

## Why Is AIDS Ten Times Worse among Black Americans?

### SILENCE STILL EQUALS DEATH

Algernon Austin, Ph.D.

In the late 1980s, AIDS activists began chanting “Silence Equals Death.” These activists were aware that the failure to speak about AIDS guaranteed that people would continue to die from AIDS. Today, there are drug therapies for HIV/AIDS that did not exist in the 1980s. The rate of AIDS deaths has fallen significantly and the AIDS movement has declined in turn.

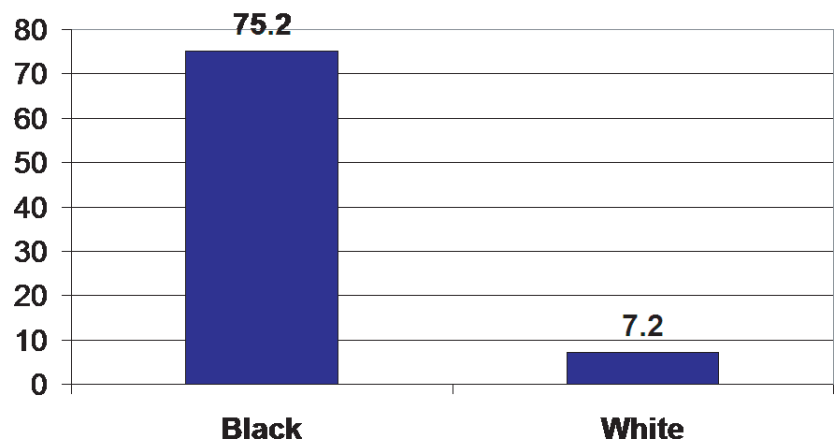
AIDS activism, however, never fully reached black America. In 1989, the adult black AIDS rate was almost four times the white rate. As the adjacent chart shows, today it is more than ten times the white rate. AIDS is the seventh leading cause of death among blacks. No other racial group is so afflicted.

It is important to be clear: because of medical advances, Americans of all races are less likely to die from AIDS today than during the peak of the epidemic in the early 1990s. The reason for the worsening *relative* standing of blacks is because the improvements in HIV/AIDS prevention and care have been much greater for whites than for blacks. In the fight against AIDS, blacks have been falling further and further behind.

Silence still equals death. Too few blacks speak out about HIV/AIDS and too little has been done to reduce HIV and AIDS rates among blacks. This issue of *Black Directions* discusses the extent of the black HIV/AIDS problem, the many reasons for the continuing ravages of AIDS among blacks, what is being done to address the problem and what more needs to be done.

[Find notes for this article at <http://www.blackdirections.com>.]

**Figure 1. Estimated Adult AIDS Rate (per 100,000 people), 2003**



# Causes and Solutions to the Black HIV/AIDS Problem

Algernon Austin, Ph.D.

## THE MAGNITUDE OF THE PROBLEM

It is worse than you think. Today, there are more black Americans living with AIDS and dying from AIDS than any other racial group. Once diagnosed with AIDS, a black person is likely to die sooner than a person of any other racial group. AIDS is the seventh leading cause of death among blacks. For no other racial group is AIDS in the top ten causes of death. And the most recent indications are that things are getting even worse.

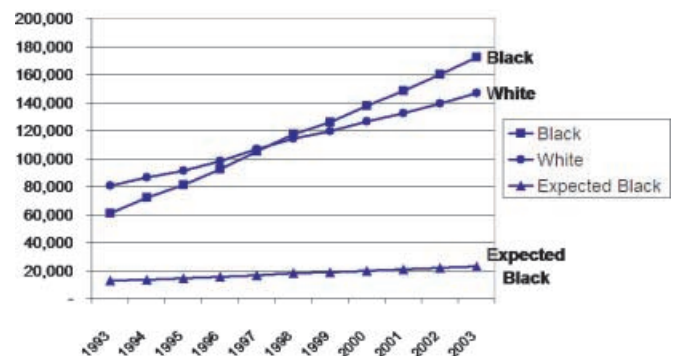
The number of newly diagnosed AIDS cases declined by three percent among whites from 1999 to 2003. There should have been a similar decline for blacks, but instead newly diagnosed AIDS cases among blacks *increased* by seven percent. While there has been a slight downward trend in the number of new AIDS cases among whites, there has been an upward trend among blacks. This slight increase is on top of the already high rates of AIDS among blacks. As Figure 1 on the front page showed, overall, black Americans are suffering from AIDS at a rate ten times that of white Americans.

When we examine the rates for males and females separately, we see significant differences (see Figure 2). The rate for black men is twice that for black women. AIDS is impacting black men more severely than black women. On the other hand, black women are much worse off in comparison to white women than black men are in comparison to

white men. Black women are being diagnosed with AIDS at one-half the rate of black men, but white women are being diagnosed at one-sixth the rate of white men. The black male rate is eight times that of white males, but the black female rate is twenty-five times that of white females.

One more figure will help us fully grasp the overrepresentation of AIDS among black Americans. Figure 3 shows the number of blacks and whites living with AIDS. For every 100 whites in the US, there are about sixteen blacks. In a world of full racial equality, for every 100 whites living with AIDS one would expect there to be sixteen blacks living with AIDS. In Figure 3, I have presented a rough approximation of this expected black AIDS rate.

Figure 3. Estimated Number of People Living with AIDS: Blacks and Whites

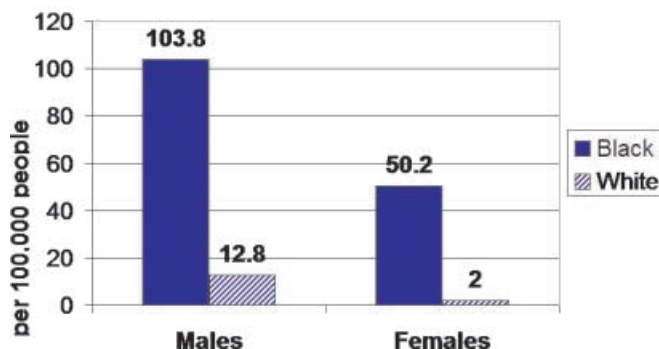


Source: CDC, *HIV/AIDS Surveillance Report*, 2003, vol. 15, p. 20; CDC, *HIV/AIDS Surveillance Report*, 2000, vol. 12, no. 2, p. 37.

When we compare the reality to the ideal expected rate, we see that there were roughly 150,000 too many blacks with AIDS in 2003. In an ideal world of racial equality, the numbers of blacks with AIDS should be dwarfed by the numbers of whites with AIDS. In our world, there are more blacks with AIDS than whites.

**There were roughly 150,000 too many blacks with AIDS in 2003.**

Figure 2. Estimated Adult AIDS Rate by Race and Sex



Source: CDC, *HIV/AIDS Surveillance Report*, 2003, vol. 15, p. 14.

## CAUSES AND SOLUTIONS

**HIV/AIDS** thrives among the marginalized, poor and powerless. The list of solutions to specific causes below is not complete but it does address most of the major issues. It is organized based on guesses about the amount of political and economic resources that would be necessary to address each problem. The problems that are assumed to require the most political will and the most economic resources come first. Problems requiring little political and economic resources may still be very difficult to address if they require challenging deep-seated beliefs and values.

### 1. Reduce Black Poverty

People infected with HIV who have access to good health care can receive treatment that greatly prolongs their life. Poor people are less likely to have health care. If they have health care, it is not likely to be of the best quality. Poor people are also more likely to engage in sex for money. These factors all directly lead poorer people to have higher rates of AIDS deaths. Blacks are more than twice as likely as whites to be impoverished.

Being poor and living in a poor community also indirectly facilitates the spread of HIV/AIDS. Poor communities suffer from lower quality education, higher street crime rates and other social problems which make addressing and preventing the spread of HIV difficult. Some of these issues will be addressed in more detail below. Poverty among blacks increases the rate of HIV/AIDS.

### 2. Provide Quality Universal Healthcare

Quality universal health care would address a large amount—but not all—of the health care disparities between blacks and whites. Universal health care would, therefore, reduce some of the disparities in HIV/AIDS treatment between blacks and whites.

### 3. Provide Drug Treatment for Substance Abusers Especially Injection Drug Users

People who are intoxicated are less likely to make smart decisions about sexual behavior. Drug addicts may engage in a wide range of activities that put them at risk for HIV transmission. For example, drug addicts may engage in unprotected sex for money or drugs.

Although blacks and whites are equally likely to inject illegal drugs, black injection drug users are more likely to transmit HIV.

This HIV disparity is probably because black injection drug users are more likely to share injection equipment. HIV researchers know that poorer injection drug users are more likely to share injection equipment. So, HIV among black injection drug users is probably linked to black poverty. More and more effective drug treatment programs will reduce black HIV/AIDS rates.

### 4. Provide Quality Health Care, HIV/AIDS Education, Condoms and Sterile Tattooing Equipment to the Incarcerated

The “war on drugs” and “get tough on crime” policies have greatly increased the numbers of drug users and blacks in jails and prisons. Injection drug users and crack cocaine users have high rates of HIV infection. The relatively high concentration of these and other drug users is one factor that causes the prison population to have a rate of HIV infection nine times higher than the non-prison population.

Prisons are highly conducive to the transmission of HIV, and blacks are six times more likely than whites to be in prison. Although sex, drug use and tattooing are all illegal in prisons, they all occur. All of these activities directly or indirectly can lead to the transmission of HIV.

**HIV among black injection drug users is probably linked to black poverty.**

Prisons are also an excellent site to begin combating HIV/AIDS among blacks because they are dealing with a high-HIV-risk captive population. Well-staffed and well-equipped prison health care systems could find many blacks in the early stages of HIV infection and

prevent these blacks from developing AIDS. There should be more and better drug rehabilitation programs in prisons and these programs should be linked to civilian programs that can provide treatment and support when the inmate is released. Prisons could educate blacks about HIV/AIDS. Not only could this knowledge be used to prevent the spread of HIV within prisons, when prisoners are

released they would carry this knowledge back into their communities. Since sex and tattooing occur in prisons, condoms and sterile tattooing equipment should be made available to prisoners to reduce the transmission of HIV.

## 5. Improve Black Patient-Physician Dynamics

Generally, even when blacks see a physician they receive lower quality medical care. For HIV/AIDS specifically, researchers have observed black-white disparities in care. One study found that blacks with white physicians received antiretroviral HIV therapy later than did blacks with black physicians. Late antiretroviral therapy is one of the reasons for higher rates of black AIDS deaths.

Many black patients may also be less than ideal patients for a variety of reasons. False popular ideas about HIV medications may make blacks resistant to taking medications. Many blacks may be also struggling with a variety of other social and economic problems in addition to HIV/AIDS. For example, some blacks postpone medical care simply because they do not have transportation to the doctor's office. Someone wrestling with drug addiction also has a major challenge that may interfere with her being the ideal HIV/AIDS patient.

## 6. Promote Regular HIV Testing for Blacks

Most Americans who are tested late for HIV are black. A person is defined as being tested late if she develops full-blown AIDS within one year after her HIV test. In these cases a person typically is tested for HIV infection after they are already sick. Early testers tend to take an HIV test because they recognize that they are at risk for infection even if they show no sign of illness. Late testers are more likely to die from AIDS than early testers. Given the high rate of HIV infection among blacks, blacks should be regularly tested for HIV. This practice will increase the number of black early testers.

## 7. Reduce Homophobia and Sexism among Blacks

Blacks express more homophobic and sexist attitudes than whites. Homophobia and sexism both contribute to the transmission of HIV. The higher levels of homophobia in black communities make black men who have sex with men more likely to conceal their behavior, marry and identify as heterosexual than white men who have sex with men. Individuals who are to some degree in denial about their sexuality cannot take responsibility for their sexuality.

It is also likely that if women had more influence over male condom use, condoms would be used more often.

Women who are in relationships with men who physically or emotionally dominate them are less likely to report consistent condom use. Black women also have attitudes that would support slightly more consistent condom use, but they do not appear to have much influence over the condom use of their partners.

**Given the high rate of HIV infection among blacks, blacks should be regularly tested for HIV.**

**Individuals who are to some degree in denial about their sexuality cannot take responsibility for their sexuality.**

## 8. Educate Blacks about HIV/AIDS and Confront False HIV/AIDS Conspiracy Beliefs

Blacks are more likely to have false conspiracy beliefs about HIV/AIDS. These false beliefs most likely reduce blacks' use of medical care for HIV/AIDS and black men's use of condoms. (See "Conspiracy Beliefs, AIDS and Combating Racism" in this issue.) These behaviors would lead to more AIDS and AIDS deaths among blacks.

This is a daunting list. These are not easy solutions to implement. The educational work, however, is at least relatively inexpensive. Readers are encouraged to educate themselves about HIV/AIDS by exploring the "HIV/AIDS Resources" below and to share them with others.

The good news is that the root causes of the disproportionate impact of the HIV/AIDS problem are the same as for many other problems facing black Americans. Reducing black poverty, for example, will address not only a major factor behind HIV/AIDS rates but also an important factor in other health problems, in educational problems, and in criminal justice problems. All of these problems stem largely from black marginalization, poverty and powerlessness. A single, effective progressive political mobilization could therefore improve the status of blacks on many fronts simultaneously.

[Find notes for this article at <http://www.blackdirections.com>.]

**A single, effective progressive political mobilization could therefore improve the status of blacks on many fronts simultaneously.**

## HIV/AIDS Resources

*CIRA Research Summary*, Center for Interdisciplinary Research on AIDS at Yale University, <http://www.yale.edu/cira>

*HIV/AIDS Fact Sheets*, Division of HIV/AIDS Prevention, Centers for Disease Control & Prevention, <http://www.cdc.gov/hiv/pubs/facts.htm>

*HIV Prevention Fact Sheets*, Center for AIDS Prevention Studies, University of California, San Francisco, <http://www.caps.ucsf.edu/FSindex.html>

The Black AIDS Institute, <http://www.blackaids.org>

*POZ [magazine]: Health, Hope & HIV*, <http://www.poz.com>

*Real Health [magazine]: The Guide to Black Wellness*, <http://www.realhealthmag.com>

# Conspiracy Beliefs, AIDS and Combating Racism

Algernon Austin, Ph.D.

Correct and consistent condom use is one of the most effective ways of reducing one's likelihood of contracting HIV. Laura M. Bogart and Sheryl Thorburn, in a study published in the *Journal of Acquired Immune Deficiency Syndromes* ("Are HIV/AIDS Conspiracy Beliefs a Barrier to HIV Prevention Among African Americans?," Vol. 38, No. 2, 213-218), found that black men who subscribe to HIV/AIDS conspiracy beliefs are less likely to use condoms consistently. These men are putting themselves and their sexual partners at risk for HIV infection.

HIV/AIDS conspiracy beliefs are also likely to be an obstacle in the delivery of medical care for blacks with HIV/AIDS. Blacks who believe that doctors and medical institutions cause HIV/AIDS will be reluctant to seek out medical care for HIV/AIDS or to follow the directions of the medical care given. To prevent AIDS and deaths from AIDS, blacks need more and better medical care, not less.

The good news from Bogart and Thorburn's research on HIV/AIDS beliefs among blacks (see Table 1) is that 75 percent of blacks have faith that medical institutions are trying to stop the spread of HIV. Of course, 95 percent would be better.

There is much bad news however. Less than 40 percent of blacks have faith in HIV medicines. More than 40 percent of blacks believe that HIV medication is part of some sort of ominous experiment. It is not clear exactly what blacks mean by saying that taking new HIV medicines amounts to being "guinea pigs," but generally people do not wish to be guinea pigs. The belief that HIV medications cause AIDS, while a small minority view, is extremely dangerous. More blacks believe that the government is telling the truth about AIDS than that AIDS was created to somehow control blacks. But only a minority of blacks trusts the government about AIDS.

Certainly the history of racism and inequality in American society and in the American health care system in particular is at the base of these attitudes. Anti-black discrimination and inequality continues today. But supporters of these conspiracy beliefs have misunderstood the basic logic of racial discrimination.

Anti-black discrimination works to keep goods, resources and opportunities away from blacks. The Tuskegee syphilis study was about *denying* medical treatment to blacks to observe the complete natural course of the disease. Whites have received in the past, and still receive today, more and better medical care than blacks. Generally, the goal for blacks should be to obtain the same goods, resources and opportunities that whites receive. *AIDS conspiracy beliefs work to prevent blacks from receiving the medical care that whites receive.*

It is important that people who believe in racial equality speak out against these harmful ideas. Black leaders must speak out and educate blacks about the facts about HIV/AIDS. Silence equals death.

**AIDS conspiracy beliefs work to prevent blacks from receiving the medical care that whites receive.**

**Table 1. Black HIV/AIDS Beliefs** (% Agreeing Somewhat or Strongly)

The medicines used to treat HIV are saving lives in the black community.	38%
People who take the new medicines for HIV are human guinea pigs for the government.	44%
The medicine used to treat HIV causes people to get AIDS.	6%
The government is telling the truth about AIDS	37%
AIDS was created by the government to control the black population.	16%
Medical and public health institutions are trying to stop the spread of HIV in black communities.	75%

# Stories of AIDS and Black America ←

Joy B. Davis, Ph.D.

**J**acob Levenson's *The Secret Epidemic: The Story of AIDS and Black America* is superbly written and timely. Levenson skillfully interweaves the narratives of HIV positive persons, affected families, activists, researchers, and politicians in this chronicle of the tangled relationship between the AIDS crisis and black Americans.

Levenson's journey begins in the South of 1996. Due to high rates of teen pregnancy and sexually transmitted diseases including syphilis and gonorrhea, a spreading crack problem and virtually no AIDS prevention programs, states like Alabama were ill-equipped to deal with the virus. The South, Levenson writes, was fated to become the "new frontier of AIDS in America."

In the 1980s, one of the first AIDS frontiers was among gay white men in areas like the Castro in San Francisco and Washington D.C.'s Dupont Circle. Gradually, those working in the trenches with black heroin and crack users recognized that AIDS, then perceived to be "junkie pneumonia," had the potential to begin an epidemic which would wreak havoc on black American communities.

Among the other stories Levenson tells are those of Drs. Mindy and Bob Fullilove. These doctors note the lack of qualitative research on black sexual behaviors and begin to probe the psyches of some of the young male crack dealers who engage in rampant, unprotected sex in ghettos near the Castro and in Oakland. With the data that the Fulliloves and their assistants gather, they begin to draw conclusions about the effects of shared despair, repeated trauma and urban displacement around the country.

The reader also meets David deShazo, a white Alabamian social worker on a mission for Mobile AIDS Support Services. He drives his Pontiac through dusty, forgotten towns in the South, hoping to provide condoms and services to those at risk as well as to those who are infected. We follow him in his dogged pursuit of two black HIV positive teenaged sisters who live in a trailer with their mother and their kids. They conceal their sero-positive status from their neighbors and relatives and are often noncompliant regarding their treatment.

Mario Cooper is a young, gay African-American mover and shaker. He is steadily climbing the political ladder when he becomes enraged by a system that seems to force whites and blacks to compete for resources to combat AIDS. Perhaps even more upsetting to him is the lack of an organized response by black leaders to the emerging AIDS crisis that he foresees.

With chapters entitled "Smoke," "Fire" and "Surfacing," *The Secret Epidemic* is so much more than a textbook accounting of the toll of AIDS on African Americans.

Levenson addresses the oft asked questions: Why haven't some of the same interventions that helped gay white men reduce incidences of infection worked with African Americans? Where is black America's organized response, now that the face of AIDS is so clearly a brown one? Levenson identifies many of the commonly discussed theories, such as the belief that African Americans are less disclosing about sexuality, especially homosexuality and bisexuality. This theory would certainly help to account for the fact that African-American women are now the most HIV-vulnerable population. Poverty, always inextricably linked to issues of race in the United States, is implicated as another factor. But, Levenson probes deeper still.

**Gradually, those working in the trenches recognized that AIDS had the potential to begin an epidemic which would wreak havoc on black American communities.**

The book is at its most riveting when he investigates less conventional possibilities to explain how AIDS consumed so many African-American lives. For instance, Dr. Mindy Fullilove develops the concept of “psychology of place.” The concept

denotes the searing effect that the physical destruction and spiritual dissolution of urban communities has had on black residents. She comes to believe that with the loss of a sense of black community, indifference and desperation provided fertile ground for the crack epidemic which in turn ignited an explosive increase in the number of addicts prostituting themselves in order to feed their habits.

We also read about the maneuverings of the public health research community and former President Clinton’s failure to support a federally funded needle exchange program for fear of the political backlash, even when he is presented with research to suggest it could reduce HIV transmission. Behind closed doors, states and AIDS organizations battle for AIDS funds, leaving the least politically savvy out in the cold. We

are made privy to black church leaders’ complex feelings of “empathy and secrecy” regarding homosexuality, which influences their hesitancy to organize against AIDS early on.

“The crack house of today has become what the gay bathhouse was yesterday with regard to all sexually transmitted diseases,” a CDC director declared in 1998. And yet, somehow, American policy-makers, religious leaders, health researchers and experts failed to prevent the rampant spread of AIDS in black communities, despite the efforts of so many who worked at the grassroots level. *The Secret Epidemic* grapples with complex, shifting constructs: race in America, community, sexuality, poverty, hopelessness. None of these alone accounts for AIDS’ devastating effect on black America in 2005. It is this predicament that Levenson succeeds in shining a light on and describing in moving detail.

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**Even more upsetting to him is the lack of an organized response by black leaders to the emerging AIDS crisis that he foresees.**

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# Challenges in HIV/AIDS Treatment and Prevention: *An Interview with Leif Mitchell*

**Leif Mitchell** is Assistant Director of the Center for Interdisciplinary Research on AIDS at Yale University, <http://www.yale.edu/cira>.

## **Black Directions:** What is CIRA?

**Leif Mitchell:** CIRA is the Center for Interdisciplinary Research on AIDS. Our mission is to support the conduct of interdisciplinary research that's focused on HIV prevention and the reduction of negative consequences of HIV disease among vulnerable and underserved communities. We're funded through the National Institute of Mental Health as an AIDS research center and as an infrastructure center and we support affiliated research projects.

## **BD:** What are the vulnerable and underserved communities in the US?

**Mitchell:** In the US, blacks, Latinos, drug users, sex workers, and Men who have Sex with Men (MSM) are communities that are marginalized or disproportionately impacted by HIV and AIDS.

## **BD:** CIRA is interdisciplinary. Why interdisciplinary?

**Mitchell:** We have over 13 different departments here at Yale that are involved with CIRA. They include anthropology, psychology, epidemiology and public health, internal medicine, sociology, psychiatry and infectious diseases among others. It's extremely important to focus on the other factors that are involved, beyond the purely biomedical, in applied research. For example, there are sociological, economic and psychological factors that are involved in HIV prevention. All of those factors are very important. Because our focus is on HIV prevention research rather than research on care or clinical trials, one must look at all of the other factors involved with the individual before and after they contract HIV.

**BD:** CIRA supports needle exchange programs for injection drug users. I imagine some people would feel that you're encouraging people to use drugs.

**Mitchell:** Overwhelmingly the research does not suggest that. Instead it suggests that it's reducing the amount of HIV within the community. It's a needed service that has proven to be effective, not only cost effective but effective overall. And scientists here at Yale actually were involved in the first evaluation of the syringe exchange program in the country and found them to be effective and cost effective.

## **BD:** What are your thoughts on the "down low" discussions about black men who secretly have sex with men?

**Mitchell:** The issue is something that's been discussed within the HIV/AIDS community for years. It has only recently broken into the general media.

I think it's extremely important that individuals identify themselves however they want to identify themselves. I have a lot of problems with people wanting to put labels on others. Just because a black man has sex with other men doesn't mean that he's gay, doesn't mean that he is on the down low. It doesn't mean anything. It's behavior, and identity and behavior are different. I think that point gets lost in this whole discussion.

That being said, I think if we had comprehensive sexuality education in schools early on then perhaps that would have an impact on the homophobia and the sexism within all communities. That would in turn have a positive impact on HIV risk. So, certainly that is also important.

**It's extremely important to focus on the sociological, economic and psychological factors that are involved in HIV prevention.**

## Challenges in HIV/AIDS Treatment and Prevention: *An Interview with Leif Mitchell*

Continued from page 9

**BD:** One issue that has been an obstacle to providing HIV/AIDS care among blacks is conspiracy beliefs. What are your thoughts on black conspiracy beliefs?

**Mitchell:** Conspiracy beliefs, I think that that's also something to educate people about. I can understand why someone wouldn't trust a healthcare facility or research and I think we have to move beyond that. I don't know when we will get to a place where everyone will feel comfortable in a healthcare setting. That's sort of the ideal. So we have to acknowledge that that stigma is there and then accept the reality of it and be able to work through it.

**If someone doesn't have a house or food, how can they worry about whether or not they're taking their HIV meds?**

**BD:** How can you work through it? How can you get beyond it?

**Mitchell:** I've heard some people say that, people should be able to go to physicians that are from their similar background. I don't think that should be the end goal, but people need to feel comfortable going to their healthcare provider. It's a partnership between the patient and the doctor and one should be able to negotiate that.

**BD:** Many blacks believe that AIDS was made in a government laboratory. How do you respond to this belief?

**Mitchell:** Just from my own experience, this was probably 10 years ago when I was doing HIV prevention work with mainly inner city youth in Cincinnati, Ohio, and issues came up constantly about, "Oh, the government created this to get rid of poor people," and, you know, and I would have to just come back with, "We don't know where HIV came from. I understand that you feel that way and I can't provide you evidence that says that's not the case. But we know that it's here and we have to deal with it, so why don't we focus the conversation on that instead." So I don't think it helps to think about it from the past. That's just one thing that comes to mind.

**BD:** What do you think the future is for HIV/AIDS?

**Mitchell:** Well, it's hard to be optimistic. The Ryan White Care Act provides emergency funding for people living with HIV and AIDS throughout the country, and President Bush came out with his recommendations for the reauthorization and they're very disturbing. Under the current rules, Ryan White Title I Planning Councils, people living with HIV and AIDS, community leaders, HIV providers and community health planners come together and decide what the priorities are for the community to access Ryan White Care Act emergency funding.

The President wants to eliminate that planning process. He wants it be administered through the State Health Department but with no input mandated by the community as the act originally had called for in 1994 when it first started. So that's problematic.

There's also set categories of funding for the Care Act: Primary Care, Substance Abuse Treatment, Mental Health, Case Management, Drug Reimbursement through the AIDS Drug Assistance Program, and Dental Care. Those six are the essential services we've identified through the different planning bodies in Connecticut. Although those six are essential, we've identified an additional seven that are part of the Ryan White Care Act that funding must go towards in order to enroll and maintain people living with HIV/AIDS in primary care. These include: Housing Assistance, Transportation, Alternative Therapies, Food, Emergency Financial Assistance, Outreach and Medication Adherence.

Secondary services are just as important as the six essential services. If someone doesn't have a house or food, how can they worry about whether or not they're taking their HIV meds? There's a real shift to move away from the transportation, housing, the financial assistance, all of those services and to focus just on the six essential services, but it won't work here in Connecticut.

Then you also have the AIDS Drug Assistance Programs and I think they're at least twelve states that have waiting lists for those programs, so they're out of funding basically. In Connecticut, we're lucky. The state government actually contributes to the overall budget as well. So you've got the AIDS Drug Assistance Program from the federal level and then there's the Connecticut AIDS Drug Assistance Program together. But in some states the formula that's used hasn't been accurate, or they've identified more HIV positives and so you've got people on waiting lists and people dying because they can't get meds. So, I think there are some issues with that program, obviously, and the amount of funding that's been allocated to it hasn't been sufficient. And, you know, now we've reached a point nationwide where there are over a million people that are infected and living with HIV and a third of them that don't know their status. So, with funding decreases and HIV prevention not working at the level that it should, it's scary. It's definitely scary.

**BD:** If there were adequate funding with all of these programs, would you then be optimistic or does something else need to happen?

**Mitchell:** Well, I think there needs to be more of a bridge between the scientific community and the providers implementing HIV prevention interventions. Often you have these rigorous scientific research projects that develop interventions for HIV prevention and they're funded at a certain level. Then you have the funding that comes out to implement those interventions within the community and that is at different funding levels. Obviously more funding needs to go into researching interventions, but I think it is difficult for the community-based organization to then implement the intervention as well.

And there's sort of a time lapse that takes place from when an intervention is researched versus being published to when it then becomes packaged as an intervention that can be easily implemented within the community. So that needs to work better so that the intervention can be out there in place. If that were the case, I think that we'd be much further along.

We also have to look past the ideological conversations and focus on the science itself. So, condoms should be made available in our schools; condoms should be made available in prisons; clean syringes should be made available wherever they are needed. They should be available in prison as well. You know, if you talk to members in the Department of Corrections, they say that, yes, sex and drugs do happen in prison; but, there's liability in prisons and I think they're afraid to admit that illegal things are happening under their "roof." Acknowledging the scientific findings rather than being persuaded by ideological arguments would be helpful.

**With funding decreases and HIV prevention not working at the level that it should, it's scary. It's definitely scary.**

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# The Alphabet Approach to HIV/AIDS Prevention: A, B, C . . . T

## **A**bstinence

Abstaining from sex is the best way to prevent sexually transmitted diseases. If you cannot abstain . . .

## **B**e faithful

A monogamous sexual relationship between people who are HIV negative is very safe. If you are not in this type of relationship . . .

## **U**se **C**ondoms

Correct and consistent use of condoms is the next best option if one is not in a monogamous sexual relationship with an HIV negative partner. One should also . . .

## **G**et **T**ested for HIV Regularly

The earlier you find out that you are HIV positive the more likely it is that you will be able to obtain the appropriate care and prolong your life. Because of the high rates of HIV infection among blacks, it makes sense for blacks to make HIV testing part of their routine medical care.

## **BLACKDIRECTIONS**

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