THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY BRIEF

POLICY BRIEF

The Minority AIDS Initiative

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OVERVIEW

The Minority AIDS Initiative (MAI) was created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. It provides new funding designed to strengthen organizational capacity and expand HIV-related services in minority communities. Beginning with $166 million in FY 1999, funding for the MAI has more than doubled since then, and is expected to total $404 million in FY 2004. Although the MAI funds a number of critical direct services and has both political and symbolic significance, it represents less than 5% of federal discretionary funding for HIV/AIDS in FY 2004 ($8.7 billion).[1]

The MAI's principal goals are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV-related health disparities. Central to these goals is the MAI's focus on efforts to strengthen the organizational capacity of community-based providers, in particular minority providers; improve the quality of HIV services; expand the pool of HIV service providers; and enhance the ability of minority service providers to compete for other HIV/AIDS funding in the future. In an effort to complement, rather than replace, other federal HIV/AIDS funding and programs, the MAI takes a multi-pronged approach that focuses simultaneously on HIV prevention, care, treatment and research. Administration of the MAI is decentralized across eight federal agencies and offices, primarily within the Department of Health and Human Services (DHHS). Today, the MAI supports over 50 distinct programs targeting racial and ethnic minorities including the highest risk and hardest to serve populations.

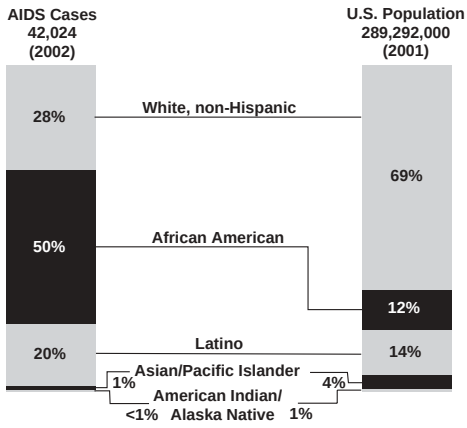
This policy brief provides an overview of the MAI. The first section provides background on the MAI's creation, goals, administration, and funding history. The second section provides a summary of current issues and challenges facing the MAI based on interviews with key stakeholders. An Appendix provides descriptions of select MAI-funded programs by Agency.

THE CREATION, ADMINISTRATION, AND FUNDING OF THE MAI

The Disproportionate Impact of HIV/AIDS on Racial and Ethnic Minorities

Racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic and this impact has become more pronounced over time. Today, racial and ethnic minorities represent the majority of new HIV infections, AIDS cases, people living with HIV/AIDS and AIDS-related deaths in the United States.[2] African Americans are particularly hard hit, accounting for approximately 12% of the U.S. population, but more than half of all new HIV infections estimated to occur each year and half of estimated new AIDS diagnoses.[2,3] A similar, yet less pronounced, impact exists among Latinos, who represent 14% of the U.S. population, but accounted for 20% of estimated AIDS diagnoses in 2002.[2] Together, Asian/Pacific Islanders and American Indian/Alaska Natives represent 1–2% of estimated new AIDS diagnoses[2] (See Figure 1).

Figure 1: Estimated AIDS Diagnoses (2002) & U.S. Population (2001) by Race/Ethnicity[2,3]



The Creation of the Minority AIDS Initiative

The creation of the Minority AIDS Initiative (MAI) in October 1998 was both the beginning of a new initiative and the culmination of a community-based advocacy campaign that began more than six months earlier in Atlanta, Georgia. It was in March of that year when the Centers for Disease Control and Prevention (CDC) convened a meeting of African American service providers and community leaders to brief them on the agency's African American Initiative.[4]

As part of the briefing, the CDC provided new surveillance data indicating alarmingly high rates of HIV infection among African Americans. These data prompted community leaders to declare a "state of emergency" in the African American community with respect to HIV/AIDS and to call on then Surgeon General David Satcher and President Clinton to make such a declaration on behalf of the federal government.

The statement of emergency also included a call for: various federal agencies to develop new strategies targeting African Americans within 90 days; the provision of federal demonstration funding to test new community planning and program models; and an analysis of the correlation between the allocation of federal AIDS funding to communities and epidemiological trends.[5]

In the weeks following the meeting in Atlanta, a number of national and local groups, including the White House's Presidential Advisory Council on HIV/AIDS and the Congressional Black Caucus (CBC), endorsed the community leaders' call for a state of emergency.[6,7] While stopping short of declaring a formal public health emergency, President Clinton ultimately declared HIV/AIDS to be a "severe and ongoing health care crisis" in racial and ethnic minority communities during a White House ceremony announcing the creation of the MAI.[8]

Community members worked closely with the CBC and the House Appropriations Committee in 1998 to secure funding in the FY 1999 Labor, Health and Human Services and Education (LHHS-E) appropriations legislation for the new initiative.[9] At the conclusion of the appropriations process, the Omnibus

Consolidated and Emergency Supplemental Appropriations Act of 1999 included over $110 million in new funding and another $46 million in reprogrammed funds for what eventually became known as the MAI, to be administered primarily by the Department of Health and Human Services (DHHS).[10] Later, DHHS reprogrammed an additional $10 million in funding toward the MAI for a total of $166 million allocated in FY 1999.[11]

In its first year, the MAI was most commonly referred to as the "CBC Initiative," reflecting the CBC's leadership in creating the framework and securing funding. Its name was subsequently changed to the Minority AIDS Initiative to reflect a broader focus on disproportionately affected racial and ethnic minority communities in general. After the first year, support for the MAI in Congress also expanded. In June 2001, the CBC, Congressional Hispanic Caucus (CHC) and Congressional Asian Pacific American Caucus (CAPAC) held a hearing on HIV/AIDS among racial and ethnic minority communities, focusing on early implementation of the MAI. This was their first-ever joint hearing on any topic.[12]

Goals of the Minority AIDS Initiative

The primary goals of the MAI are to improve HIV-related health outcomes and reduce HIV-related disparities for racial and ethnic minority groups. As stated by Congress in FY 2002 appropriations report language, the MAI:

> … was designed to focus special attention on solving a growing public health problem and to develop and improve the capacity of minority community based organizations to more effectively serve their communities … This approach was tailored to yield innovative and successful strategies specifically targeted to the highest risk and hardest to serve populations, which for the past two decades have eluded more traditional HIV/AIDS prevention, treatment and education efforts." [13]

The MAI has a particular emphasis on capacity-building, which is a distinctive feature of the initiative. In addition to funding direct services, the MAI supports training and other technical assistance designed to strengthen community-based organizations' core capacities in such areas as financial management, program development, administration, planning and evaluation. Such efforts have been directed primarily towards minority community-based organizations (MCBOs). Though numerous definitions of an MCBO exist, the term generally applies to organizations with a history of providing services in minority communities and whose boards of directors, management and/or other key staff are representative of the minority populations they serve. The MAI's emphasis on capacity-building within MCBOs is an effort to strengthen their ability to provide high quality services, expand the number of minority service providers in the HIV/AIDS system of care, and enhance their ability to compete for broader HIV/AIDS funding on an ongoing basis.

When creating the MAI, Congress stipulated that its funding be used to complement other federal HIV/AIDS activities targeting racial and ethnic minority communities.[14] This intent would presumably apply to all major federal AIDS programs, which, given the epidemiology of HIV/AIDS, serve large numbers of racial and ethnic minorities. Moreover, as noted previously, the MAI focuses simultaneously on HIV prevention, care and research and, within these broad categories of funding, on direct services; technical assistance, training and capacity-building; planning; and evaluation.

Administration of the MAI

Reflecting the MAI's multi-pronged approach, program administration is spread across eight federal agencies and offices within DHHS, as well as the Indian Health Service (through a Memorandum of Agreement).

Though MAI implementation is decentralized, the DHHS Office of HIV/AIDS Policy convenes a steering committee to coordinate MAI implementation and evaluation.[13] The committee's membership is comprised of representatives from various agencies and offices that administer MAI-funded programs. In addition to this internal steering committee, in September 2003, DHHS Secretary Thompson appointed an ad hoc advisory committee on the MAI that is co-chaired by community leaders and federal officials. The charge to this group is to develop recommendations related to future funding and implementation of the MAI.[16]

Funding for the MAI

Since its inception more than five years ago, overall funding for the MAI has more than doubled, from $166 million in FY 1999 to $404 million in FY 2004[17] (See Figure 2). Although the MAI has experienced substantial growth—particularly during its second and third years—these funds represent less than 5% of federal discretionary HIV/AIDS funding in FY 2004.[18] President Bush has requested $407.6 million for the MAI in FY 2005.[11]

Figure 2: Federal Funding for the Minority HIV/AIDS Initiative by Agency—FY 1999–2004
(US$ Millions)[17]

	1999	2000	2001	2002	2003	2004
HRSA	24	74	110	124	130	130
CDC	48	61	88	96	103	103
NIH	8	9	7	5	5	0
SAMHSA	26	48	92	105	111	110
OMH	10	10	10	10	11	11
OWH	0	0	0	1	1	
Office of Secretary*	50	50	50	50	50	50
Total	**$166**	**$251**	**$358**	**$391**	**$411**	**$404**

HRSA: Health Resources and Services Administration
CDC: Centers for Disease Control and Prevention
NIH: National Institutes of Health
SAMHSA: Substance Abuse and Mental Health Services Administration
OMH: Office of Minority Health
OWH: Office of Women's Health
*For the "Minority Communities Fund" under the direct control of the Office of the Secretary of HHS but distributed to sub-agencies and offices for contracting and administration purposes. Previously, these funds have been referred to as General Department Management (GDM) funds or the Public Health and Social Services Emergency Fund (PHSSEF).

The MAI is funded through the Labor/Health and Human Services and Education appropriations bill and report language for the bill directs the vast majority of MAI funds to specific DHHS agencies for use in programs serving racial and ethnic minority communities. These agencies and offices provide funding to eligible entities through grants and cooperative agreements, most of which are made based on competitive review processes that are developed and administered by each individual agency. In some cases, the agencies develop their own projects and initiatives.

In addition to direct agency-specific allocations, each year Congress has appropriated $50 million to the Office of the Secretary for General Department Management (GDM), more recently called the Minority Communities Fund.[15] These funds are allocated by the Secretary to various agencies for use on MAI-related activities, based on applications submitted by agencies.

Today, the MAI supports over 50 distinct programs targeting racial and ethnic minorities including the highest risk and hardest to serve populations. Descriptions of some of the largest MAI-funded programs are provided in an Appendix.[9]

Eligibility for MAI Funding

Congress has expressed its intent that MAI funds be used to serve racial and ethnic minority communities through the following report language:

> These funds are for activities that are designed to address the trends of the HIV/AIDS epidemic in communities of color based on the most recent estimated living AIDS cases, HIV infections and AIDS mortality among ethnic and racial minorities as reported by the Centers for Disease Control and Prevention.[19]

MAI funding is provided by DHHS agencies and offices to community-based organizations, research institutions, minority-serving colleges and universities, health care organizations, faith-based organizations, state and local health departments, and correctional institutions.

The inclusion and role of MCBOs specifically as recipients of MAI funding has been the subject of discussion since the initiative's implementation. This focus on MCBOs is an intended acknowledgement of the cultural and geographic linkages such organizations often have to the target populations.[20] At the same time, it is widely understood that many non-minority community-based organizations also provide high-quality, culturally competent HIV prevention and care-related services to racial and ethnic minority communities.

FY 2001 report language stated explicitly that MAI funds were to be used to fund minority providers and organizations. Since then, report language related to MCBO targeting has changed, reflecting the differing opinions of

Members of Congress and community leaders, as well as varying interpretations by legal counsel in the Clinton and Bush Administrations about the extent to which pre-existing case law affects the ability of the federal government to target funds to minority organizations.

Two court cases, in particular, may have bearing on this question. The first is a 1995 Supreme Court ruling referred to as *Adarand Constructors, Inc. v. Peña* in which the Supreme Court held that federal programs that use racial or ethnic criteria be subject to "strict judicial scrutiny." While not completely ruling out affirmative action programs, under strict judicial scrutiny, the federal government must demonstrate a "compelling" government interest in pursuing an affirmative action, and the action itself must be "narrowly tailored" to serve that interest.[22] The second potentially relevant case is a 2003 Supreme Court ruling entitled *Grutter v. Bollinger* in which the Court upheld the University of Michigan Law School's affirmative action program.[23]

In FY 2003 appropriations report language, Congress stated its expectation that programs funded under the MAI be tailored as narrowly as possible to maximize the participation of MCBOs. Congress also requested that DHHS provide a report detailing how each DHHS agency and office that receives funding under the MAI has distributed such funding and the extent to which the participation of MCBOs has been maximized.[24]

In its implementation of the MAI, the Bush Administration has developed the following statement of eligibility, which addresses the targeting issue as it relates to both clients and providers:

> Funding will be directed to activities designed to deliver services specifically targeting racial and ethnic minority populations impacted by HIV/AIDS. Eligible entities may include: not for profit community-based organizations, national organizations, colleges and universities, clinics and hospitals, research institutions, State and local government agencies and tribal government and tribal/urban Indian entities and organizations. Faith based and community-based organizations are eligible to apply. This general statement is subject to program specific statutory and/or regulatory requirements.[25]

VIEWS ON THE EFFECTS OF THE MAI, IMPLEMENTATION CHALLENGES, AND ISSUES ON THE HORIZON

In order to identify issues facing the MAI and inform future policy discussions, interviews were conducted with over a dozen experts in Washington, DC and in local communities across the country. Interviewees included congressional staff, federal officials involved in administration of the MAI, AIDS service providers, and community members. While these interviews do not constitute a representative sample, they do provide insight into a range of issues facing the program in the coming years. Key interview findings are presented below:

Perceived Effects of the Minority AIDS Initiative

- *Increased Attention to the Impact of HIV/AIDS on Racial and Ethnic Minorities.* Many respondents noted that the MAI has focused much-needed attention on HIV/AIDS in racial and ethnic minority communities and put this issue on the agenda of federal policymakers in Congress and the Clinton and Bush Administrations. It has strengthened leadership on HIV/AIDS in minority communities and by members of the Congressional Black, Hispanic and Asian Pacific American Caucuses, in particular.
- *Development of Important New Partnerships.* The MAI has fostered new partnerships at many levels: between minority communities and local, state and federal governments; between community leaders and policymakers; and between the various Congressional Caucuses.
- *Increase in the Number of HIV Service Providers, Particularly Minority Providers.* According to respondents, the availability of MAI funding has increased the number of HIV service providers, particularly smaller, minority community- and faith-based organizations. In so doing, it has expanded service options for racial and ethnic minorities living with the disease.
- *Led to an Important New Source of Funding for Services for Minority Communities.* The MAI served as a timely infusion of new funding for services at a time when the need for services outstripped the capacity of many community-based organizations.
- *Focused Attention on the Importance of Capacity Building.* The MAI helped to focus attention and resources on the issue of organizational capacity-building and the importance of such efforts for improved quality and availability of services for racial and ethnic minorities. At the same time, the MAI has shown that making services available does not necessarily guarantee their use, and that issues such as location, outreach and community attitudes and beliefs will also affect utilization.
- *The Role of Community Involvement.* Several respondents cited the MAI's emphasis on the important role of community involvement in the fight against HIV/AIDS as an important feature of the Initiative.

Implementation Challenges

- *Targeting MAI Funds*. As noted above, the MAI includes language prioritizing the delivery of MAI services through MCBOs. However, there is not yet consensus between community leaders, members of Congress and the Bush Administration on the extent to which an explicit policy of targeting MAI funds to MCBOs is permissible under federal law. This has led to tensions in some areas of the country where MAI funding has been used to support services provided by non-MCBOs.
- *Defining the Role of Capacity Building Efforts.* The MAI's focus on capacity-building and

infrastructure development activities at times conflicts with the desire to use MAI funds for direct service delivery, particularly to address unmet service needs. Indeed, the MAI continues to be an important source of services funding. In general, the subject of capacity-building raised numerous issues among interviewees, including: how it is defined; identifying and documenting best practices in the field; the need for long-term, but not necessarily permanent, investments in organizational development; and how to appropriately measure the impact and effectiveness of such services.

- *Level of Funding for the MAI.* Most respondents raised the issue of overall funding for the MAI. The FY 2004 appropriation for the MAI is $404 million, significantly less than the $610 million requested by the community.[26] Several respondents felt that without increased funding, the MAI will never be able to reach its full potential.

- *Allocation of MAI Funds Across Programs and Agencies.* Interviewees raised two specific issues related to the allocation of funds. First is the MAI amount allocated to the Ryan White CARE Act's AIDS Drug Assistance Program (ADAP), which provides prescription medications to people with HIV. MAI funding through ADAP is intended to support outreach to racial and ethnic minorities, to increase their access to HIV treatments. Interviewees raised concerns, however, that, given the current fiscal crisis facing states, including the imposition of ADAP waiting lists by several states, increased outreach may not translate into increased access to treatments. In addition to this ADAP issue, each year, some community members have sought to increase MAI funding to the Office of Minority Health (OMH), which would enable it to significantly expand its traditional role in policy and planning to include a much greater role in service delivery. Funding for this Office has remained level for the 5 years of the initiative.

- *Managing Unrealistic Expectations.* An issue raised by several respondents is that of unrealistic expectations for the MAI. The availability of targeted MAI funding may have led some to perceive the MAI as a main or sole source for funding such activities, ignoring the need for the much larger HIV/AIDS portfolio to also be responsive to the needs of racial and ethnic minorities. Respondents were concerned that such an expectation may cause some to believe that MAI-funded programs alone can reverse daunting epidemiological trends.

- *Reporting Requirements.* In an effort to track the use of MAI funds across populations and service categories, DHHS agencies require MAI grantees to submit regular reports that detail how funds are used. The exact requirements and frequency of such reports vary by agency and by program. Some interviewees expressed concern that, in some cases, MAI reporting requirements are quite cumbersome compared to reporting requirements for other sources of funding. This was a particular concern for newer and/or smaller MCBOs that may not have the capacity to fulfill such requirements.

- *The Difficulty of Evaluating the MAI.* As previously noted, the MAI represents a very small proportion of federal AIDS funding and of services for minority communities affected by HIV/AIDS. This fact, combined with the MAI's emphasis on capacity building, makes it difficult to isolate the impact of the MAI on HIV/AIDS in minority communities and to identify appropriate outcomes against which to measure effectiveness. Some respondents expressed concern that this dynamic has led to closer scrutiny of MAI-funded providers compared with others, including more stringent reporting requirements. At least two federal agencies, the CDC and HRSA, have contracted for external evaluations of their MAI-funded activities.

- *Cultural and Language Barriers.* The HIV service delivery system is not immune from issues of race and class that affect access to and quality of health care more generally.[27] One respondent described tensions that have developed between some MCBOs and federal program administrators when federal officials are perceived as being unwilling to consider a range of program models designed to meet

the particular needs of minority communities. In addition, many felt that the complexity of the federal grants process interfered with the ability of smaller and newer CBOs to apply and compete for federal funding. The Plain Language Initiative, organized by the Department of Health and Human Services "Leadership Campaign on AIDS", is one attempt to simplify the federal grants process and make grant language more accessible.

Issues on the Horizon

- *Continuation of the MAI in Future Years.* Respondents raised several questions and concerns related to continuation of the MAI. These include: whether parts of the MAI should be incorporated into the Ryan White CARE Act during the next reauthorization in 2005 (with some seeing this as an important way to institutionalize the program and others fearing it would weaken its distinct focus); whether CDC's new prevention initiative, which includes an emphasis on prevention efforts targeting those who are already HIV positive,[28] will shift funding away from MAI-funded prevention programs and newer providers that are not focused on prevention for HIV-positive individuals; whether MAI funding will increase to the level requested by community leaders; and if the MAI should continue indefinitely, or after some time, be incorporated in full or in part into the larger HIV/AIDS portfolio. Other issues raised included the fact that the MAI has never been authorized and that no funds have been made available for administration within or across DHHS agencies.

- *Clarification of MCBO Targeting Language.* As noted previously, in 2003, the Supreme Court upheld the University of Michigan Law School's affirmative action program *(Grutter v. Bollinger).* Some believe that this ruling provides another opportunity for the Bush Administration and Congress to review the MAI's MCBO targeting language and clarify the original intent of Congress.

- *Maintaining Focus on Capacity Building.* The MAI will continue to be forced to manage the inherent tension between using funds for capacity-building and organizational infrastructure and using funds for direct services. Relatively modest increases, or in some cases, flat discretionary funding for federal HIV services in recent years has likely contributed to this tension as communities attempt to keep pace with growing caseloads.

- *Need for More Program Information.* For both FY 1999 and FY 2000, DHHS issued a guide to resources available through the MAI, which described each program, and in some cases, listed the names of grantees. Since FY 2001, relatively little written information on the MAI has been made available to the public or to Congress. This includes basic information on spending patterns, progress or outcomes. Several non governmental organizations (NGOs), including the CAEAR Coalition Foundation[29] and the National Minority AIDS Council,[9] have prepared reports that focus on parts of the MAI. Additional program information would help inform the future direction of the MAI.

- *Need for Long-term Investments/Commitment.* Experience in the first five years of the MAI has shown that bringing new providers into the HIV delivery system and working to build organizational capacity that is sustainable in the long-run are not simple tasks. These goals may require more long-term commitments by funders, including the use of longer grant cycles.

- *Identifying, Linking to Care Racial and Ethnic Minorities with HIV During ADAP Funding Crisis.* Expanding access to care and improving health outcomes for racial and ethnic minorities living with HIV/AIDS is one of the primary goals of the MAI. As mentioned earlier, if not addressed, the funding crisis facing many state ADAP programs—which in some cases has led to waiting lists and other program restrictions—could compromise this goal since newly identified clients often lack private health insurance and may not be enrolled in Medicaid.

- *Ensuring Providers' Ability to Serve Low-Income Clients Effectively.* The MAI has helped bring new clients into care. This population is increasingly very poor and many

present with mental health or substance abuse issues, as well as other "collateral needs," medical conditions endemic to minority populations that may not be directly related to HIV/AIDS but nonetheless require attention. The future of the HIV service delivery system will increasingly depend on providers' ability to offer a comprehensive range of quality services to this hard to reach population.

- *Integrating New Providers into the System of HIV Care.* Outreach efforts by federal funders and grantees have helped bring new service providers into the system of HIV care (including small, newly created organizations, faith-based organizations and providers with substantial experience providing non-HIV services in minority communities). Several respondents noted the importance of integrating these providers into local planning processes and service systems, as well as the need to ensure that in the long run, their funding is diversified such that they are not fully dependent on any single source, including the MAI.
- *Identify/Share Lessons Learned with Respect to Capacity Building.* Recognizing both the importance and complexity of strengthening organizational development through capacity-building activities, several respondents suggested the need for a more coordinated approach that would allow grantees across agencies and MAI programs to share and learn from the experiences of others.
- *Maintaining Long-Term Momentum in Support of the MAI.* The creation and initial implementation of the MAI have led to significant momentum and attention to the impact of HIV/AIDS on racial and ethnic minorities. Some respondents asked whether there are steps that should be taken now to maintain such momentum in the long term. A related issue raised is the need to ensure that growing US attention to global HIV/AIDS issues does not overshadow the continued need for leadership and funding domestically.

CONCLUSION

The Minority AIDS Initiative has grown substantially since its creation in 1998. What began as a community-based advocacy campaign to focus national attention on the disproportionate impact of HIV/AIDS on African Americans, has since grown into a $400 million federal initiative that supports over 50 distinct programs targeting racial and ethnic minorities, including the highest risk and hardest to serve populations.

The MAI's emphasis on capacity-building is a distinctive feature of the program. Across federal agencies, the MAI funds programs designed to strengthen minority community-based organizations' capacity to provide high quality services to racial and ethnic minorities and expand the number of minority HIV providers. The MAI has also served as an important source of funding for direct services for minority communities. Designed to complement, rather than replace, other federal HIV/AIDS programs, the MAI has taken a multi-pronged approach that focuses simultaneously on HIV prevention, care, treatment and research.

Looking ahead, the MAI faces many important issues, including: maintaining and enhancing its focus on capacity-building; clarification of MCBO targeting language; the dissemination of information on MAI program activities and evaluation results; managing program and political expectations; integrating new service providers into the HIV service delivery system; and continuation of the program in future.

APPENDIX
Select MAI-Funded Programs[30] by Agency

Health Resources and Services Administration (HRSA):

Ryan White CARE Act—With more than $130 million in MAI funds appropriated in FY 2004 across the CARE Act, state, local and community-based grantees and sub-grantees provide a wide range of services designed to strengthen HIV service delivery in minority communities and expand access to and utilization of high quality HIV treatment and care.[30]

Peer Treatment Educator Training—This program supports the training of HIV/AIDS peer treatment educators in highly impacted areas of the country in order to engage and retain more racial and ethnic minorities in local systems of HIV care.

Supporting Networks of HIV Care (SNHC)—The SNHC Project provides regional trainings and on-site, individualized capacity building training and technical assistance to small and moderately sized non-profit, community- and faith-based organizations. The goals of the program are to strengthen organizational infrastructure, enhance the quality of HIV service provision and expand the number of organizations in the federally funded system of HIV care.

In addition to these programs, MAI funds are also used for an external evaluation of HRSA-administered MAI programs. In previous years, HRSA also used GDM funds for the Targeted Provider Education Demonstration (TPED) program. TPED provided training on the HIV-related health care needs of racial and ethnic minorities for non-clinical, HIV health and support service providers (i.e. case managers, treatment educators and outreach workers) in minority community based organizations. At the conclusion of the demonstration grant, elements of the TPED program were incorporated into the AIDS Education and Training Center (AETC) program of the CARE Act.[31]

Centers for Disease Control and Prevention (CDC):

Cooperative Agreements—Approximately $15 million in CDC MAI funds in FY 2002 was allocated to state and local health departments through existing cooperative agreements to assist them in meeting the CDC requirement in HIV community planning cooperative agreements that the allocation of federal prevention funding match the racial and ethnic demographics of the HIV epidemic locally.

HIV Prevention Among Racial and Ethnic Minority Men Who Have Sex With Men (MSM), Including Young MSM—Through one of two grant programs, the CDC funds community-based organizations, national, regional and local minority organizations to provide health education, outreach, counseling and testing and prevention case management services to minority MSM, as well as technical assistance to help these organizations strengthen service delivery. Since FY 2001, a second young minority MSM project encourages linkages between organizations that serve minority youth and those working on HIV prevention.

Innovative Testing Strategies—These funds are used by state and local public health entities and CBOs to promote and implement nontraditional, community-based HIV testing strategies to increase knowledge of serostatus among high-risk racial and ethnic minorities and link individuals who are newly diagnosed to care. This includes support for National HIV Testing Day, the expanded use of rapid testing, and the use of multi-media, consumer-driven marketing strategies as part of the "Know Now" campaign.

Capacity Building and Technical Assistance—Through several program announcements, the CDC supports a national program of technical and capacity-building assistance for directly funded CBOs, state and local health departments and other organizations conducting HIV prevention activities with a focus on high risk minority communities.

The above examples are just a few of the more than 20 MAI-funded programs administered by the CDC. Others include: support for directly funded community- and faith-based organizations, including indigenous CBOs with a history of working in African American communities; research, evaluation and collaborative demonstration projects for the incarcerated; prevention among HIV positive individuals; and projects designed to establish linkages between local HIV, STD, TB and substance abuse programs. CDC also uses MAI funds for minority communications strategies and two ongoing evaluations of the agency's MAI activities.

National Institutes of Health (NIH):

Office of AIDS Research (OAR)—With general funds appropriated by Congress to the NIH, the OAR supports a range of activities with goals that are consistent with those of the MAI, including: recruitment of individuals from under-represented racial and ethnic groups into research careers; increasing the number of minority principal investigators conducting research in HIV/AIDS and substance abuse; ensuring adequate minority representation in clinical trials; and building research infrastructure in minority institutions. In addition, a number of NIH Institutes support and conduct population-specific studies that focus on minority populations.

In the first year of the MAI, the NIH was awarded GDM funds to support two additional programs: Project ACCESS, a social marketing campaign designed to raise awareness of the risk of HIV and encourage the use of testing services by minority youth; and the Equal Access Initiative, a grants program designed to facilitate the distribution of patient and provider knowledge through grants to minority CBOs for computers, training and Internet access. Over time, these activities have been incorporated into other programs.

Substance Abuse and Mental Health Services Administration (SAMHSA):

SAMHSA's HIV/AIDS grant activities are carried out in its three Centers: Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS).

Targeted Capacity Expansion (TCE) Grants for Substance Abuse Prevention and HIV Prevention (CSAP)—This TCE grant program supports both service and planning grants to community- and faith-based organizations to expand their capacity to provide integrated substance abuse prevention and HIV prevention programs for minority populations disproportionately affected by HIV/AIDS. Planning grants, awarded for one year, are specifically designed to expand infrastructure and leadership capacity of such organizations through the development of local strategic action plans. Service grants are awarded for multiple years.

Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS (CSAT)—This program provides grants to community-based organizations to increase the accessibility and availability of substance abuse treatment and HIV/AIDS services (including services for other STDs, Tuberculosis and Hepatitis B and C) for African Americans, Latinos and other racial/ethnic minority substance users.

Treatment Outreach Grants (CSAT)—These grants to state and local health departments and community-based organizations fund outreach workers to provide HIV counseling and testing services, health education and risk reduction information and referrals to health and support services for African American and Latino injecting drug users and other drug users at high risk for infection in cities with high rates of HIV/AIDS.

Mental Health HIV Services Collaborative (MHHSC) Program (CMHS)—In FY 2001, this program provided five-year grants to 21 community-based organizations to enable them to expand their capacity to provide culturally competent mental health treatment and referrals to other health and support services targeting racial and ethnic minorities living with HIV/AIDS who also have a diagnosed mental health disorder. A national coordinating center is also funded to provide clinical and evaluation assistance and to work with sites to design and implement a voluntary, cross-site evaluation.

Indian Health Services (IHS):

School Health Program—Through a Memorandum of Agreement (MOA) with the CDC, the IHS provides teacher training, curriculum support and other technical assistance to improve school-based HIV prevention efforts targeting Native American youth attending Bureau of Indian Affairs schools and public schools.

American Indian/Alaska Native Health Care Provider Training Initiative—Through an MOA with HRSA, this program partners AIDS Education and Training Centers (AETCs) with American Indian/Alaska Native and or Urban Indian Health Centers to develop and implement HIV training programs for health care providers and paraprofessional health care providers serving tribal areas and communities.

Behavioral Surveillance and Assessment—As part of this assessment, the IHS and CDC are evaluating HIV/AIDS case reporting practices at IHS, Tribal and Urban health facilities in order to strengthen the collection of surveillance data for American Indian/Alaska Native communities.

Office of Minority Health (OMH):

Technical Assistance and Capacity Development Demonstration Program for HIV/AIDS-Related Services in Minority Communities—This program provides grants to public or tribal governmental entities and private, non-profit organizations to provide technical assistance and mentoring to community-based, minority serving organizations. The goal of the program is to stimulate, foster and support the development of effective and sustained HIV prevention and treatment service delivery capacity within such CBOs.

Minority Community Health Coalition Demonstration Program, HIV/AIDS—These grants support local coalitions working to increase understanding of HIV/AIDS and improve access to HIV/AIDS prevention, testing and treatment services. Coalitions must include a community-based, minority serving organization with extensive experience in conducting HIV/AIDS prevention and outreach activities, an AIDS service organization, and at least one organization rooted in the community with no prior experience in an effort to expand the network of HIV service providers.

State and Territorial Minority HIV/AIDS Demonstration Program—This program provides funds to state and territorial offices of minority health to: assist in identifying local HIV/AIDS prevention needs; facilitate linkage of community-based, minority serving organizations with other recipients of federal HIV funds to develop greater resource capacity; and assist in coordinating federal resources in high need minority communities.

HIV/AIDS Regional Resource Network Program (RRN)—This capacity-building project focuses on community-based organizations in minority communities with disproportionately high rates of HIV/AIDS and STDs. The program's goals are to improve the quality and coordination of HIV/AIDS service delivery by facilitating involvement of CBOs serving minority communities, including small, minority CBOs, in federal regional initiatives, planning and networking efforts, and by providing training and technical assistance to build CBO service capacity.

Office of Population Affairs (OPA):

Integration of HIV Prevention and Title X Family Planning Clinics—These funds expand on-site HIV counseling, testing and referral services in select Title X family planning clinics operating in areas of the country with high rates of HIV/AIDS in minority communities.

Office of HIV/AIDS Policy (OHAP):

The Leadership Campaign on AIDS (TLCA)—TLCA, created in 1999, works with local and national leaders in minority communities, as well as policymakers, community-based organizations, and the private sector, to increase awareness of HIV/AIDS and reduce stigma and discrimination. Program activities include: leadership development; partnership building; training; media and community outreach; events; and materials development. TLCA also works with federal employees to strengthen HIV programming and broaden access to federal grants through the Plain Language Initiative.

Crisis Response Teams/Rapid Assessment and Response Emergency (RARE) Initiative—Through the RARE Initiative, a team of federal and/or national health officials partners with local health and community leaders in minority communities that are highly impacted by HIV/AIDS to assess the changing dynamic of the epidemic locally and to identify potential strategies to enhance HIV prevention, care and treatment efforts in these areas.

Office of Women's Health (OWH):

Incarcerated and Newly Released Women with HIV/AIDS/STDs Program—This program supports demonstration projects designed to build a continuum of health and support services for incarcerated and/or newly released racial and ethnic minority women living with HIV/AIDS. Projects focus on pre-release, discharge and transition planning in order to link women to community-based services.

Model Mentorship Program for Strengthening Organizational Capacity—This program partners seasoned, minority health organizations with newer, less experienced community- and faith-based organizations focusing on racial and ethnic minority women and HIV/AIDS in order to expand organizational capacity to provide HIV/AIDS services.

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[13] U.S. House of Representatives Committee on Appropriations, *House Report 107-229, Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Bill, 2002,* October 9, 2001.

[14] U.S. Congress, Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (PL 105-277), October 21, 1998.

[15] In previous fiscal years, this $50 million in MAI funding was appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) within the Office of the Secretary, DHHS. More recently, the Department has also referred to these funds as the Minority Communities Fund.

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[20] U.S. Congress, Conference Report on H.R. 4577, Consolidated Appropriations Act for Fiscal Year 2001, December 15, 2000.

[21] This discussion is based on interviews with key stakeholders and does not constitute a legal analysis.

[22] For text and an analysis of *Adarand Constructors v. Pena* (93-1841), 515 U.S. 200 (1995), see: http://supct.law.cornell.edu/supct/html/93-1841.ZS.html.

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