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**Today's Topics in Health Disparities -
What Would it Take to Eliminate the Disproportionate Burden
of HIV/AIDS Among African-Americans?
Kaiser Family Foundation Broadcast Studio
August 2, 2007**

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Marsha Lillie-Blanton, Dr.PH.: Hello, welcome to the Kaiser Foundation's third discussion in the series Today's Topics in Health Disparities. I am Marsha Lillie-Blanton your moderator for today and Senior Advisor on Race, Ethnicity and Healthcare at the Foundation. Today's Topics in Health Disparities, is a series of conversations that address issues relating to health and healthcare disparities in the US. The goal is to raise the level of understanding of these disparities and encourage greater dialog about the problems and promising interventions. Today's topic: What Would it Take To Eliminate the Disproportionate Burden of HIV/AIDS among African Americans? addresses what has been described by one of our panelists, Phill Wilson, as the defining health and justice issue of our time. I assume you know the statistics, so I won't dwell on them, but to assure we're all at a common starting point for today's discussion, let me begin by reviewing two very basic facts. First, in 2005, African Americans represented roughly 12 percent of the US population and yet half of all new AIDS cases and second, HIV related deaths are higher among African Americans than any other racial ethnic group, a disparity that has existed since the beginning of the epidemic and has worsened over time. Our conversation today will focus on what's being done and what more could be done to eliminate

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this disparity. The webcast will include a short pre-taped interview with Gloria Ruben, an actress who played an HIV positive character in the award winning show, ER, and scenes from the HBO movie, Life Support, which focuses on a family dealing with HIV. We welcome your questions so email us at Today'sTopics@kaisernetwork.org. In our studio today, we have three distinguished guests whose bios are available on our website. We are pleased to have with us Dr. Kevin Fenton, Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention of the Centers for Disease Control Intervention. Phill Wilson, Founder and Executive Director, Black AIDS Institute and Jen Kates, Vice-President and Director, HIV Policy Kaiser Family Foundation. Thank you all for joining us. Dr. Fenton, I would like to start with you. Working at CDC, I know you are used to focusing on the epidemic in terms of statistical terms, but for our audience could you describe the toll of the epidemic in the African-American community in human terms on families, on communities, on neighborhoods?

Kevin Fenton, M.D., Ph.D.: Thank you so much. We need to remember that in the United States today, there are over one million people believed to be living with HIV and the sad thing about this epidemic is that more than a quarter of these individuals are undiagnosed and as you mentioned, African-

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Americans really bear a disproportionate burden of disease. We also know that HIV is no respecter of individuals or age, race, or gender. That it is your mothers or fathers or cousins or friends who are living with this disease. We see tremendous disparities in HIV/AIDS among African-Americans. For example, African-American men have rates which are nearly 7 times higher than white men and African-American women have rates which exceed 20 times those of white women. So not only do we see a very pervasive epidemic within our communities, but we see tremendous disparities which needs to be addressed.

Marsha Lillie-Blanton, Dr.PH.: Jen, Dr. Fenton talked about the epidemic, still in fairly technical terms, help a policymaker or stakeholders understand what he means when he is talking about rates and the impact of the difference between diagnosed cases or just help us understand, what are the implications for those distinctions in our work?

Jennifer Kates M.A., M.P.A.: Those distinctions are really important and they are really important to understand. The reason we use rates, the reason that we try to help people understand that concept is, you mentioned earlier, Marsha, that blacks in the United States are about 12 percent of the population. That's a much smaller share of the US population overall than whites for example, which about 68 percent. So if we just look up your numbers, we wouldn't really get a sense of

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the concentration of the epidemic in the community and from the rates that Dr. Fenton was talking about and the numbers that that you presented in the beginning. What it basically says is the concentration of this epidemic among black in the United States is so much higher than among whites. A much smaller population of people, but the concentration is higher, and that's the problem because it is going to affect families, individuals, communities, who have to understand that impact and confront it and the one other thing about not knowing the diagnosis, the 25 percent not knowing, if a significant share of people don't even know they're infected they can't take the steps that they need to protect themselves, to protect others, to get treated, to get health care. So this is really significant.

Marsha Lillie-Blanton, Dr.PH.: Phill, can you help us understand the why? Why is this epidemic hitting the black community hardest?

Phill Wilson: Well, I think I would do two things if I can. First, is to kind of consolidate both what Jen and Dr. Fenton said in a way that lay people need to understand, assuming that some of the folks that are watching are lay people and put simply. Now, AIDS in America today is a black disease, now it is not just a black disease and is no less tragic when other people get infected or get sick or die, but

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when you look at the epidemic from the lens of gender or sexual orientation, or age, or economic class, or education level, or region of the country where you live, black folks bear the brunt of the AIDS epidemic in America today. Now, there are many reasons that speak to that. Chief among them are two, one, that black America was slow to respond to the epidemic for a whole host of reasons, two, that the AIDS epidemic was originally mischaracterized as a white gay disease when it never was a white gay disease, although quite frankly many folks weren't white or gay, wanted it to be a white gay disease cause that meant that they didn't have to deal with it and that was true in black America as well. In addition to that, black America is only now beginning to be mobilized around the disease now and too often what's happened is people thought of it as someone else problem or to the extent that we have been engaged, we thought of it as being an issue for small percentage or marginalized subset of our community, when in fact is an issue that all of us need to address. What's really important is a part of that is that the driving engine of the epidemic is not necessarily that black people are more sexually active than other racial ethnic groups or that their sexual behaviors in and of themselves are riskier than other ethnic racial groups, but the issues around help disparities in general, knowing your HIV status and the fact that in a mature

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epidemic, which is what we have, we are 26 years into the epidemic, that the sexual activities in black communities are an environments where you begin with a higher risk or higher rates of HIV.

Marsha Lillie-Blanton, Dr.PH.: I am going to try to integrate some of the questions that have come in from our viewing audience and to some extent you have already answered it Phill, but one of the question, this is someone from Spokane, Washington, is: What is the specific primary activity within the African-American community that is driving new infections?

Phill Wilson: Well I would say denial, quite frankly and a lack of mobilization, that we are not engaged at every level of our community. You know, we need to be calling on every sector in our community to be mobilized around this issue, because while HIV is clearly a health issue, it is also a civil rights issue, it's also a urban renewal issue, it's also a justice issue. Now, it permeates everything that we do. Now, we have no chance of reaching racial justice if in fact all of us are being decimated by this deadly disease.

Marsha Lillie-Blanton, Dr.PH.: Dr. Fenton, on our, on the Kaiser website in promotion of this webcast, there's a fact sheet with state by state data on AIDS case rates. That facts sheet also includes data on infant mortality rates, diabetes

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related mortality rates. What is striking about that fact sheet is the similarity across conditions-

Kevin Fenton, M.D., Ph.D.: That's right.

Marsha Lillie-Blanton, Dr.PH.: -and similarities within a state of cross conditions. What accounts for the similarities, I mean of cross conditions? Is it racism; is it poverty, all of the above? Is it our health care system?

Kevin Fenton, M.D., Ph.D.: You know, I am so glad you asked that because that really is focusing us not only on what the epidemiologist called the individual-level determinants of disease, but the importance of social contexts. The social determinants of disease and the reality is that the social determinants whether it's poverty, poor access defective services, lack of education, high rates of incarceration. These social factors and these social context are driving factors for multiple epidemics. So as Phill has said, you will see in the same jurisdictions high rates of HIV, which will overlap with high rates of sexually transmitted diseases and quite likely high rates of chronic diseases, cardiovascular disease, diabetes as well, because these are the social determinants which create that environment for either the spread of infectious diseases or the perpetuation of some of disparities that we spoken about today. So that is an important aspect of understanding why we are seeing some these very high rates

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within the community and why our approaches can not only be focused at individual-level behaviors but we need to move, what we call upstream. To talk about and to think about the structural things that need to be changed in our HIV field.

Jennifer Kates M.A., M.P.A.: I cannot agree more with that and one other thing I want to put in the mix here, that I think it is always important to remember, when we look at, when we talk about 50 percent of new AIDS cases today are among blacks in the US or if you look at mortality rates, if you look at any way you want to look at the data or slice of the disparity is quite evident, that's a reflection of patterns and transmission patterns that began in the past. What we see today is the reflection of let's say the lack of understanding the significance of this in every community on part of, within in the black community itself but also with government with all the sectors that really need to focus. What we're seeing now is the result of not focusing on that in the past. What that means is that today in the US blacks doing the very same thing that whites are doing sexually or other groups are more likely to encounter HIV in their networks in their sexual networks than others. Then their counterparts who are white for example, and that alone is a factor in addition to high risk behavior and other things, and that's so critical to combat, but it's related these larger structural challenges that we face.

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Marsha Lillie-Blanton, Dr.PH.: Before we look at the interview with Gloria Rueben, let's talk about women. Jen, we know that women, African-American women, represent over half of the new cases of AIDS. What's driving the epidemic? There's been has been a lot of discussion of men on the down low. I mean, is there any evidence that that is a factor driving it? Are there other factors unique or specific that are driving the epidemic among women?

Jennifer Kates M.A., M.P.A.: Well, first what the data tells us is that among women, African-American women, are about two thirds of the new cases, so among women that's the reality, but also if you look at rates, we looked at rates earlier, and why rates are so important to understand the concentration. The highest rates in the country are among black men. The second highest rates are among black women, higher than the rates among white men, for example. So what Phill said, our conceptions of the disease haven't always been what the data show us. I think that alone is part of the problem. Many black women might not feel at risk. So that's one issue, if you don't feel at risk, if you're not hearing the story, the messages, the concentration of this epidemic in your community is higher, you don't feel at risk, secondly, empowerment. The ability—this is a unique factor for women. All of the other things we talk about poverty, in structural challenges that are going to

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affect women, but some of the unique factors that affect women are about empowerment. Can women take the steps even if they do feel at risk? Can they take the steps they need to take to protect themselves, and this whole issue of men on the down low, I am so glad you brought that up because, that has, I think been, while it's an important thing to understand which is the idea that are men who are having sex with both men and women and are infected and putting women at risk, as it is very critical, but I think what is happened is that has been almost a diversion away from what we know is that that behavior isn't disproportionate in black communities, relative to white communities in the sense that it is driving anything more. It's a factor, it's a factor in general in HIV, once one person doesn't know their status or is having risky sex and they are infected, that's going to put somebody else at risk, but it's not the driver among women, among black women, it's a factor. I think unfortunately it allows people to say, "well I don't have to worry about that," and it also has a negative effect by scapegoating black men who aren't doing something at a higher rate than others. So I think that the factors around women are all the things that we said and these other factors that are around, not feeling at risk, not being empowered to take steps, and one other thing is if these structural challenges in communities are isolating people within communities that don't

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have resources, that don't access where frankly men may be going in and out of the jail system as Dr. Fenton mentioned and you hear, you see from studies around challenges about who people are able to have relationships with, it's going to affect everyone's risk.

Marsha Lillie-Blanton, Dr.PH.: I can see that both of you want to get into this question. Let me bring in a question that's come in from our audience. This is from someone, from San Francisco, California and the question is: Are all women within the African-American community at risk for HIV or is it a select cohort within this community? and Jen, I think you answered it in part, but could one of you respond to that? Is it a small segment, is it all, is it parts?

Kevin Fenton, M.D., Ph.D.: The reality is that we, for any given population, if you're looking at African-American women, if you're looking male sex with men, you're going to have differences in risk across the population. It's important that all African-American women are in fact aware of the risks. They should be informed of how HIV's transmitted. They should be having authentic and honest and open conversations with their partners. They should be testing for HIV and they should encourage there partners to test. So everybody should be aware of the risk of HIV within the community. Now, whether an individual woman is at a higher risk than another really

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depends on a number of key factors. As we mentioned earlier, it depends on patterns of risk behavior, how many partners she may have had in the past. But also bear in mind that her risk for HIV depends on her partner's risk as well, and many of the infections which we see in African-American women, are among, are from partners. Many African-American women have been infected sexually from individuals or partners who are themselves are HIV positive or who may be having high risk behaviors. So, at the individual-level, it is really important that each women, African-American women or any individual really accesses their own risks, looks at their own behaviors, talks to their partners, have open conversation about risk and make decisions about HIV testing and protecting themselves.

Marsha Lillie-Blanton, Dr.PH.: I want to now turn our conversation from the discussion of the problem to talk more about what can be done to address the problem, and I want to start this segment with a pre-taped interview with Gloria Reuben, who played the HIV character, Jeanie Boulet, on the television show ER and she is, also, in the HBO movie, Life Support, which stars Queen Latifah. So, if we could run that clip.

Gloria Reuben: And it was right around the time when I started working on the show on ER. It was second season that I

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was on the show when Jeanie, when we brought into the story line the fact that Jeanie was HIV positive.

Female Speaker 1: Your character the physician's assistant.

Gloria Reuben: Right, the physician assistant yes, Jeanie Boulet, and it was at the time where in the United States the triple cocktail had just started and so people were beginning to, people who are HIV positive, were for the most part were able to take medications and it was the first time where lives were literally being extended and people were gaining there zest for life and literally their lives back.

Female Speaker: Your were recently in a movie Life Support with Queen Latifah, it was about Queen Latifah's HIV positive, takes place in an African-American community. What were your expectations about what this movie might say about the state of the epidemic among black Americans?

Gloria Reuben: What were my expectations for the movie?

Gloria Reuben: My expectations for Life Support, which actually were met and hopefully will continue to be met, it's just the fact that people weren't even aware of how it has impacted African-American women.

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Gloria Reuben: Okay, the female condom girls. If we're teaching women how to take care of themselves then they got to take care of themselves.

Female Actress 2: I have such a hard time getting our young sisters to even try it. There like what's that, I don't like it, I don't think it's going to feel good. Then I say well listen, this will put you in control of protecting yourself and your own sexuality.

Female Actress 3: But a lot of the older women don't know about reality and female condoms. They've never heard of them.

Female Actress 4: The Muslim women, they'll take the reality before they take, and I don't know maybe it's something to do with their husband, they get questioned less with the female condom then they would with a male condom.

Female Actress 5: You could always tell them that they could put that on like 8 hours before they partner get there.

Queen Latifah: I think that's some good little key right there. We got to defiantly let know that they can wear it for awhile. You know what I mean, because dress before you go to the club, [interposing] if you plan on getting down like that, you know.

Female Actress 2: I can order the vagina demonstrator and we can use that to take it out to the field with us.

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Queen Latifah: I think you should order that.

Female Actress 2: Just okay to invoice. [Inaudible]

Queen Latifah: I just thank the quicker we can use it, shown how easy it is to do, it will make it as simple as putting on a condom in their minds. You know what I mean?

Gloria Reuben: It was great today. [Inaudible] just walked in. Got a couple of minutes? She was asking for you.

Queen Latifah: Yeah, sure I do.

Gloria Reuben: The beauty of that movie is that it deals with so many, the layers of being HIV positive, began taking medications. This women who used to be a drug addict, she's lost one of her kids. Like, one of her children lives with her mother. She is a part of a outreach program, which is an actual outreach program in Brooklyn called Life Force.

Female Speaker 1: And having participated in ER and now many years later having participated in Life Support how are the issues of AIDS in the African-American community portrayed? Was it different from the mid 90's to 2007?

Gloria Reuben: I think the issues were very different. I think primarily because the medications were just beginning to work in 1996-97. That was a whole other different time. You know, there was a lot of hope and there was really, there was like hope for the future, for people that were HIV positive. Cut to 10 years later where, you know, the issues are more

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about denial and still that issue of stigma that is associated with HIV/AIDS. That issue in particular disturbs me a lot. Anybody would have, would be afraid to get tested. I mean I get it. I know when I got test, the first time I got tested; I mean I was scared out of my mind. I think it's a natural thing to have a lot of fear before you get a test and yet especially today you know when you can know in 20 minutes your status, I think that it's more important to walk through that fear and get a test anyway because the fact of the matter, it's a very simple thing. If you're negative, then you know you're negative and you can steps to continue to protect yourself, hopefully one will choose to do so. If you're positive, it's best to know your status sooner then later so that can start taking care of yourself better and hopefully get medications that will work for you. If you're positive and you don't get tested, it's not going to change the fact that you are positive. The awful thing about that is that you are not going to know your status and you very well may spread the virus. That's the thing, it's like that's what I preach over over over again, know your status, get tested, because from no matter the outcome, you know what steps to take.

Female Speaker 1: We're in the Caribbean now, and again I know most of you work has been in the US, but do you presume that a lot of the issues you confront in the US, the

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stigma, the discrimination you were talking about earlier, some people's reluctance to get tested, all existing down here?

Gloria Reuben: No doubt. The troubles in the Caribbean are very parallel to the troubles in the United States as far as HIV/AIDS are concerned. Young women in particular, the virus is hitting hardest in the Caribbean. Not in just the US but in the Caribbean also. I mean it's estimated that something like 250,000 people are HIV positive in the Caribbean. That's an estimate. God knows how many others are infected and don't know it, and out of that a third of that number are young people between 15 and 24 years old. That's really young. A third of that number between 15 and 24 years old are HIV positive and out of that third 69 percent are girls. So, there's a big problem and there are so many factors, you know, poverty is a big issue, missed education, government. If the governments are stepping up and getting the word out about education, and awareness, and prevention, that's a huge issue. It's like the more that we do things like this and the more that we just talk about it, and the more that hopefully the media just deals with it in a way that is informative and truthful, but not like a taboo. Do you know? Like how we talk about cancer, then the easier it will get, then the easier that it will get then the more people are more apt to get tested. Then if the more get tested then the more that they will protect themselves

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hopefully if they are negative or the more that they will take care of themselves and they'll get the health needs that are necessary if they are positive, and hopefully the virus will stop being spread.

Female Speaker: Thank you very much.

Gloria Reuben: You are very welcome.

Marsha Lillie-Blanton, Dr.PH.: Let's talk about what's being done, in particular let's start with the media. Gloria Reuben is one of many media stars that have been actively engaged in health education and outreach. Is using media stars a technique for education that we should encourage?

Phill Wilson: I think it can be a very effect strategy. I think that it has to done strategically though. I think that Gloria is fantastic; we work with her all the time. That she is committed. She is informed, she's committed to being educated as she's out there, and so certainly when we talk about an epidemic and we talk about trying to reach young people and we try to talk to reach people of color, often celebrities bring a lot of attention that can be extremely valuable. I think there are a number of people out there who are doing remarkable work. You know, recently we did, as a part of national HIV testing day; we did a testing event with black celebrities where 41 black celebrities across entertainment fields, actors on television, and movies, and athletes, and

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music all got tested publicly. We did a partnership with SAG and with AFTA(ph), 41 people got tested and in addition to Gloria participating in it, Regina King participated in it from Jerry Maguire and Miss Congeniality too, and Jimmy John [inaudible] who was on Heroes participated and a number of people from television, and it is extremely important fact that while we were doing the testing, and we were doing it live, people came down to SAG to get tested. So, I think that they can be used in an extremely effective way, and I think in black communities, what it does, is it normalizes the whole issue around HIV, it changes the conversation, it lets people know that it's something that's alright to talk about and alright to address. But I do think it's important, extremely important that when we use artists, that we take the time to make sure that they are educated.

Marsha Lillie-Blanton, Dr.PH.: Let's talk about the industry a little bit, because some have viewed the industry as contradictory in the sense of not promoting sexually responsive behavior but then running public service announcements. So is there a contradiction there that then we should encourage media stars to help the industry address?

Jennifer Kates M.A., M.P.A.: Well, I want to broaden it beyond just stars and just think about the media a little bit. First thing, that's really important that everybody know

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from surveys that we have done and other people done, people say the most common place where their getting there HIV information is the media. So it behooves all of us to make sure that that information is as accurate, timely, and helpful in a language that they can understand or relate to whether they are a 15 year old, 25 year old, 50 year old, that they can relate to that information and get what they need. We know that's where people are getting there information so we can't ignore that, and media can be so powerful, whether it's a star, whether it's a program, whether it's a young person being able to see in a magazine one day something about HIV, on TV the next something else. That's a really powerful message, and I think it recognizes where people are getting information and helps them inform what they need to know. Media alone, are never going to solve the AIDS crisis. Without media, I question whether we can solve the AIDS crisis. So it's an integral part. On these issues of the contradiction, the media is a reflection of society. We have a lot of contradictions in society. We can't write off the media because sometimes the media is promoting, that might be counteractive. We have to work with the media. What we found at Kaiser, is for over a decade the media has been more than a willing partner. When there engaged and we go to the media and you say, you know what you do best, you know how to reach people, you know how to entertain people.

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We know that HIV is a problem, can we work together? The media often say yes.

Kevin Fenton, M.D., Ph.D.: I just want to support what my colleagues have said; I also think that we also need to be strategic in using the media as well. We need to become assent(ph) that media stars are role models, may not have wide spread appeal, especially when we are looking at young people and we need to think about who are the current media role models that we need to be working with, and also what are the important media infrastructures, should we be using the internet for example, youtube. How do we use various types of media to actually reach the target audience? So there complexitives(ph), but I think it's just a fascinating area for us to explode as we move forward with our HIV prevention activities in the United States. I think there's a wider discussion apart from media in thinking about role models, and I'm hoping that we have a chance to talk about other role models in society and for the African-American community thinking about the church, thinking about historical black colleges and universities, and the role models in those sectors can help to play in HIV prevention.

Marsha Lillie-Blanton, Dr.PH.: That's go to those, but I would like to follow-up on something that Jen said, the media alone can't do it and Gloria Reuben mentioned the government

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have got to step up to the plate and do more, and since your hear representing CDC, representing the federal agency in our government that has primary responsibility for prevention.

Let's talk more about what is CDC doing to address the epidemic in the African-American community.

Kevin Fenton, M.D., Ph.D.: Well, thank you so much for asking that question and giving me a chance to outline what we have been doing as well as how CDC is conceptualizing moving forward with tackling HIV among African-American community. CDC has certainly been at the forefront of looking at the epidemic and characterizing the epidemic, describing the epidemic and highlighting where our funds should be targeted to meet prevention needs and over the past few year CDC has been realigning our investments to insure that the moneys which are going out to the communities are actually being used to target African-American communities. More recently CDC has launched an enhanced or heightened national response to HIV among African-Americans and in part being driven by the realization that we're continuing to see high numbers of infections occurring in the African-American community, and in March of this year, we launched this heightened national response, in which we brought to Atlanta over 75 African-American leaders to not only talk about the state of AIDS among black America but to think about and to make commitments to tackling HIV/AIDS in African-

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Americans. Part of this heightened national response has four key sectors. First of all, promoting HIV testing among African-Americans, second, looking at insuring that our prevention interventions dig more deeply into the African-American community, third, investing in research to understand what are the driving factors for HIV/AIDS among African-Americans and what we should be doing to move forward with that, and then finally really looking at how use our investments and insure that we are continuing to monitor and evaluate what we are doing as far as prevention is concerned. So this is CDC's heightened national response to the HIV/AIDS epidemic and underpinning this is mobilization of the African-American community that you've heard about today. So in other words, working with leaders, working with communities, getting the message out about HIV and insuring that every aspect of the African-American community, everyone takes individual, as well as, collective responsibility to stopping this epidemic.

Marsha Lillie-Blanton, Dr.PH.: We have a few questions on this, but before I go to the questions, I want to come to Phill and just talk more about the response of the community, which is something that hasn't been asked about. With the Black AIDS Institute, you have been in the trenches, talk more about what you have been doing as well as what more can be done from

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community based organizations, from the faith community, from elected officials.

Phill Wilson: Well in some ways, I am more optimistic than I have ever been before. You know, I think that finally black leaders get it. Jen talked about the media. I cannot toot the horn of black media, just not enough. They have been remarkable. Every black news paper in America has made a commitment to cover HIV/AIDS every week. These are local, small businesses, who have said we're going to take this message forward. Black cable stations from BET, who've done a remarkable job with the wrapped up campaign. To TV1, who's focused on this issue, radio stations, American Urban Radio networks. Now in Radio 1, now has been on the front line. Black voices on AOL and Black Planet and now Black Racist now has a new entire blog system dedicated to HIV. In fact, I am going to be the guest editor on that blog for the next three months, and I am really excited about that.

Marsha Lillie-Blanton, Dr.PH.: That's a major responsibility.

Phill Wilson: I am scared to death as a matter of fact, but it allows us to get message out to a huge percentage of people and Kevin is absolutely right about the different sectors. We look at civil rights groups like the NAACP and the Urban League, and Rainbow Push and 100 Black Men and 100 Black

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Women, who all made commitments last year at the international AIDS conference. 25 black leaders, unheard of, attended the conference and made a declaration of commitment. Black churches who worked [inaudible] is doing through the various denominations are stepping up. You know the mega churches like TD Jakes and Potter's House now in Dallas, West Angeles, in Los Angeles, in Trinity in Chicago, and River Side in New York City. So there is a movement that is happening. The story of AIDS now has been a story of a lack of leadership and I think that the good news is that the leadership is starting to mobilize around the epidemic, but I do think that at the end of the day it has to be a partnership. A partnership with government, with civil society and the way of black institutions with individuals, individuals making commitment, with funders, foundations, and corporations and the private enterprise, working together. I think up till now, quite frankly we've been tinkering around the edges. We have been really taking nibbles at it. You know kind of fibling[ph] while the proverbial Rome is burned. AIDS is a huge issue and it's going to require a major effort in order for us to solve it.

Jennifer Kates M.A., M.P.A.: You know, I am going to toot your horn a little bit, and also you know, talk about leadership from CDC on the new initiative. Something has

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shifted and you wouldn't have said that optimistic stated five years ago.

Phill Wilson: I probably wouldn't had said it a year ago.

Jennifer Kates M.A., M.P.A.: Right, but I think it's because of the Black AIDS Institute, because of the enheightened response, because of something is shifting, and I think we want to harness that and keep that energy, from all sectors, because we really, that, I think, is going to be the tipping point.

Kevin Fenton, M.D., Ph.D.: And I also want to acknowledge the grass routes efforts which are occurring across the country. The heightened national response is only going to be a success because we are building on top of what people have been doing for the past few years. Colleagues like Phill. Colleagues working at the grass routes level. So that partnership is so important and we need to look at partners, who we haven't engaged, I would argue, as much as we should have. For example, the business community, how do we strengthen our efforts with the business community? CDC has interventions where we are looking at business leaders who are responding to AIDS and we are creating networks of business leaders. But I would argue that we have far more that we can achieve using that route as well.

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Marsha Lillie-Blanton, Dr.PH.: Phill, we have a specific question to you and it sounds like someone who knows a little bit about the work that you all have been doing. He says that you were supposed to release, or the Black Aids Institute is suppose to be releasing a coordinated strategic plan with the groups who attended a conference that was held last year. Where are you in that process and can you talk about some of the key points it'll address?

Phill Wilson: I did not submit that question, I swear, but I am so happy someone did. Yes, last year as I mentioned a minute ago, black leaders came together to issue a call to action and a declaration of commitment, and as a part of that 15 black organizations made a commitment to develop strategic action plans over the next five years, and we are in the middle of writing those strategic plans. We had a summit in April in Arizona, where a number of organizations came together. We are planning on releasing those strategic action plans as a part of a state of AIDS in black America report that will be released in connection with the Congressional Black Caucus week which is the end of September, in fact there is going to be a press conference on September 26, where we will be releasing the state of AIDS report, which will look at where we are in the AIDS epidemic and black communities right now, as well as these strategic action plans, as well as a roll out of activities

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that will happen over the next year. Our various organizations, in fact, are working fast and furious to make sure that there ready for that release in September.

Marsha Lillie-Blanton, Dr.PH.: I am glad we got that question because we should all stay tuned, so September 26, that's good. I want to talk a little bit about care and treatment, and Jen I know you have worked a lot on public and private sources of financing of medical care for persons with HIV/AIDS. Can you tell us more about what are some of the challenges that African-American's in particular face in getting access to medical care that might be financing related and what more we could do to reduce or remove those barriers?

Jennifer Kates M.A., M.P.A.: That's a great question, and one of the things that we need to understand about HIV care in this country is that it's a patch work. It is a complex system that includes programs like Medicaid, which are entitlements, they provide the bulk of care and support to people with HIV who are low income in this country, but are not the whole story, because people don't always qualify for Medicaid, people may be uninsured and then are relying on Ryan White, which is the nations program of care and support for people with HIV who are uninsured. So, there a patch work, private insurance, Medicare, the VA, there's lots of different sources of care. What ever happens with those, that complex

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patchwork, whether that complex patchwork is difficult to access, gets easier to access, changes, and it varies across the country. That's going to effect African-American's and we know from the larger structural issues that were brought up earlier, African-Americans already face disproportion access barriers to care in general, so that's going to carry over into HIV and I would say is part of the challenge that we're face with. Studies have shown that there's a disproportionate access to HIV care among African-Americans, the type of care that people are able to get, there's a lag in getting the right quality care. All of these things permeate, so the system of care and support that we have for people with HIV in this country needs to address the African-American communities and sets the majority of people with HIV and any challenges that we face there, whether it's shortages, differences across the states are going to affect African-American's more.

Marsha Lillie-Blanton, Dr.PH.: Dr. Fenton, earlier you mentioned testing. Jen is financing a barrier to testing, and that's actually one of our questions as well from someone from Indiana.

Jennifer Kates M.A., M.P.A.: There's two answers to that question one, staying with the care thing for a second, one of the challenges that I think we're all grappling with is we know we need to increase testing, we know that people need

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to know their status who don't know their status, and we want testing to be more of the norm, and in fact that's what CDC recommends now that in medical care people get tested. We also know if that works, more people are going to know their infected, and that's going to put more demands on a care system that's already facing challenges, and one of the challenges the care system is facing is financing. So that's a challenge, and I think it's one that we're grappling with and it's going to need these partnerships that we talked about. Secondly is this issue of financing of testing. CDC is financing testing in public centers, you know Kevin can talk about that, all over the country, but there are potential barrier in certain sectors to financing the recommendation that everyone get test in the medical environment. That's general screening. Not all plans cover general screening. Medicare, for example, doesn't cover general HIV screening, Medicaid in certain cases. So, I think as we roll out, we can't not do something on the testing side, because the care system is not quite equipped yet, but these things need to happen in concert.

Phill Wilson: But we also need to be clear that we are taking a gamble. Now I think in some ways, while it's appropriate to be pushing for testing, it is field of dreams, that if you build they will come. Well the truth of the matter is if you build it and they that are coming, our population is

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already marginalized, already suspicious of the health care delivery system and we have a health infrastructure that is already tattered, and they come and there's no care, then what, and I think that it is a gamble and Jen is absolutely right that there has to be a relationship and they are inextricably connect. That if we in fact say to folks, you need to know you're HIV status particularly if we're saying to marginalize folks we're saying, to black folks we're saying, who folks are already suspicious of the healthcare delivery system, you need to know your HIV status. What I'm hearing in the field every single day is why. Why do I need to know? Okay, if I found out, are you going to provide care and treatment to me, and right now the answer is we don't know. You know, we need to be working diligently to make sure that when those folks, they'll come and they find out that there HIV positive, that in fact we have something to offer to them, because if we don't have something to offer to them at that point, we are going to lose them and we're going to undermined our ability to reach this population for a very long time.

Kevin Fenton, M.D., Ph.D.: But I also want to get in here. While I agree with my colleagues and we know that there pressures in the system, there are a couple of other things I want to just add to the mix. First of all, an individual who is diagnosed, with positive treatment it's certainly one important

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aspect of the services that there going to have, but also remember that HIV testing is also an entry point for management of that individual's partners, so they can know about their HIV status. That people can benefit from risk reduction constantly. They can benefit from other types of services, which they can have to manage their HIV disease. So where I agree that access to treatment and linkage to care is incredibly important and I just wanted say, that there are other services which are also going to be there as well.

Marsha Lillie-Blanton, Dr.PH.: I want to mention thought, Phill I think you have already addressed the issue of trust, but that is one of the questions that came from someone from Spokane, Washington who said the lack of trust is a barrier to testing and how do we increase the trust and increase early HIV testing. So I think you have already addressed that issue. I want to spend at least our last fifteen minutes or so, talking about what more could be done. Because as we move along the path of addressing the epidemic, we have to look at both science and are we applying the science. How do we develop new knowledge so that we can make a difference? So Dr. Fenton, I would like to start with you. Are we applying the science that we know now, and in particular let's talk a little about needle exchange.

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Kevin Fenton, M.D., Ph.D.: Yes, we are applying the science that we know now. Do we have enough science; do we have the science in the areas which can help us to refine our prevention efforts as the epidemic is evolving? I would say no, and that really highlights the importance of investing in research, especially investing in African-American researchers to do some of the research that needs to be done as well. But, if we look at CDC's prevention portfolio, a lot of what we do is actually based on good science. So whether it is the science behind recommendations behind HIV testing, whether it is the work and our recommendations on preventing mother to child transmission for HIV, or whether it is the work at that we've done and the research that we've done on preventing HIV infection through contaminated blood. For example, preventing that kind of transmission, this has all been evidenced based. Now you specifically asked about needle exchange programs, and I am glad you did, because this is an area where policy, and science, and politics often intersect. We know that there are limitations on the use of federal funds to support needle exchange programs, but never the less CDC and the federal government have produced publications which have highlighted the importance of needle exchange programs and the contribution of these programs to reducing HIV incidences, and prevalence within communities, especially among injecting drug users. The

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decision to invest in needle exchange programs can be made at the local level without using federal funds and there are a number of needle exchange programs around the country which have been, in which local jurisdictions and states have decided to fund needle exchange programs. So I think just to summarized, I think the important thing is we need to continue to have effective science and good science to help us to tailor and targeted interventions, where there are barriers or difficulties between politics, and policy, and science that we need to work with our partners, both at state and local level to move forward.

Marsha Lillie-Blanton, Dr.PH.: Phill, do you agree with that assessment.

Phill Wilson: Well, I certainly think that a lot of what the CDC does is based on good science, absolutely. But the bottom line is that science has no value if it does not influence policy, and so I think that absolutely the CDC has released reports that say that needle exchange programs now are effective and they work, and at the end of the day, show me the money. Now that if the science and if that information does not drive where there investing there dollars in, then that's not good science, and think there are three areas where the federal government is failing miserably. One, is that there should be federal dollars to support needle exchange if the science says

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that it's helpful in ending the epidemic and the federal government has an obligation and a commitment to end the epidemic, then they should be investing in needle exchange programs, full stop, end of conversation. Number two, now on the issue of absence only, now the science tells us that we need comprehensive HIV prevention the CDC is saying that we need comprehensive HIV prevention and yet we are investing millions of dollars, now often to the detriment of comprehensive prevention at risk for absence only programs. They don't work and in fact they do harm. Number three, Jen pointed out that black women in this case are the second most at risk population, ahead of them are black men, and we're not having conversations with black men and we're particularly not having conversations with black men who have sex with men, now, and at that the dollars are not following the epidemic, what the science tells us about it. Now a lot of these things are driven by politics and there driven by other issues other than science, and so on three issues that are critically important to black America and that is focusing prevention efforts where the epidemic is which means having honest, and open, and authentic conversations with men who have sex with men, with having conversation about the relationship between men and women where you involve men and not just focus on a conversation with women, because that's an easy conversation to

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have. It goes to the conversation that we're having with babies. It's easy to talk about innocent babies, because there victims. It's easy to talk about black women, because now you can paint black women as victims, as opposed to having honest conversations that move us in a trajectory that will end the epidemic. Now, so on three levels, the issues around men, gay men in particular, the issues around absence only, and the issues around needle exchange, I think that this is broader than the CDC, but I do not think that are federal government is following the science of the epidemic.

Marsha Lillie-Blanton, Dr.PH.: Let's also talk about prisons. There've been a number of studies which suggest that HIV infection rates in prisons is one of the drivers of the epidemic. Are we doing what we could do in terms of curtailing the epidemic in prisons, or could we do more?

Kevin Fenton, M.D., Ph.D.: I certainly think we do a lot more. CDC has certainly published studies looking at risk factors for acquiring HIV in prison, we've demonstrated the benefits of both HIV testing on entering into prison as well as HIV testing prisoners exiting the prison system, and we've also done studies which demonstrate the very close relationship between disease transmission in the prison as well prevalent disease in the prison, as well as in communities, especially in communities where you have individuals circulating to and from

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between the prison system and the community. That is very very well defined, so the key question is how we leverage the resources that we have to insure that we are targeting effective services in prisons. It is difficult because the prison systems and much of the jurisdiction for prisons really resides at the state and at the local level. So it requires, I think, a number of things. First of all, establishing national standards and national recommendations for best or promising practices for HIV prevention in prisons. It requires working very very closely with correctional services to ensure that these recommendations are adopted and implemented, and it also requires advocacy from our colleagues and communities, people who are effected by HIV, to say listen, this is important for us, as a tool for preventing HIV transmission in the prison setting. So I agree with you, this is an important part in the African-American community of HIV transmission and we need to do more. It's an area where we could be doing more to prevent transmission.

Marsha Lillie-Blanton, Dr.PH.: Actually, one of our questions ask, has CDC done any research that actually looks at the impact of prisoners coming home from there communities on HIV transmission. So it sounds like you all do have studies and that they could, the person who that sent in this question, could contact you to get the specific studies?

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Kevin Fenton, M.D., Ph.D.: Absolutely. We certainly looked at it both from HIV as well as sexually transmitted diseases, because again we see that very close relationship in the epidemics which occur within the prison system as well as within the communities, and we demonstrated the benefits of intervening at the point of exit. So, ensuring people are screened before exiting the prison system and that impact on the community.

Marsha Lillie-Blanton, Dr.PH.: Phill did you?

Phill Wilson: I think that the way we are handling the prison conversation, now goes back to a flaw in the way we've addressed the aids epidemic from the beginning. It's another example of looking for boogie man. You know, that now it was black gay men, then it was on the down low, and now its prisons all the sudden. But no one is in fact actually having conversations to talk about a few things. One is that we talk about the mass incarceration of black men in general, that's going to destabilize communities, and that's going to contribute to whole bunch of health illls in our communities. Number two, that if you look at whose in prison, this is saying folks who are at risk for HIV, even if they weren't in prison. Now, and I would eventually guess that quit frankly that the issue is not necessarily that folks are actually getting infected in prison, although some are, but that the folks who

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are being imprisoned are folks who are most at risk for HIV to begin with. Now, there are drug users, there are people who are poor, non violent folks, we're just in some ways just going through the streets and arresting black men in mass. Now that's what looks is like. So and why are they being arrested? There non violent drug users. Now that's a risk for HIV. Now there poor, there not educated about HIV, or they don't know there risk factors, there marginalized to begin with, there alienated, all of these risks. So I think that if we want to talk about the relationship between prisons and HIV, we should talk about interventions that will keep people out of prison, and when we have the conversation about prisons, I also think that while it is appropriate to look at what we're doing at the point of exit. We need to look at what we're doing at the point of entry. So, if your going to say to me that we should be testing prisoners upon exit, I am going to say to you, we should be testing them upon entry, because if we are testing them upon entry, doing the [inaudible], when there in prison, we have an opportunity to educate them, we have an opportunity to get them on treatment if that's appropriate, we have the opportunity to talk about risk reduction behavior. Now, if all we want to do is to test them exit, what is that about, that's because we aback our responsibility to provide care for these and it's because it really at the end of the day, we don't

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really care about them, and they know that. That created a maladaptive relationship between the penal system, the health system, and communities at large. So if we're going address this issue again, we have to go back to comprehensive solution.

Kevin Fenton, M.D., Ph.D.: Comprehensive solution.

Marsha Lillie-Blanton, Dr.PH.: We have time for one more question. I want to ask each of you if there were one intervention that you could do to address the HIV aids epidemic in the African-American community, what would that be?

Kevin Fenton, M.D., Ph.D.: You know, I am not going to answer because I don't think there's one thing that needs to be done, and what you've heard from the discussion today, and what has been repeated consistently is the need for comprehensive approaches to HIV prevention in the African-American communities. Approaches which move up stream, so not just focus on the individual but look at the systems where there's incarceration, whether it's poor access to care, and the only way, we are going to achieve this is through true partnership between federal agencies, affected communities, advocacy groups, as well as business leaders. So perhaps that would be my one thing in moving us towards so much more comprehensive approach to HIV prevention.

Jennifer Kates M.A., M.P.A.: I'll just add, cause I agree I am not going to answer it either, but I think we're at

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an important point, and just to go back to the research question a minute, one of the things that we're standing at this point of knowing from the research that there is individual risk factors, individual level risk factors, but these more social and these entrenched factors, we know that that has been documented. I think we're getting to a point where we can actually start to understand, what are the interventions that we can take on that we can affect larger entrenchment. That's exciting, that's where we need to go, that's through operational research, that's the research CDC is doing, that's the research and efforts that partners can do with CDC. So I feel optimistic about that.

Phill Wilson: I would also dodge the question by a calling on [inaudible] the founder of the Black Find, "who said nobody can say what's from us but us," and so I guess what I wouldn't say that there is an intervention, if I had the power to make one thing happen, that one thing would be mass mobilization in black communities, so that every institution in our community, every sector in our community, every individual in our community, would take ownership of the disease. I think that's one of our major challenges. Absolutely, I agree with Dr. Fenton, he said it requires a partnership between government, and business, and communities, both in the grass routes, and at the leaders level, but at the end of the day,

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now if the government does not come to our rescue, if business does not come to our rescue, we still have to survive. At the end of the day if there's nobody but us, it has to be us. So the one thing that I will put out there is for each and every one of us to make a commitment to end this epidemic. To get over with it, because I think we can.

Marsha Lillie-Blanton, Dr.PH.: Actually before I close, I just want to thank Dr. Fenton, Phill Wilson, and Jennifer Kates for participating in today's conversation, and I want to thank all of you for your questions, and for joining us. On our webpage, you will find resources on today's topic that maybe useful to you. Again, I'm Marsha Lillie-Blanton of the Kaiser Family Foundation.

[END RECORDING]

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