

Addressing HIV/AIDS in the Southern United States

Background facts:

An estimated 41% of Americans with HIV/AIDS live in the South. As of 2005, the U.S. Centers for Disease Control and Prevention (CDC) reported that HIV prevalence rates in Georgia, Florida, and Louisiana had surpassed 200 per 100,000 people, a higher rate than anywhere in the U.S. except the Northeast and the Caribbean. The CDC also documents HIV infection rates – the sign of the AIDS epidemic to come – to be extremely high in Florida, Louisiana, Mississippi, and South Carolina.¹ The Mississippi Delta has the highest rates of heterosexually-acquired HIV in the U.S., as well as the highest proportion of HIV diagnoses among young people aged 13-24 years (18.4%). More than three quarters of people diagnosed with HIV in the Mississippi Delta and the Southeast Region are African American, and diagnosis rates are higher among African Americans and Hispanics than whites in all regions.²

Data from an HIV Cost and Services Utilization Study published in 1999 by the Rand Corporation indicated that only one-third to one-half of people living with HIV/AIDS were in regular HIV care as of 1996, and that these rates were worse in the Southern U.S.^{3 4} The Institute of Medicine in 2004 suggested that, “the combination of financing structures and individual characteristics such as race/ethnicity and low income level interact to exacerbate disparities in health care.”⁵ Fewer than half of the people in the South who meet government criteria for use of antiretroviral treatment are likely to be receiving these drugs, and a significant share of people who have HIV and AIDS are tested too late in the course of disease to benefit from early care.

Experts note a particular need and opportunity for philanthropic grant making for:

- Education and advocacy focused on HIV treatment and care in rural areas: In the rural U.S., HIV patients are more likely than their urban counterparts to see physicians who have treated few people with HIV and are less likely to have experience with the newest advances in combination antiretroviral therapies. Treatment education and advocacy programs can help improve quality of care and increase positive outcomes of HIV treatment.
- Community-based organizing related to HIV/AIDS: Community organizing and advocacy may help to reduce stigma related to HIV, link HIV to broader issues of civil rights and economic justice, and persuade people to acknowledge their risk, seek testing, engage in treatment, and call on rural health providers to create and deliver HIV services.
- State-level and municipal policy work: Allocation of HIV prevention and treatment funding distributed by the CDC, the Health Resources and Services Administration and other federal agencies is often guided at a state and local level. In the South, state governments are responding to fiscal pressures by reducing or restricting Medicaid benefits, imposing cost sharing requirements (including increasing Medicaid co-payments), and implementing controls on pharmacy costs. These measures, combined with delayed eligibility for both Medicaid and Medicare, create structural barriers to appropriate care by discouraging providers from treating poor individuals with HIV.

EJAF investments:

According to Funders Concerned About AIDS, the Elton John AIDS Foundation and the National AIDS Fund are among the leading 10 grant makers currently investing small HIV/AIDS grants in the Southern U.S. region.⁶ *During 2007, in partnership with the National AIDS Fund and the Ford Foundation, EJAF invested more than \$550,000 to support community-based HIV/AIDS efforts in the South.*

Addressing HIV in the Caribbean and Latin America

Background facts:

As many as 230,000 people are currently living with HIV in the Caribbean. An additional 1.6 million people are living with HIV in Central and South America, with major epidemics in Brazil, the Andean countries, and Central America. The Caribbean is the second-most HIV/AIDS affected region in the world after sub-Saharan Africa, containing nine of the 12 countries with the highest HIV prevalence in the Americas. In 2007 alone, 17,000 people in the Caribbean were newly infected with the virus. More than 100,000 people in Latin America became newly HIV-infected last year as well.

In the Caribbean, AIDS has become the leading cause of death among adults aged 15 to 44 years. An estimated 11,000 people died of AIDS in the region in 2007, and most of these deaths were avoidable. Fewer than one in ten HIV-positive individuals know their serostatus, and relatively few people are receiving HIV treatment. Across the Americas, the highest HIV-infection levels among women are in the Caribbean. Overall, HIV transmission in the Caribbean is occurring largely through heterosexual intercourse, but, among men, approximately 20 percent of HIV infection is reportedly due to sex with other men. By contrast, in Central and South America, UNAIDS states that male-to-male sex is the primary driver of epidemics in many countries. Stigma and discrimination related to HIV/AIDS is high, as are rates of poverty, lack of access to health care, and prejudice against homosexuality, impeding HIV prevention efforts and access to care.

The epidemic is not evenly distributed across Latin America and the Caribbean. Brazil alone accounts for one third of the region's people living with HIV/AIDS and one third of all new infections. In the Caribbean, the overwhelming majority (an estimated 190,000) of people living with HIV reside in four nations: Haiti, the Dominican Republic, Jamaica, and Trinidad & Tobago. In addition to these countries, HIV prevalence is higher than the regional average in most of Central America, in Guyana and Suriname, and in several Caribbean nations such as the Bahamas and Barbados.

In Haiti, the number of people living with HIV in 2006 was 180,000, translating to a rate of 3.8 HIV+ adults out of every 100 adults in the country. Life expectancy at birth in 2010 is projected to be 10 years less than it would have been without AIDS, and political unrest and deep poverty have limited the ability of the Haitian national government or local communities to effectively address HIV and other health concerns. In the Dominican Republic, 62,000 people are estimated to be living with HIV/AIDS; the national infection rate is estimated at 1.1 percent, with rates much higher in selected communities (for example, the rate of HIV among MSM is documented at 12%). Trinidad & Tobago has the third highest number of HIV/AIDS cases in the Caribbean, with 26,000 people (2.6% of the adult population) living with HIV. Across the region, fewer than one in ten HIV-positive individuals know their serostatus, and relatively few people are receiving HIV treatment.⁷

EJAF investments:

According to Funders Concerned About AIDS, Latin America and the Caribbean receive only 1% of all international HIV/AIDS grants made by the largest 50 U.S. HIV/AIDS-focused philanthropies.⁸ Private U.S. philanthropic organizations have an important role to play in

catalyzing new responses to HIV in Latin America and the Caribbean, in part due to geographic proximity and strong cultural ties with immigrant communities in the United States.

In 2007, EJAF was one of the largest investors of private philanthropic dollars to the Caribbean and Latin America, investing more than \$1.6 million through partnerships with Kaiser Family Foundation, the HIV Collaborative Fund, the Foundation for AIDS Research, and other partners.

HIV Prevention among Injection Drug Users

Background facts:

People infected through injection drug use account for more than 20% of AIDS diagnoses and represent approximately a quarter of all people living with AIDS in the United States. In the United States between 1999 and 2002, injection drug use was the second leading cause of HIV infection for women (20.3% of all infections) and the third leading cause of HIV infection for men (15.8% of all infections).

Harm reduction efforts are a highly effective method to provide HIV prevention interventions to women and men who are either HIV+ or at risk for HIV. For more than a decade, data has shown that sterile injection equipment exchanges (SEPs or NEPs) and associated harm reduction counseling and support programs reduce risks of HIV transmission.⁹ Harm reduction programs are an important way to stop injection-related HIV infections and provide a low-threshold entryway into drug treatment, counseling and interventions for sexual risk reduction, support for antiretroviral access and use, and other health and economic interventions.

Federal law prohibits the use of federal funds for NEPs. A study released by CDC in 2005 reported that, as of three years earlier, public financing for NEPs had declined and the number of syringe exchange programs in the U.S. had decreased for the first time in eight years.¹⁰ Still, the study found that the number of total syringes exchanged and total NEPs budgets across all programs had increased just as the federal response to the challenges of substance abuse has waned.¹¹

In a recent victory for syringe exchange advocates, President Bush signed legislation on December 26, 2007, lifting a nine-year ban on city funding for syringe exchange programs in the District of Columbia. Federal spending bills since 1998 made Washington, DC, the only city in the nation prohibited from using either federal or local taxpayer dollars to fund such programs, even though the use of unsterile syringes by injection drug users is the second leading cause of HIV infection in the District of Columbia, which has the highest HIV infection rate in the country. With the ban lifted, the city plans to devote \$650,000 from its budget to the expansion of syringe exchange programs.¹²

A select group of philanthropic funders, including the Levi Strauss Foundation, the Irene Diamond Fund, the Tides Foundation, and the Elton John AIDS Foundation have stepped forward to mobilize new funding for HIV prevention related to harm reduction and injection drug use. In recent strategic interviews, many experts have commended this investment and have recommended a continuation and increase of this effort. In addition, experts have suggested that drug-related harm reduction programs are also needed for gay men, particularly related to the use of methamphetamine.¹³

EJAF investments:

Since 2006, EJAF has been a major partner in the Syringe Access Fund, a \$1.3 million annual collaboration of the Levi Strauss Foundation, Irene Diamond Fund, National AIDS Fund, Public Welfare Foundation, and Tides Foundation. EJAF will continue to serve as a sustaining core partner in this effort, supporting more than 50 organizations each year who work to prevent HIV/AIDS by reaching injection drug users with sterile syringes and other harm reduction interventions.

Addressing HIV in Prison and Re-Entry Programs

Background facts:

The United States has one of the highest incarceration rates in the world; the number of individuals in prison and jail passed two million in 2002. Prisoners are heavily stigmatized and poorly served; most are non-violent offenders. Approximately 60% of federal prisoners and more than 20% of state inmates are in custody on drug charges, in many cases low-level crimes. Furthermore, the burden of incarceration falls unevenly. An estimated 12% of African-American men between 20 and 34 are behind bars, more than seven times the rate for white men the same age.

Rates of HIV and hepatitis C infection are high. According to the CDC's *Morbidity and Mortality Weekly Report*, HIV prevalence rates among prison populations in 2002 was over 1% in Federal prisons and over 2% in state prisons. Among 5,000 prisoners in New York State, 7.2% of men and 13.6% of women had HIV or AIDS. In Florida, the corresponding rates were 3.6% and 7.4%. In Georgia, 2.3% and 3.2%. As stated by the National Commission on Correctional Health Care in January 2003, "inadequate health care in U.S. correctional facilities poses a serious threat to the nation's public health." Furthermore, research in 2003 involving HIV-positive inmates has indicated that they often have unprotected sex before and after incarceration.¹⁴

Prison health advocacy can work and is needed. An August 2005 Bureau of Justice Statistics study found that the AIDS-related death rate in jails and state prisons significantly decreased over the last several years, due largely to improved medical treatment and lawsuits filed by advocacy groups to improve conditions behind bars.¹⁵ Recent state-level advocacy brought about a 2005 Illinois law mandating jails to offer HIV testing at no cost to inmates, and to provide case management and referrals for support services to HIV-positive prisoners when they are released from prison.¹⁶

Specific advocacy work can be supported that includes:

- Policy research and quality data collection about prison health expenditures, prison health service delivery, and prison health outcomes.¹⁷
- Public advocacy and communications work to increase the transparency of prison health programs, identify potential actions and individuals responsible, and hold state and federal government agencies and prison health contractor companies accountable for prisoner health.
- Communications work to articulate and frame the issues, increase public awareness, and to present data, case studies, stakeholder opinions, argument, and ethical/moral imperatives.

- Community organizing work among prisoner families and health advocacy groups to mobilize constituencies, build coalitions, and advocate through litigation, legislation, and communications.

EJAF investments:

Private foundation funding is urgently needed to monitor and improve prison health programs and prisoner re-entry programs in the United States, aiming for quality and accessibility of HIV counseling and testing, HIV and TB treatment, sound HIV prevention, and related health care. Beginning in 2007, in partnership with National AIDS Fund, EJAF supported the launch of a major national small grants program on these issues. In addition, EJAF is now supporting the ACLU National Prisons Project and Human Rights Watch to work in this area. ***In total, EJAF's 2007 investment was \$635,000.***

Addressing HIV among Men Who Have Sex With Men (MSM)

Background facts:

In the U.S., Caribbean, and Latin America, MSM continue to account for a disproportionate percentage of new HIV infections and AIDS diagnoses. According to CDC data on new HIV-infections in the United States, the most prevalent mode of HIV exposure among HIV-infected men continues to be sexual contact with other men (51% in 2005).¹⁸ In the Caribbean and Latin America, research is documenting that more than 25% of all new HIV infections are among MSM. Younger MSM are likely to be HIV infected without knowing it. A recent study found that 77% of young MSM who tested HIV positive believed they were not infected.^{19 20} Also, new statistics released by the New York City Department of Health and Mental Hygiene indicate that the number of new HIV diagnoses among gay men under age 30 rose 32% between 2001 and 2006, and among black and Hispanic gay men, the figure was 34%; HIV rates among the youngest gay men in the study – ages 13-19 – doubled during this period.²¹ Despite all evidence demonstrating that condom use can reduce sexual transmission of HIV, and that individual, group and community-level interventions can reduce HIV risk behaviors, a disproportionately small amount of funding is dedicated from government and private sources to interventions targeting gay men and MSM.²²

In the United States, black gay men are a major and disproportionately high proportion of MSM who are becoming infected. According to the CDC, the leading cause of HIV infection among African American men is sexual contact with other men.^{23 24} A report released by the Black AIDS Institute and the National Association for the Advancement of Colored People in 2006 called for an end to “debilitating stigma that helps HIV spread” in the black community, noting that stigma undermines prevention and treatment efforts, “particularly in the South and among gay and bisexual men”. In March 2007, the CDC announced plans to expand and improve HIV prevention and treatment programming for African Americans, but these plans do not represent the full scale effort that is needed.²⁵

Continued high HIV prevalence rates among gay men in the U.S. and in the Caribbean and Latin America, coupled with an insufficient government and community response, has led to an accelerated sense of crisis both within and outside of networks of gay men. Many organizations have issued calls for action, including calls to:

- Increase efforts to reach gay and bisexual men through HIV testing, STD screening, primary medical care and behavioral interventions.

- Increase research documenting effective HIV prevention strategies and behavioral interventions, and increase efforts to adapt and tailor current evidence-based interventions for gay and bisexual men.
- Enhance access for gay/bisexual men to primary medical care, STD treatment, and immunizations.
- Increase access to substance abuse treatment and mental health services for gay and bisexual men, regardless of their HIV status.

EJAF investments:

In 2007, EJAF made investments totaling \$435,000 on this topic, including support for two new initiatives, a grant to Black AIDS Institute to contribute to the national Black AIDS Mobilization, a multifaceted campaign to address HIV among black Americans, and support to amfAR for the Caribbean and Latin American launch of the MSM Initiative, a small grants program targeted to local peer-led HIV prevention, treatment, and care efforts among MSM in that region.

Improving Sexual Health Programs for Youth

Background facts:

In the United States, half of all new HIV infections are among people under the age of 25. Adolescents and young adults also account for the majority of new HIV infections throughout the world.^{26 27 28} Nationwide in the U.S., 87.9% of students have been taught in school about acquired immunodeficiency syndrome (AIDS) or HIV infection. But, according to CDC surveillance, adolescents and young adults continue to face substantial risks, illnesses and social problems related to unintended pregnancies and STIs, including HIV infection.²⁹ Surveys continue to show approximately half of high school students reporting having had sexual intercourse, and a third of high school students reporting being currently sexually active (having had sex during the preceding three months). More than a third of these sexually active high school students report not using condoms at last sexual intercourse. These rates are documented to be higher among high school students who are poorer and who are African American.³⁰

Funding is needed for programs that improve sexual and reproductive health options for youth. An array of individual studies and meta-analyses have determined that comprehensive sex education programs that include information about both abstinence and contraception can be effective at helping young people reduce their number of sexual partners, increase condom use when they do have sex, and delay the onset of sexual intercourse.³¹

Abstinence-only programs do not work. A wealth of studies and program evaluations have failed to find abstinence-only programs to be effective.³² However, since 2000, the federal government continues to spend hundreds of millions of dollars on abstinence-only-until marriage programs, and it is estimated that schools in over a third of public school districts use an abstinence-only curriculum.³³ Many high schools do not make condoms readily available to teenagers, even though research has found that in schools where condoms are available students are less likely to be sexually active and more likely to use condoms if they are having sex.³⁴

Gay youth are at particularly high risk of HIV infection. Funding is needed to meet the HIV risks of gay youth by addressing homophobia as a civil rights issue and a barrier to HIV prevention and care.³⁵ Even the U.S. CDC has acknowledged that stigma surrounding HIV/AIDS leads individuals to “deny risk...avoid testing...delay treatment...and suffer needlessly.”³⁶ The agency

has identified a variety of ways in which homophobia affects HIV prevention efforts, “from the individual at risk of infection who may deny their risk because of internal conflicts, to the broader culture, which delivers anti-gay messages, [and] institutionalizes homophobia through...laws that regulate intimate sexual behaviour, and lags in its support of sensitive and honest prevention for gay and bisexual youth, young adults and older men.”

EJAF investments:

During 2007, in partnership with Advocates for Youth, Urban Tech, and other partners, EJAF invested more than \$550,000 in this funding area.

¹ <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/map1.htm> (revised June 2007)

² Hall HI, Li J, McKenna MT. *HIV in predominantly rural areas of the United States*. J Rural Health. 2005 Summer;21(3):245-53.

³ Bozzette, S., et al. Expenditures for the care of HIV-infected patients in the era of highly active antiretroviral therapy, NEJM, vol. 334, no 11, March 2001, and, Shapiro, MF, et al, 1999. Variations in the care of HIV-infected adults in the United States: Results from the HIV Cost and Services Utilization Study, JAMA 281(24):2305-2315

⁴ Fleming et al, “HIV prevalence in the United States, 2000,” Abstract #11, Oral abstract session 5, 9th Conference on Retroviruses and Opportunistic Infections, 2002

⁵ Institute of Medicine, Public Financing and Delivery of HIV/AIDS Care: Securing the legacy of Ryan White, Washington, D.C, 2004, p. 111

⁶ Original background research information for Funders Concerned about AIDS, U.S. Philanthropic Commitments for HIV/AIDS, March 2005. Updated facts for 2005 and 2006 published September 2007 at www.fcaids.org.

⁷ All HIV statistics in this summary of Latin America and the Caribbean are quoted from UNAIDS AIDS epidemic update, December 2007.

⁸ Funders Concerned about AIDS, U.S. Philanthropic Commitments for HIV/AIDS, September 2007, at www.fcaids.org.

⁹ Lurie, P, The Public Health Impact of Needle Exchange Programs in the United States and Abroad, University of California, San Francisco, 1993

¹⁰ CDC, MMWR, July 15, 2005, vol. 54, no. 27

¹¹ The HIV-related programs at the Substance Abuse and Mental Health Services Administration (SAMSA) have seen reduced budgets over the last several years, declining from an overall agency figure of \$171.2 million in FY 2004 to \$169.9 in 2005, and with a Presidential budget request of \$168.3 for FY 2006. These budgets are small already: in FY2004, the Center for Substance Abuse Prevention provided only \$36.8 million for substance abuse prevention and HIV prevention services, particularly targeting youth and other at-risk groups in communities of color, and the Center for Substance Abuse Treatment awarded only \$61 million for substance abuse treatment capacity.

¹² “New Law Allows Funding for Syringe Exchange Programs in D.C.,” www.amfar.org

¹³ Recommendation made by experts at amfAR, Evelyn and Walter Haas Jr. Fund, Ford Foundation, Funders Concerned About AIDS, Infectious Disease Society of America, National AIDS Fund, National Association of People Living with HIV/AIDS, Tides Foundation, the University of California San Francisco, and the van Ameringen Foundation.

¹⁴ According to a University of North Carolina at Chapel Hill School of Medicine study conducted from 2001 to 2003, prior to incarceration, 72% of the HIV+ inmates in the North Carolina system had a main sex partner, and 57% of those partners were reported to be HIV negative. 78% of the HIV+ inmates who had a main sex partner reported unprotected sex with that person in the year before they were locked up. Post release, 93% of the inmates had a main sex partner, 82% of releasees returned to their prior main partner, and 26% of those interviewed again soon after release admitted to already having sex without condoms with their main sex partners.

¹⁵ Kaiser Daily HIV/AIDS Summary, AIDS-related death rates in jails, state prisons have dropped significantly, federal data say, August 23, 2005

¹⁶ Kaiser Daily HIV/AIDS Summary, Illinois Gov. Blagojevich to sign legislation focusing on HIV prevention among Blacks, from the Chicago Tribune, September 16, 2005

¹⁷ Two examples include discharge planning and opiate replacement therapy programs. Discharge planning is crucial so that HIV-positive men who are released from prison are counseled about risk reduction and ways to protect their sexual partners. Yet this is rarely done or done well. Ryan White and HOPWA do some of this funding, but it is piecemeal and HOPWA is experiencing continued funding declines. CDC funding for ‘prevention for positives’ utterly fails to meet the needs of this HIV-positive population. Community programs that have significant federal funding for transitional housing and support services can at the same time lack funding for condoms or policy and communications work. Opiate replacement therapy programs in correctional facilities have been endorsed by the American Medical Association, the American Society of Addiction Medicine, and the National Commission on Correctional Health Care. However, these programs are not yet a standard of care in federal or state prisons. No systematic national assessment of these failings has yet been completed.

¹⁸ CDC, *HIV/AIDS Surveillance Report 2005*, vol.17 (Atlanta: December 2006): 19 and 22.

¹⁹ Fleming, P, et al, Abstract #11, Oral Abstract Session 5, 9th Conference on Retroviruses and Opportunistic Infections 2002

²⁰ MacKellar DA, et al, Unrecognized HIV infection, risk behaviors, and perceptions of risk among young men who have sex with men: opportunities for advancing HIV prevention in the third decade of HIV/AIDS. *Journal of Acquired Immune Deficiency Syndromes* 2005; 38:603-614

²¹ Kershaw, S, "New H.I.V. Cases Drop but Rise in Young Gay Men," *New York Times* January 2, 2008.

²² Wohlfeiler, D. and Potterat, J., "Using Gay Men's Sexual Networks to Reduce Sexually Transmitted Diseases (STD)/HIV Transmission," *Sexually Transmitted Diseases: Journal of the American Sexually Transmitted Disease Association*, vol. 32, no. 10 (October Supplement 2005): s48-s52.

²³ www.cdc.gov

²⁴ In data presented by the CDC in June 2005, collected from the National HIV Behavioral Surveillance System during 2004 in Baltimore, Los Angeles, Miami, New York City, and San Francisco, an HIV prevalence of 46% was revealed among African American MSM. Moreover, among these men, 67% were unaware of their HIV infection. Earlier research supported by the CDC, through a national Young Men's Survey, sampled young men who have sex with men (ages 15-22) in seven urban areas, and found that, overall, 7% were infected with HIV (range: 2%-12%). A significantly higher percentage of African American MSM (14%) than white MSM (3%) were already infected with HIV.

²⁵ In March 2007, CDC released its plan for a "Heightened National Response to the HIV/AIDS Crisis among African Americans." Though increased agency focus on HIV in the black community is a welcomed development, community advocates have been quick to point out that the new CDC plan fails to address structural factors in vulnerability to infection among black Americans, does not insist on increased resources to support needed prevention efforts, and fails to provide targeted strategies to address AIDS in the black, gay community. For more information, see Community HIV/AIDS Mobilization Project, "Bush Administration's Long-Awaited African-American HIV Prevention Plan Involves No New Money, No New Strategies, and Ignores Gay Men," Press Release (March 8, 2007), <http://www.champnetwork.org/index.php?name=CDC-African-American-initiative> (accessed March 13, 2007).

²⁶ Rosenberg, et al, Declining age at HIV infection in the United States (Correspondence); *New England Journal of Medicine*, vol. 330, No. 11, 1994

²⁷ African American youth are disproportionately impacted: among 13 to 19 year olds, African Americans accounted for 65% of new AIDS cases reported in 2002 (updated data available?)(Kaiser Family Foundation, HIV/AIDS Policy Fact Sheet, The HIV/AIDS epidemic in the United States, September 2005). If adult trends track similarly to youth populations, nearly half of all new infections among youth will be due to male-male sex, and the leading cause of HIV infection among African American male youth will be sexual contact with other men.

²⁸ UNAIDS; http://data.unaids.org/pub/EPISlides/2006/epicore2006_27oct06_en.ppt

²⁹ U.S. Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance System (YRBS), 2003

³⁰ CDC, Youth Risk Behavioral Survey: 1991-2003: Trends in the prevalence of sexual behaviors, <http://www.cdc.gov/HealthyYouth/yrbs/pdfs/trends-sex.pdf>

³¹ Kirby, D, No Easy Answers (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 1997); Douglas Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 2001); and David Satcher, The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior (June 2001).

³² SIECUS (Sexuality Information and Education Council of the United States), SIECUS Public Policy Office Fact Sheet: What the research says. . . , http://www.siecus.org/policy/research_says.pdf

³³ Kelly, K, Just don't do it, U.S. News and World Report, October 17, 2005, p 46

³⁴ Blake, S, et. al., "Condom Availability Programs in Massachusetts High Schools: Relationships With Condom Use and Sexual Behavior," *American Journal of Public Health* 93.6 (2003): 955-962.

³⁵ Reiterated in strategic discussions in August-October 2005 with individuals at Advocates for Youth, Evelyn and Walter Haas Jr. Fund, Ford Foundation, and Tides Foundation.

³⁶ CDC, HIV prevention strategic plan through 2005, CDC, January 2001, http://www.cdc.gov/nchstp/od/hiv_plan/default.htm