oyk51001fQ2QNV8Vjo7d4BTw-rY00b_qLUEw9X08C3YyM4Y1u1VpMoodbNe2Rn6wQcghvwxarFtCSJ&sig=AHIEtbS6vrl2dGeNDhYYTSKbW4VrNyaOOw.
- “About PEPFAR.” <http://www.pepfar.gov/about/index.htm>.
- annonymous.
- Bazell, Robert. 2011. “Double whammy of setbacks cripple war on AIDS.” *Vitals*.
http://vitals.msnbc.msn.com/_news/2011/11/30/9124197-double-whammy-of-setbacks-cripple-war-on-aids.
- “Bronx-Wide HIV Testing Initiative: HIV/AIDS Information : NYC DOHMH.”
http://www.nyc.gov/html/doh/html/ah/bronx_test.shtml.
- Collins, Patricia Hill **Black Sexual Politics**, Routledge; First Edition edition January 27, 2004
- Clinton, Bill. 2010. “NHAS.pdf.”
https://docs.google.com/a/oxy.edu/viewer?a=v&q=cache:gpeSaHhOYNQJ:www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESj2SvkFORH2Wyyxfpr1ETmf2EAO40vSSvV3J-yrNUZbgApr_h-bj5mqTTb-yDXHrY6gzYAnSwYlBnGI0Sr83Cg1PHOvMUFJuL9uEidVfGWv-mQ04LSFhnGUzPS2YhiqHvZ9BX7&sig=AHIEtbTylRjJhDxfH6ybZfqXcc3klbwPcw.
- “Coordinating the Response to HIV/AIDS: Preventing HIV/AIDS: UNFPA.”
<http://www.unfpa.org/hiv/response.htm#scaling> (Accessed November 18, 2011).
- Fenton, Kevin.
- Freiden, Thomas. “Can the HIV/AIDS Epidemic in New York City be Stopped?”
http://www.prn.org/index.php/transmission/article/hiv_aids_epidemic_in_new_york_city_52 (Accessed November 18, 2011).
- “Frequently Asked Questions regarding the Amended HIV Testing Law.”
<http://www.health.ny.gov/diseases/aids/testing/law/faqs.htm>.
- “HIV/AIDS Policy Fact Sheet.” 2006. *Henry Kaiser Family Foundation*.
- Lange, Tamara. “HIV & Civil Rights: A Report from the Frontlines of the HIV/AIDS Epidemic.” *ACLU AIDS Project*.
- Mark Kutner, Elizabeth Greenberg, and Justin Baer. “National Center for Education

Statistics.” *National Assessment of Adult Literacy (NAAL): A First Look at the Literacy of America’s Adults in the 21st Century*.
<http://nces.ed.gov/NAAL/PDF/2006470.PDF>.

Miller, Robert.

“new_york_cs.pdf.” *Blackaids.org*.

https://docs.google.com/a/oxy.edu/viewer?a=v&q=cache:0GIg9KGA-qAJ:www.blackaids.org/docs/new_york_cs.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEE SiVNO5QyMuMLvA9-U29IMnIc9yVLOmX2QUyAJLFoSURBITGHa5LpSbNHnXsOCi2LmQNXc5w2KGBO QPy1Kxpju2GIcHsAzyHjke9TIJ3o_dCNwsEVWrFqbLVabEJnWrP6e2M2-7g&sig=AHIEtbSQiVkccEWQrpOz7fLrSLc2htrmxw.

“NYAC.” http://www.nyaidcoalition.org/news_article.php?id=118®ion=.

“NYC.gov.”

http://www.nyc.gov/portal/site/nycgov/menuitem.c0935b9a57bb4ef3daf2f1c701c789a0/index.jsp?pageID=mayor_press_release&catID=1194&doc_name=http%3A%2F%2Fwww.nyc.gov%2Fhtml%2Fom%2Fhtml%2F2011b%2Fpr282-11.html&cc=unused1978&rc=1194&ndi=1.

O’Connell, Daniel.

Parsons, Gradye. “Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action.”

https://docs.google.com/viewer?a=v&q=cache:Hw9OFhIBzgwJ:www.phewacomunity.org/images/aids-policy.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESidRgyv_9SdVKvxofSZsrsp_o5WNcemEeS9vDpEcstKbjYz0P05Ur2Sh9xCjwWlhfHxoBcm5sY37kznvr8VyEZsYVMcJdghNWzF6_OxTfGRJytUyYcrYfHaKhhEcDYH5GFwUIOq&sig=AHIEtbRxEeIMOYXhLphRpLohZrC9VNOyg.

Prejean, Joseph et al. 2011. “Estimated HIV Incidence in the United States, 2006–2009.” *PLoS ONE* 6(8): e17502.

“President Obama announces new efforts to end the AIDS epidemic in the United States.”

blog.aids.gov. http://blog.aids.gov/2011/12/president-obama-announces-new-efforts-to-end-the-aids-epidemic-in-the-united-states.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+aids%2Fgov+%28Blog.AIDS.gov%29.

“Prevention of Mother-to-Child Transmission of HIV: Expert Panel Report and Recommendations to the U.S. Congress and U.S. Global AIDS Coordinator.” 2010.

“Report: Black U.S. AIDS rates rival some African nations - CNN.” 2008.

http://articles.cnn.com/2008-07-29/health/black.aids.report_1_aids-epidemic-death-among-black-women-spending-on-hiv-prevention?_s=PM:HEALTH.

Rouse, Stella, and Brian McKenzie. *Introduction*.

https://docs.google.com/viewer?a=v&q=cache:_XBZXtwEox4J:www.bsos.umd.edu/gvpt/apworkshop/mckenzie-rouse10.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESh63qLukD7v58p6dJwdKMyorVarLKzwHQwIdwIGkL0VuAYVOK_cPZRSPf_EAhm4NIJkCYC5Mjf0aqA9Swu60jUvchy-ilxWhbKhB3eAPji78bteXN31DKEv5O5T0Gr671r-dpQ5&sig=AHIEtbRs_U0S0k8MJw98KAShHfGrhaoCbA.

Seele, Pernessia. *Significance of Black Churches in Service Delivery*.

https://docs.google.com/viewer?a=v&q=cache:8LOqREo7bQIJ:www.balmingilead.org/downloads/resources/Significance%2520of%2520Black%2520Churches%2520in%2520Service%2520Delivery.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESh_2tRqgX2Tw-8WDsilWK5F5qa2r3SasMo2aLC427IQdUAxx11BPMTpWjGjxIBv9wTUIHCaKnnrFcmNhDIqvV0BQ8AKmfWZ_fqzVG7-ul_TOpnmuV-jDvnVcucE-ULsPNnnA0I&sig=AHIEtbTBciQZQYZLprDL1wAFj4vaWIUHOA.

Spicer, Neil et al. “National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice?” *Globalization and Health* 6(1): 3.

Stone, Krishna.

Stringer, Elizabeth et al. “WHO | Monitoring effectiveness of programmes to prevent mother-to-child HIV transmission in lower-income countries.”

<http://www.who.int/bulletin/volumes/86/1/07-043117/en/> (Accessed November 18, 2011).

“The State of AIDS in Black America, 2009.” *The Root*. <http://www.theroot.com/views/state-aids-black-america> (Accessed April 17, 2012).

Thompson, Justin.

Wiley, Debra. 2010. *Sex education & Faith: Implications for the Black Church*.

<http://etd.ohiolink.edu/send-pdf.cgi/Wiley%20Debra%20T.pdf?ucin1277465340&dl=y>.

Wilson, Phill, Kai Wright, and Michael Isabell. 2008. “left_behind.pdf.”

https://docs.google.com/a/oxy.edu/viewer?a=v&q=cache:ili2cjVD7gUJ:www.blackaids.org/docs/7_08_left_behind.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESgB50u_6xPIvaaZXlviXZzbUZqtKZbAjmgsR6GvwMNsVckxletp7UnH4gcfPCvonby2gbrazYvNCZ_fhANszrmtT6H21VM9yQmUzQ6edmKNr4j5xPL_RSs41awV2yeQBRixGk6k&sig=AHIEtbQCAH73iCF831B8DckEZYmQENqR_A&pli=1.

Wilton, Leo.

Wright, Kai, and Michael Lavers. 2011. “Majority of People Living With HIV in U.S. Aren’t in Successful Treatment.” *Color Lines New for Action*.

http://colorlines.com/archives/2011/11/vast_majority_of_people_living_with_hiv_in_us_arent_in_successful_treatment.html.