



GETTING THE MOST OUT OF PARTNERSHIPS ON HIV/AIDS AND PUBLIC HEALTH IN THE U.S.

**GBC RECOMMENDATIONS TO THE OBAMA ADMINISTRATION AND
ILLUSTRATIVE PARTNERSHIP CASE STUDIES**

GETTING THE MOST OUT OF PARTNERSHIPS ON HIV/AIDS AND PUBLIC HEALTH

The traditional view of public-private partnerships (PPPs)—in which corporations contribute money and volunteers to programs and partners—is giving way to a new generation. Companies are leveraging their unique skills, assets and reach alongside public partners in ways that are making deeper impact in a time of ever-tightening budgets.

It's a new movement in the business fight against HIV/AIDS and other public health challenges.

It's the leading creative minds at BET and MTV joining forces with public health experts to plan and execute awareness campaigns that lead to measurable behavior change. It's the dozens of companies whose workplace programs and policies are educating and protecting the health of employees in the U.S. and abroad. It's 500,000 hairdressers, during routine trainings by L'Oréal, becoming equipped to educate their customers about HIV risk reduction strategies. And it's so much more.

The White House Office of National AIDS Policy underscored the importance of such innovative approaches when it included explicit recommendations for such private-sector partnerships in America's first-ever comprehensive National HIV/AIDS Strategy and Federal Implementation Plan.

In order to maximize the effectiveness of these and other partnerships, GBC and our partners are making three key recommendations to the Administration. **While these recommendations were developed specifically in the context of the U.S. HIV epidemic and GBC's engagement around the White House's National HIV/AIDS Strategy, they have implications and "power" that extend far beyond the realm of HIV and AIDS and, if implemented, will transform the way that the U.S. public and private sectors work together to achieve a variety of health and other priorities.**

GBC's recommendations:

1. **That the Administration and its various agencies reach out to the business community in radical new ways**, enlisting new engagement and support around a diverse array of HIV/AIDS and broader health priorities. That means traditional philanthropy, volunteerism, social marketing and biomedical research—but also beyond those more obvious realms, to engagement around workplace programs, core competencies, advocacy and more. Businesses, large and small, employ and touch the vast majority of Americans, and are well-positioned to contribute a wealth of skills, technology and other assets—as well as help legitimize and destigmatize conversations about HIV, sex, sexuality and health more broadly.
2. **That the Administration create explicit, partnership functions and designate senior-level point persons** within the Department of Health and Human Services and its agencies, akin to the senior partnership functions within the State Department, e.g. the director of public-private partnerships at PEPFAR. It is our belief that doing so will help the Administration and the nation catalyze and reinforce those health partnerships that make the most strategic sense and have the greatest potential for impact.
3. **That the Administration provide support and resources for health partnerships where appropriate**, to ensure that the partnerships are as strategic, well-managed, accountable, sustainable and effective as possible. It is our view that partnerships must be well-designed, well-managed and appropriately resourced, in order to achieve results—and that the results achieved will far outweigh the costs.

To support these recommendations, GBC has collected case studies from 23 different partnerships in the U.S., representing a cross-section of sectors and approaches that are redefining the business community's roles in the fight against HIV/AIDS—our present area of focus—as well as a few examples from related health arenas. These three recommendations are rooted in the needs identified in these case studies, and in the many successes of the State Department and PEPFAR models—which already operate in accordance with the above.

A PROVEN APPROACH

Until this year, the U.S. lacked a comprehensive and cohesive strategy for fighting HIV/AIDS at home the way it has done abroad. The new U.S. HIV/AIDS strategy is the beginning of something transformative—a framework that already is re-establishing the nation’s program, policy and investment priorities, and allowing key parties from every sector to work together in a more strategic and aligned way.

Now that we have a comprehensive National HIV/AIDS Strategy and federal implementation plan, we face the challenge of execution, across multiple geographies and notably diverse stakeholder groups, including business. Fortunately, we can look abroad for precedent.

PEPFAR, which began in 2003, organizes the U.S. government’s HIV/AIDS programs around the world. It’s an unprecedented effort that’s been getting results on the ground through a wide array of activities and partnerships. Among those partners is the private sector.

Thanks to vigorous U.S. government efforts to enlist corporate involvement in international development efforts; appointed ambassadors for public-private partnership; and federal support and resources, business has been able to fill critical gaps in PEPFAR programs, in many cases helping to forge, fund, sustain and scale partnerships across key stakeholders, with stunning results.

“At PEPFAR, we looked to business as a partner with unparalleled potential for impact,” said Mark Dybul, former U.S. Global AIDS Coordinator. “We found that we needed to staff a public-private partnership unit and provide resources to get those partnerships off the ground. It’s an approach that had remarkable results in a global setting and I’m confident it will work domestically.”

Becton Dickinson and Company (BD) has been a leading partner for the U.S. government in the fight against HIV/AIDS abroad. Earlier this year, the company partnered with PEPFAR and the Government of Kenya to launch a joint, multi-year initiative to improve diagnostic practices in clinics and hospitals. The initiative ultimately aims to support training for thousands of healthcare workers in sub-Saharan Africa, tracking and assessing hundreds of thousands of blood draws per year within each participating country.

“We believe that well defined and well executed public private partnerships can address under-served health needs effectively,” said Renuka Gadde, Senior Director, Global Health at BD. “In our experience, solving complex challenges can be best accomplished through collaboration. The private sector brings its business process savvy, technical assistance and resources. On the other hand, the public sector often sets the framework to facilitate program reach so that ultimately government actors can own both the process and the progress.

The first step in designing a partnership is engaging a dialogue between public and private sectors, addressing common goals and planning how they will be accomplished. The U.S. government is able to create stellar partnerships through their PEPFAR program abroad. There is an opportunity for the government to pursue a similar approach on the domestic home front.”

On occasion, companies have forged comparable partnerships with the U.S. government in order to support domestic health priorities, particularly during times of crisis. For instance, in 2009, Walgreens partnered with the CDC to increase the number of people who were immunized against H1N1. After both partners recognized the strategic role Walgreens and other retailers could play in encouraging and providing H1N1 vaccinations, they worked together to focus the immunization campaign on five priority groups. The Walgreens-CDC partnership provides an excellent example of partnerships done well, with each party focusing on its unique area of expertise: CDC providing critical technical knowledge and resources, and Walgreens bringing to bare its imbedded network of 7,000 stores, media and PR expertise and team of pharmacists.

The end result of that collaboration: Walgreens not only provided 5.4 million season flu shots during the 2009-2010 flu season—over four times the amount provided the previous year—the company also administered two million H1N1 vaccinations in all 50 states.¹ Going forward, CDC leaders have expressed an interest in forging additional partnerships with Walgreens and other major retailers to conduct in-store HIV screening in key geographies nationwide (pending funding)—another, ideal pairing of public expertise and corporate assets.

We've seen what a strategic approach to partnerships can accomplish abroad. We've also seen what strategic partnerships can achieve domestically, on a relatively small and ad hoc basis, and during times of crisis. Now it's time to redouble our focus on partnerships here in the U.S. – and do so in a strategic, sustained, and significant way.

BUSINESS STANDS READY TO HELP

The following 23 partnerships underscore the private sector's commitment to ending the HIV/AIDS epidemic in the U.S. The highly engaged companies featured in these case studies also shed remarkable light on what's already working on the ground, what isn't and how we can make things work better.

Businesses from every sector and every geography stand ready to engage and support where they can. But they can't do it alone. Businesses have skills and competencies that partners need, but sometimes lack deep knowledge of the U.S. HIV/AIDS epidemic and other health issues. Even with technical and project management support from intermediaries like the Kaiser Family Foundation, the National AIDS Fund, Funders Concerned About AIDS, GBC and others, businesses still require the "invitation", expertise, guidance and partnership of the federal government.

The lessons learned from PEPFAR and elsewhere help point a way forward—to more strategic, scalable and effective public-private partnerships; breakthrough partnerships that will help turn the tide in ways unseen and perhaps unimaginable to us today. Already, public-private partnerships are having tremendous impact in the U.S. But, with stronger federal partnership and support, they have the potential to go even deeper, helping us bring about a faster end to the HIV/AIDS epidemic in our communities and across our nation.

¹ Walgreens NIVS Immunization Excellence Awards Nomination, 2010; Walgreens Pinnacle Awards Submission, 2010.

ACKNOWLEDGEMENTS

On behalf of the GBC membership and partners, a heartfelt thanks to the leadership of the White House Office of National AIDS Policy, the U.S. Department of Health and Human Services, and the U.S. Centers for Disease Control and Prevention for your continued vision and commitment.

GBC also wishes to thank its own “U.S. HIV/AIDS Corporate Strategy Advisory Group”. In developing this document we are fortunate to have benefitted from the participation and insights of prominent U.S. business executives, community-based organization leaders, and advocates. Each of you has contributed immeasurably to our findings and case studies, and to our collective commitment to building true, multi-sector knowledge, relationships, and commitments.

A very special thank you as well to Dr. Mary Margaret Frank, professor at the University of Virginia’s Darden School of Business. Dr. Frank has been a critical advisor to the GBC team, helping us evolve our conception and articulation of public-private partnerships based on research scholarship, as well as lived experience. Many thanks as well to Dr. Frank’s MBA, graduate and undergraduate students, who served as researchers and co-authors of many of the mini-case studies included here, and of anticipated, future cases. Your diligence and dedication are very much appreciated.

Many thanks to the National AIDS Fund and Funders Concerned About AIDS for years of service to the domestic HIV/AIDS community, and for your partnership on this project. Your work, integrity and commitment have been extraordinary.

Thanks also to the Kaiser Family Foundation for your assistance with the BET and MTV case studies—and for your long-time leadership on HIV/AIDS domestically and globally.

Finally, we are extremely grateful to Benjamin Weil, who researched and authored several of the in-depth case studies included in this document.

CASE STUDIES OVERVIEW

Thirty years after its first visible and devastating appearance, HIV/AIDS continues to exact a significant toll on the U.S., in human, social and economic terms. The disease undermines the social fabric and growth potential of our nation, as well as many of our most vibrant cities and communities.

Fortunately, the Obama administration has re-focused the nation's attention on the U.S. HIV/AIDS epidemic, releasing America's first-ever comprehensive National HIV/AIDS Strategy and federal implementation plan. The strategy focuses on the areas of greatest need and potential impact, including: intensifying HIV prevention efforts in communities where HIV is most heavily concentrated; educating all Americans about HIV and how to prevent it; redoubling efforts to link those who need it to care and treatment; and reducing HIV-related health disparities and stigma. The end result will be a more coordinated national response to HIV/AIDS that will improve and save lives.

The White House's National HIV/AIDS Strategy strongly embraces the idea of public-private partnerships. Moreover, the strategy explicitly calls upon the CDC to work with the private sector to improve the reach and impact of U.S. HIV prevention campaigns. One of the best, fastest ways to make public education more effective is to draw on the marketing and communication skills and assets of the private sector. Business has tremendous expertise in those areas, including talented professionals willing to share what they know and help where they can.

It is in the same spirit of partnership that we have assembled the following set of case studies, reflecting a diverse cross-section of corporate efforts to address HIV/AIDS in the U.S. As such, we hope the programs highlighted here will provide a roadmap for continued and expanded business engagement on HIV/AIDS, and will inform future partnerships between the corporate community and federal, state and local governments.

The companies included in this document reflect a broad diversity of industries, including: oil and gas; entertainment; biotech and pharmaceuticals; travel and tourism; PR and marketing; consumer goods; and consulting services. By the same token, the programs in this document reflect varying degrees of scale and complexity, as well as documentation and program evaluation. Our partners were particularly challenged by the lack of data about the impact of programs that, from all appearances, seem well-conceived, well-executed and very likely effective. Even so, the case studies represented in this compilation provide a starting point for further discussion and analysis. In some cases, they provide strong models for scaling and replication.

In the coming months, GBC and our partners will add additional case studies detailing proven and promising U.S. HIV/AIDS partnerships and related learnings. Likewise, based on our experience developing these case studies, GBC also hopes to help the corporate community to design and document programs better—including tracking impact, improving knowledge sharing and replication, and ensuring that the most innovative and effective models get the attention they deserve.

U.S. HIV/AIDS CASE STUDIES

The following is a chart highlighting major public-private partnerships on HIV/AIDS in the U.S. and which of the three White House National HIV/AIDS Strategy goals they met.

❖ <i>Case Studies Included in this Document</i>	REDUCING HIV INCIDENCE	INCREASING ACCESS TO CARE	REDUCING HIV-RELATED HEALTH DISPARITIES
COMMUNITY ENGAGEMENT & SOCIAL MARKETING			
BET: “Rap-It-Up” campaign ❖	✓		✓
L’Oreal: “Hairdressers Against AIDS”	✓		
MTV: “GYT” campaign ❖	✓	✓	✓
Get Screened Oakland partnership	✓	✓	✓
Ogilvy & CDC: “America Responds to AIDS” campaign ❖	✓	✓	✓
CORE COMPETENCIES			
BMS & National AIDS Fund: “Positive Charge”		✓	✓
Boehringer Ingelheim: “Women Living Positive” ❖		✓	✓
The Female Health Company *	✓		✓
Walgreens: H1N1 campaign			
WORKPLACE POLICIES & PROGRAMS	✓	✓	✓
The Brink’s Company ❖			
The Chevron Corporation ❖			
The Coca-Cola Company ❖			
Colgate-Palmolive ❖			
Levi Strauss & Co. ❖			
Merck & Co. ❖			
Pfizer, Inc. ❖			
PHILANTHROPY	✓	✓	✓
Kimpton: “Red Ribbon Campaign” ❖			
Macy’s: “Passport Program” ❖			
Funder’s Concerned About AIDS (Appendix C)			
COMPREHENSIVE PROGRAMS	✓	✓	✓
Levi Strauss & Co. ❖			
MAC AIDS Fund			
ADVOCACY			
Deloitte LLP & Lambda Legal ❖			✓
Syringe Exchange Programs: Lending the Business Voice to End the Federal Funding Ban	✓		✓

BET: RAP-IT-UP CAMPAIGN

Rap-It-Up is a public health information campaign that addresses HIV/AIDS and related issues among Black Americans. BET utilizes multiple media platforms to achieve the Rap-It-Up campaign objectives:

- Leverage the BET brand to address the high incidence of HIV/AIDS among Black Americans;
- Increase knowledge and dispel popular myths and misconceptions about HIV/AIDS;
- Promote behaviors to reduce the spread of HIV, including condom use and testing.
- Reduce stigma and discrimination.²

ORIGINS

Rap-It-Up grew out of a public information partnership formed with the Kaiser Family Foundation in 1998 to focus on sexual health issues, including HIV/AIDS, affecting young people. The partnership included “Teen Summit” town halls, the first of which focused on “AIDS: A Crisis Among African Americans,” and targeted public service messages. In November 2000, the partnership was expanded and renamed “Rap-It-Up.”

The decision to focus on HIV/AIDS was two-fold: HIV/AIDS was an issue of growing concern in the Black community, and BET was uniquely positioned to address an increasingly vulnerable demographic. This decision was reinforced by an invitation from the National Black Leadership Commission on AIDS to attend a convening of AIDS service organizations and community-based organizations to discuss the issue of HIV/AIDS in the Black community. BET was the only company represented at the meeting, a sign that the media company was a trusted source of information within the community.

Initially, addressing HIV/AIDS among Black Americans presented a challenge for the company due to a nationwide information gap (or blindspot) about the epidemic’s impact on Black Americans. Despite this challenge, BET staff began the Rap-It-Up campaign with a series of focus groups to determine how best to convey HIV/AIDS education messages to the BET audience, which today consists of up to 86 million households. Through these focus groups, as well as with guidance from expert partners such as the Kaiser Family Foundation, BET discovered that its audience wanted information about HIV/AIDS prevention and testing, but sought anonymity.

To provide confidential and comprehensive information about HIV/AIDS for viewers, Kaiser worked with BET to develop a dedicated website (www.rap-it-up.org, now called www.rapituppresents.org) and support a toll-free hotline (1 866 RAP IT UP) and SMS service (RAPIT) to serve as a referral for all Rap-It-Up programming. Since 2000, Rap-It-Up has evolved to become a public health campaign without precedent or parallel among Black media companies.³

CAMPAIGN COMPONENTS⁴

Over the past 12 years, Rap-It-Up has made use of the following media to equip a broad segment of the Black community with accurate information and resources about HIV/AIDS:

Public service announcements and ads: BET and Kaiser have produced more than 60 public service announcements on HIV/AIDS and related issues since 1998, including: “Reality Check,” which focused on young people living with HIV/AIDS, and “25 Heroes,” about 25 remarkable Black Americans who have worked tirelessly in the struggle against HIV/AIDS. BET joined with CBS, UPN and other Viacom properties on the company-wide “Know HIV/AIDS” campaign from 2003-2008, also developed with the Kaiser Family Foundation.

Rap-It-Up radio ads have aired on Infinity and Westwood One stations.

² *Black Entertainment Television (BET) Community Intervention Case Study*: Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC), 2006; Henry J. Kaiser Family Foundation website (www.kff.org/entpartnerships/bet2/index.cfm). Accessed on February 17, 2010; James, M. et al. (2005).

“Leveraging the power of the media to combat HIV/AIDS.” *Health Affairs* 24(3):854-857.

³ Vikki Johnson, Senior Manager Public Affairs, BET. Personal communication, March 2, 2010.

⁴ *BET Community Intervention Case Study*: GBC, 2006. Vikki Johnson. Personal communication, March 2, 2010; *Rap-It-Up/BET One Sheet*, 2010.

In 2007, Rap-It-Up won an Emmy for best national public service campaign.

Full-length special programming: The 34 specials that BET has produced with Kaiser since 1998 have reached 13.3 million viewers.

Rap It Up's 30-to-60-minute specials have featured celebrities and focus on HIV testing, including specialized programming for World AIDS Day, National HIV Testing Day and Black American HIV Testing Day. Likewise, BET and Kaiser have produced programs with specialized themes such as the effect of HIV/AIDS on Black women, and sexuality and sexual identity in the Black community, explored through formats like *The Naked Truth*, an award-winning series of documentaries. In addition to developing specialized programming, BET has made a commitment to integrating HIV/AIDS messages into general entertainment programming, including Viacom television sitcoms and dramas.

Informational Resources: Since 2000, Rap-It-Up has been supported by a dedicated website (www.rap-it-up.org, now called www.rapitupresents.org) that includes basic information about HIV/AIDS, answers common questions about HIV testing and refers users to nearby testing sites. The site encourages users to discuss HIV/AIDS with their partners and includes a series of short videos featuring celebrities and others talking about HIV/AIDS. With the encouragement of BET's executive vice president of marketing, BET also incorporated information about HIV/AIDS and other sexual health issues for the BET website.

A dedicated toll-free hotline (1 866 RAP IT UP) designed and underwritten by Kaiser provides answers to frequently asked questions about HIV/AIDS, and allows callers to connect to counselors at the CDC or local Planned Parenthood health centers. An SMS service (RAPIT) was added in 2007 that allowed viewers to get information about local HIV testing locations sent to their mobile phones. Approximately, 1.5 million people have called the Rap-It-Up hotline and more than 60,000 have texted RAPIT to find a local testing center.

Rap-It-Up's website along with its toll-free hotline and SMS service have been particularly well-received because they have allowed people to anonymously inquire about HIV/AIDS without fear of stigma or discrimination.

Free sexual health information guides: Rap-It-Up has distributed more than 400,000 copies of "It's Your (Sex) Life: Your Guide to Safe & Responsible Sex," a comprehensive, 30-page booklet produced for the campaign by the Kaiser Family Foundation.

Topics Education Curricula: In partnership with the Kaiser Family Foundation, BET has produced four HIV/AIDS curricula for teens. These curricula, available either as hard copies or online to middle and high school teachers at no charge, incorporate the Rap-It-Up documentary series: *The Naked Truth*, *Jeff Johnson Chronicles*, and *Sex, Myths and the Real Deal*, and provide multi-day lesson plans, discussion guides and other resources. Similar to partnerships with local health departments, this partnership is effective in re-exposing the target audience to reputable, HIV/AIDS public education messages in an environment tailored to the audience. Rap-It-Up's curricula have been effective in equipping middle and high school teachers as reliable sources of HIV/AIDS information for their students.⁵

On-the-ground activities: The Rap-It-Up campaign focuses its on-the-ground activities in areas with high HIV prevalence among Black Americans. BET collaborates with public health departments to supplement local testing and awareness events with Rap-It-Up assets (e.g., concerts, celebrity appearances, movie viewings), on-site HIV testing and distribution of educational materials. These road tours piggy-back on some of the nation's largest Black community events. In addition to community testing events, Rap-It-Up tours fourteen historically Black colleges each year in partnership with groups such as the United Negro College Fund. The college tour program began with events at King's Dominion theme park in Virginia, where Rap-It-Up offered free concert tickets as an incentive to take an HIV test.

BET also sponsors outreach events at public high schools: BET talent hosted the Teen Summit Forum, which features people living with HIV/AIDS and public health experts. The Teen Summit Forums have created a platform for people

⁵ *Rap-It-Up/BET One Sheet*, 2010.

living with HIV/AIDS to share their experiences with the teen audience. **Over 20,000 teens have participated in Rap-It-Up teen forums in over 33 markets in the United States, the Virgin Islands and Canada.** For instance: in March 2010, Rap-It-Up hosted a forum at the Women’s Academy of Excellence in the Bronx, NY, in partnership with the Mary J. Blige Foundation (Blige was the keynote speaker at the event).

THE POWER OF PARTNERSHIPS

BET’s campaign successes are predicated on the company’s commitment to partnership. The Rap-It-Up campaign has proved effective because BET has shared key messages with its broad-base national audience and reinforced those messages with deeper engagement activities at the community level. To successfully achieve this strategy, BET has formed partnerships and alliances based on the particular needs of each campaign component.

The Kaiser Family Foundation

BET’s partnership with the Henry J. Kaiser Family Foundation has been important for two reasons: as an operating foundation, Kaiser serves as a strategic and substantive partner as well as provides financial resources toward the campaign. The Kaiser Family Foundation draws on its long history working in HIV/AIDS policy and communications to bring to Rap It Up a deep understanding of the U.S. HIV/AIDS epidemic and a dedication to impact and results.⁶

BET and Kaiser collaborate on Rap-It-Up with a clearly articulated set of roles and responsibilities; the partnership was designed to capitalize on each organization’s strengths. BET, as a media company with demographic savvy and creative expertise, works with Kaiser, an organization with public health expertise, helping BET integrate public service ads on HIV/AIDS and prevention messaging into much of its network programming. Kaiser has been particularly important for the broad national components of the campaign.

To implement Rap-It-Up, each year BET and Kaiser draw up a “memorandum of understanding.”⁷ BET provides creative and communications expertise; on-air programming on the issues addressed by the campaign; and guaranteed placement of public service ads to reach target audiences. Kaiser’s contributions include issues research; briefings for writers, producers and other media staff; substantive guidance on message development; and funding to support program production and the creation of informational resources for consumers.⁸

Local Health Departments

Rap-It-Up complements and operationalizes its national messaging through partnerships with local communities. National broadcasts expose the audience to broad HIV/AIDS prevention and awareness messages, while community events provide a real-time opportunity to take action on HIV/AIDS prevention and testing in local communities. BET cites its interaction with local communities, most often facilitated by the local health department, as an especially effective form of partnership.

Typically health departments contact BET to request support for HIV prevention, testing and special events. Rap-It-Up employs the BET brand to drive audiences to an event and asks the health department to engage local community-based organizations and provide basic resources (such as HIV tests, venue and media engagement). For its part, BET also provides celebrity power and giveaways for events. Notably, BET’s on-the-ground presence extends beyond the event day, as the events are influential to positioning the local health department as a credible, reliable resource for the community. Rap-It-Up plays an important role in encouraging the community to rely on local health departments for information and resources beyond the event date.⁹

RESOURCE REQUIREMENTS

⁶ Vikki Johnson. Personal communication, March 2, 2010.

⁷ Stephen Massey, Associate Director, Entertainment Media Partnerships. Personal communication, February 18, 2010.

⁸ Stephen Massey. Personal communication, February 18, 2010.

⁹ Vikki Johnson. Personal communication, March 2, 2010.

Initiatives like Rap-It-Up require human resources, including staff to oversee the program and its partnerships and to implement key activities, as well as creative staff. BET has three staff members dedicated to the Rap-It-Up initiative.

In addition to significant strategic and substantive staff support, Kaiser has invested more than \$5.2 million in the partnership with BET to support production of PSAs and other programming and the core informational resources that support the campaign (website, toll-free hotline, SMS service, printed materials) since 1998. BET makes a major investment in Rap-It-Up through the air time, talent, and creative resources it provides, valued at many millions of dollars. The early commitment of BET senior management to Rap-It-Up facilitated this valuable contribution. Where direct funding is limited, Rap-It-Up is able to draw upon its relationships with partners to provide support.¹⁰

OUTCOMES

In 2004, a Kaiser Family Foundation survey of 800 Black Americans aged 18 to 24 demonstrated the impact of the Rap-It-Up campaign on the community's attitudes about HIV/AIDS, their knowledge of HIV risk and transmission, and what, if any, action they had taken. The survey results showed:

- 82% reported that they learned a significant amount about HIV/AIDS and other sexually transmitted infections, and about how HIV/AIDS affects the Black American community in particular.
- 83% reported that they were more likely to take their sexual relationships seriously.
- 77% were more likely to use condoms if they engage in sexual activity.
- 45% learned how to talk to a partner about HIV/AIDS.
- 52% said that they had spoken to a partner about safer sex.
- 28% had been tested for HIV/AIDS.
- 23% had visited a doctor.
- 37% had either visited a doctor or were tested for HIV/AIDS.
- 57% learned how prejudice against gay people contributes to the HIV/AIDS epidemic.¹¹

The survey results have proved essential as BET continues its education and outreach to the target audience. However, this type of detailed monitoring and evaluation is rare, as the cost often is perceived as prohibitive.

Upon reflection, BET staff cite a number of factors contributing to the campaign's successes to date:

- The company's willingness to invest in multiple platforms for message integration, both nationally and in local communities, so that the audience receives not only broad, but also tailored messages;
- Monitoring and evaluation have permitted an increased investment in BET staff resources (e.g., media platforms, celebrity endorsement);
- Unfailing commitment of senior leadership within the company.

CONCLUSION

BET together with Kaiser has spent the past 12 years building Rap-It-Up and establishing a virtual "safe space" for Black Americans to discuss HIV/AIDS. BET uses the power of its brand to draw in its audience. Rap-It-Up builds upon the Black community's trust in BET, and extends the power of that trust to transform the media company into a reliable source of health information, as well as entertainment. By the same token, the campaign has been extremely beneficial to the BET brand.

The Rap-It-Up campaign will continue its efforts to reach youth and young adults (ages 13 to 30) with a particular focus on HIV/AIDS prevention for Black American women. Going forward, the campaign will begin integrating prevention messaging for men and women over 40. Throughout all of Rap-It-Up's segmented messaging, the campaign will continue

¹⁰ Stephen Massey. Personal communication, February 18, 2010; Vikki Johnson. Personal communication, March 2, 2010.

¹¹ Victoria Rideout. *Assessing Public Education Programming on HIV/AIDS: A National Survey of African Americans*. Henry J. Kaiser Family Foundation: Menlo Park, CA, 2004.

to address the issue of stigma. BET's ultimate ambition is to continue to arm its audience with HIV prevention and testing tools, although HIV/AIDS message fatigue is a constant challenge to this goal.¹²

¹² Vikki Johnson. Personal communication, March 2, 2010.

BOEHRINGER INGELHEIM: WOMEN LIVING POSITIVE PROGRAM

Headquartered in Ingelheim, Germany, Boehringer Ingelheim operates globally with 138 affiliates in 47 countries and approximately 40,000 employees. Boehringer Ingelheim Pharmaceuticals, Inc. is a member of the Boehringer Ingelheim group of companies—one of the world’s 20 leading pharmaceutical companies—and is the engine behind Women Living Positive, a program that provides information about HIV/AIDS and resources within American communities to enable women with the disease to live healthy, affirming lives. The Women Living Positive program’s design is based on a survey of HIV-positive women that Boehringer Ingelheim Pharmaceuticals, Inc. conducted, which identified key knowledge gaps within the target population.

THE SURVEY AND RESULTS

A baseline survey of 700 HIV-positive women carried out in partnership with the Well Project formed the foundation for Boehringer Ingelheim and Women Living Positive to address critical knowledge and behavior gaps. The survey showed that 55 percent of women with HIV interviewed had never discussed with their health-care provider how HIV medications might affect them differently from men. More than half of the women surveyed had never discussed with their health-care provider how pregnancy might affect their illness and general health. Finally, almost three quarters of the women surveyed indicated that HIV/AIDS was a struggle in their daily lives. Based on these results, and in consultation with the Well Project, Boehringer Ingelheim developed the “Women Living Positive” program.

THE PROGRAM

Boehringer Ingelheim’s Women Living Positive program is notable for the unique way in which it is helping HIV-positive women take control of their health and build stronger, supportive bonds with one other. The project taps into strong partnerships between Boehringer Ingelheim, the Well Project, and community-based organizations to provide innovative programming that increases HIV-positive women’s knowledge of their own medical condition, extends their ability to access resources related to their illness, and ultimately improves their quality of life in general.

The initiative has accomplished these objectives through a series of seven summits across the country, which have brought together more than 650 HIV-positive women, along with local AIDS service organizations and leaders from the HIV/AIDS community. The summits have featured key-note addresses by notable women living with HIV/AIDS, such as Andrea Williams, the inspiration for the HBO original movie “Life Support,” and activist Michelle Lopez. Additionally, the summits have covered topics unique to women living with HIV/AIDS, including family planning, preventing mother-to-child HIV transmission, and the challenges many women face living with HIV/AIDS and being primary caregivers for their children. Also, each summit has been webcast in English and Spanish.

The Women Living Positive program and its affiliated summits have proved an effective way of reaching out to HIV-positive women and encouraging them to tap into existing resources to help manage their disease. For example: In surveys following the summits, 97 percent of attendees said they planned to speak with their doctors about creating an individualized treatment plan. The program also has led women to develop similar, and longer-term, support structures for themselves and others, after attending the summit. One woman from a rural area who expressed frustration at not being able to find local support created her own support group with contacts she made at the Fort Lauderdale summit.

Boehringer Ingelheim also made generating media awareness a core component of the initiative. The company identified a well-respected infectious disease specialist and HIV/AIDS patient advocates in each market to help raise media consciousness and understanding of the issues facing HIV-positive women. The resulting media coverage—of which 90 percent included key HIV/AIDS messages—reached a combined audience of 11.4 million through radio, print and television reporting.

PUBLIC-PRIVATE PARTNERSHIP

The strong partnership and close collaboration between the Well Project and Boehringer Ingelheim make the project possible. The Well Project possesses knowledge of the HIV/AIDS service organization landscape and a practical understanding of the challenges faced by women living with HIV/AIDS, gaps in care, and challenges faced by organizations seeking to deliver care and support. Likewise, Boehringer Ingelheim's capacity to conduct the large-scale surveys necessary to identify key issues for women living with HIV/AIDS has been critical to the success of the Women Living Positive program. And, because of the program's careful design, partnership infrastructure, and promising results, the Women Living Positive model is a great candidate for deeper study and for replication in other cities and regions.

DELOITTE LLP: REMOVING THE HIV/AIDS TRAVEL BAN

From 1987 through the end of 2009, the United States Department of Health and Human Services imposed a travel ban on HIV-positive visitors to the country, under the premise that HIV falls into a category of “dangerous and contagious” diseases that present a public health risk. The ban was not codified into law, however, until 1993, at the behest of U.S. Senator Jesse Helms, much to the chagrin of human rights advocates around the globe. This legislation made HIV the only specific medical condition mentioned as grounds for inadmissibility to the United States.

Over time, the law evolved to prohibit foreigners from immigrating or obtaining a travel visa to the United States without submitting to an HIV test. If they were positive, they were required to disclose their HIV status, and were prohibited from entering (but could apply for a special visa waiver). The ban’s many opponents argued that the legislation was just another in a long string of U.S. HIV/AIDS policy inconsistencies. Recently, Dr. Helene Gayle, President and CEO of CARE and Chair of the Presidential Advisory Council on HIV/AIDS under President Obama, noted that the ban was at odds with the U.S.’s demonstrated, global leadership via PEPFAR (the President’s Emergency Plan for AIDS Relief).

As of 2009, only about a dozen countries around the world maintained a travel ban on people living with HIV, among them: Iraq, China, Saudi Arabia, Libya, Sudan, Qatar, Brunei, Oman, Moldova, Russia, and Armenia—alongside the United States.

On July 30, 2008, President Bush signed into law a five-year, \$48 billion bill to fight HIV/AIDS, malaria and tuberculosis around the world, as well as lift the U.S. ban on HIV-positive travelers. Despite President Bush signing the bill mandating removal of the ban, HIV remained on the list of “dangerous and contagious” diseases that may prevent entry into the United States. As such, the Department of Health and Human Services had to write a new “rule”, submit it for public comment, and finalize it.

In the summer of 2009, the U.S. Department of Health and Human Services (HHS) issued a request for public comment about proposed HHS language to rescind the travel restriction—and also feedback on any public health, economic, and other implications stemming from the rule change. While many in the HIV/AIDS and human rights communities felt well-equipped to speak to the human injustices resulting from the ban, few felt qualified to speak credibly to the economic questions, analyses, and trade-offs put forth by the Administration.

To that end, GBC provided its own letter of support for lifting the ban, noting that the burdensome policy violated the right to privacy, freedom of movement, and freedom from discrimination for people with HIV/AIDS, with adverse implications for civil society, for America’s standing in the world—and for U.S. and multi-national companies, whose HIV-positive employees and executives face significant and undue hurdles to entering the United States even for routine business purposes. In many cases, the HIV ban policy also required that companies disregard their own policies prohibiting HIV status discrimination in the workplace. Likewise, GBC members Pfizer Inc., Levi Strauss & Co., and OraSure Technologies also submitted letters expressing support for the ban’s lifting.

Lambda Legal Defense and Education Fund and the Whitman Walker Clinic turned to Deloitte, a leading global consultancy and accounting firm, to review the Administration’s economic analyses. Ultimately the Deloitte team’s assessment concurred with that of the Administration: the economic impact of lifting the ban would be negligible (see Appendix A for full report).

In October 2009, President Obama signed into effect an order overturning the 22-year-old travel and immigration ban against people living with HIV.¹³

¹³ Case study based on interview with Immigration Equality senior leaders and externally available information

FEMALE HEALTH COMPANY: THE FEMALE CONDOM PROJECT

Partnerships with both the public and private sector have proved crucial to the success of the Female Health Company's female condom, the only available FDA-approved product controlled by women that offers dual protection against sexually transmitted infections, including HIV/AIDS, and unintended pregnancy.

Since the mid-1980s, private investors have provided more than \$140 million to develop, secure regulatory approval of, and launch the female condom. Global public-sector agencies, country governments, and public and private donors have been instrumental in helping the Female Health Company achieve its goal of providing "women affordable access to woman-initiated HIV prevention and putting the power of HIV prevention in women's hands."

Thanks in large part to these partnerships, the female condom is now available in over 100 countries worldwide. The company's global market and distribution network has been significantly enhanced by working with public-sector partners with expertise in social marketing to key demographic groups.

U.S. PARTNERSHIPS

The Female Health Company has achieved success globally by building effective public-private partnerships with the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA) and a wide array of bilateral aid agencies, private foundations, and international NGOs committed to advancing women's access to HIV prevention.

The U.S. context has proved different, however. The female condom's U.S. market is largely underdeveloped—further compounding the problem that the female condom is more expensive to produce than the male condom. In order to survive and succeed within the U.S. market, the Female Health Company has entered into multiple innovative public-private partnerships to provide increased access to and information about the second-generation female condom, FC2.

Backed by a \$500,000 grant from the M•A•C AIDS Fund, and in concert with CVS Pharmacy, the Washington AIDS Partnership, and the D.C. Department of Health, five local non-profit organizations are distributing over 500,000 female condoms through a grassroots prevention and education program in the neighborhoods of Washington, D.C. hardest hit by HIV/AIDS.

Additionally, female condoms is available for widespread purchase at 56 CVS Pharmacy stores in the District to help increase female condom access and normalize female condom use. The program represents a paradigm shift in HIV/AIDS prevention activities targeting women and offers a new weapon to combat the epidemic.

The Female Health Company is also supporting the Chicago Female Condom Campaign. This social marketing initiative includes a coalition of 20 HIV/AIDS, reproductive justice, and women's and men's health organizations that will work together to mobilize outreach to women and men at risk for HIV/AIDS in Chicago. The campaign is conducting a multifaceted communications and marketing effort to promote the female condom as both an acceptable and affordable HIV-prevention option for women and men.

With funding and technical support provided by the Female Health Company and other partners, the campaign is supporting in-person training to equip Chicago-area service organizations with the skills to promote female condom use. The campaign is also using a mixture of social media channels to increase awareness, launching a "Female Condom" website, a Facebook fan page, and a Twitter account. The Female Health Company also aids in the distribution of free FC2 female condoms and has created a bulk purchasing program for public health clinics, health-care providers, family-planning centers, and other local organizations. Through large-volume purchases, the program is providing FC2 female condoms at a discounted cost, an incentive that the campaign hopes will expand the product's usage.

Additional public private work is ongoing for female condom introductory programs scheduled for San Francisco and Houston.

RESOURCES

The Female Health Company is the sole manufacturer and marketer of the female condom, with direct-to-consumer sales in 15 countries since 2005. Global public-sector agencies, national governments, and public and private donors also have been instrumental in helping the female condom gain greater global acceptance. Comparatively high production costs for the female condom versus the male condom have necessitated subsidies, in addition to volume-based pricing, for public-sector distribution. The Female Health Company sells FC2 in the United States to city and state public health clinics, as well as not-for-profit organizations such as Planned Parenthood.

The Female Health Company has entered into several partnership agreements to raise awareness of, expand access to, and ensure the affordability of the female condom for at-risk populations within the United States. As such, the company is dependent upon U.S. municipal and state public health departments, in addition to appropriate private-sector partners and donors, to continue HIV/AIDS prevention programs that include FC2 as a component of such programs.

PARTNERSHIP GOVERNANCE

Governance of the Female Health Company's public-private partnerships is relatively informal. For the D.C. partnership, a representative is appointed from each of the key players—the Department of Health, M•A•C AIDS Fund, CVS and the Female Health Company—to oversee the partnership. However, unlike a corporate board of directors, there is no regularly scheduled review of activities. As the partnership moves out of the start-up phase and into the monitoring and evaluation phase, greater performance measurement is expected. While there is no formal contract binding the four partners together, there is a contract between the M•A•C AIDS Fund and the U.S. Government for the \$500,000 grant.

The Female Health Company's Board of Directors has adopted Corporate Governance Guidelines to assist the Board in the exercise of its responsibilities. These guidelines reflect the Board's commitment to monitor the effectiveness of policy and decision-making at both board and management level, with a view to enhancing shareholder and community value over the long-term.

MUTUAL BENEFITS

The Female Health Company's public-private partnerships strengthen HIV/AIDS education and prevention programs, as well as the distribution of female condoms to at-risk populations within the public sector. The Female Health Company benefits from increased product awareness through these partnerships, which coincides with its product re-launch to the commercial sector. This partnership also fulfills partners' shared commitment to address the link between poverty and HIV/AIDS, by supporting diverse organizations, particularly organizations in underserved communities.

Through its private-public collaborations, the Female Health Company has increased U.S. and global distribution of the female condom, for the prevention of HIV/AIDS, other STIs, and unintended pregnancy, and forged a public-private partnership model that is replicable and scalable. The success of this effort illustrates how leveraging and maintaining relationship with the public and private sectors can positively advance HIV/AIDS prevention.

KIMPTON: RED RIBBON CAMPAIGN

The Kimpton Hotel and Restaurant Group, Inc., is the largest chain of boutique hotels in the United States. Founded in 1981 and headquartered in San Francisco, California, Kimpton's corporate mission is to "offer a unique hotel and restaurant experience with personalized services for its clientele." Kimpton's corporate mission is complemented by its community mission to lend unique support to the communities in which employees live and work.

Since the company's founding, Kimpton, its employees and its guests have been impacted deeply by the HIV/AIDS epidemic, in San Francisco and throughout the country. In response, Kimpton's management, including its founder, Bill Kimpton, instituted a series of initiatives to assist HIV/AIDS service organizations across North America, culminating in the "Red Ribbon Campaign," a fundraising effort that focuses on HIV/AIDS awareness and education in communities where Kimpton operates.

As an outgrowth of the U.S. Centers for Disease Control, Business Responds to AIDS (BRTA) decision in 2001 to engage the hospitality industry, the National AIDS Fund, as a BRTA grantee, set forth to establish relationships with leaders in the industry, like Kimpton, to build meaningful collaborations between NAF, hospitality companies and BRTA. NAF presented the Kimpton Group with a business and philanthropic case for engagement—a strategy that would become the Red Ribbon Reservation campaign.

In 2003 Kimpton partnered with the National AIDS Fund (NAF) to pilot the "Red Ribbon Reservation Campaign". Across the country, Kimpton's seven Hotel Monacos launched the "Red Ribbon Reservation", a fundraising effort focused on AIDS awareness and education. For a two-month period, the program offered guests the chance to book a Red Ribbon reservation; in turn, the company would donate a portion of its proceeds to the fund. NAF used the funds raised to support its 29 Community Partnerships across the United States—providing the Kimpton Group with national marketing visibility and local impact.

Tent cards featuring HIV/AIDS facts and HIV testing information, as well as information about the Red Ribbon Reservation program were placed throughout each hotel property, including prominently at the front desk, in the restaurant/bar areas and in every guest room. A special pin card, featuring HIV/AIDS facts and information on the Red Ribbon Reservation program was placed on the pillow of every bed in the hotel. This card also featured an AIDS Red Ribbon pin and guests were encouraged to wear the pin in support.

In the two-month trial, the Red Ribbon Reservation program raised \$10,000 for NAF's Community Partnerships. The campaign met with great success and appreciation from GLBT guests as well as the public at large, providing a new awareness of the market support. "The thanks we received were truly gratifying," said Andrew Freeman, then-Vice President of the Kimpton Group. "The level of support told us that we were on to something and we had good market share."

In 2004, the Red Ribbon Campaign went national to include all Kimpton properties, and in 2005, Kimpton made a commitment to raise additional funding during a yearlong campaign. Kimpton also hosted nationwide fundraising events at ten of its hotels on World AIDS Day in 2005, as well as provide company-wide HIV/AIDS awareness and workplace sensitivity training for all employees, including management.

Today, the Red Ribbon Campaign's primary focus is to provide philanthropic support to HIV/AIDS non-profit organizations in the hotel group's many United States locations—approximately 50 hotels in 20 cities. Kimpton continues to raise money for local AIDS service organizations through a variety of community-based activities each year, including:

- "Join the Fight by Staying the Night": \$10 of the room rate goes to a local HIV/AIDS service organization.
- "Kimpton Style": An online "shopping-for-a-cause" site. Kimpton donates 100% of the proceeds to its Red Ribbon Campaign.

- “Red Hot Nights”: Kimpton’s Annual Red Ribbon Fundraising Parties. Every November and December, Kimpton staff and guests band together for fun and to raise money for local HIV/AIDS service organizations.
- “Cocktails for a Cure”: Kimpton donates one dollar of every cocktail purchased in a Kimpton restaurant or lounge to a local service organization.

PARTNERSHIP ROLES AND RESPONSIBILITIES

Each Kimpton city has a local champion and a committee for the Red Ribbon Campaign initiative. One to two Kimpton employees is/are responsible for managing and monitoring Kimpton’s relationships with local non-profit organizations (the committee role is an additional responsibility for employees and is not their sole function). Each committee typically adopts one local non-profit organization as its primary Red Ribbon partner, and often supports other non-profits in the area. The Red Ribbon committees from each city meet on a quarterly basis to share information and best practices. Red Ribbon Campaign committee members are incentivized through company-wide recognition programs.

Kimpton has hired outside contractors to oversee and monitor its initiatives, as well as ensure that each committee adheres to the company’s national strategy. Andrew Freeman (Andrew Freeman & Company) helped form the Red Ribbon Campaign in 2003 and coordinate, with David Paisley, the Red Ribbon Campaign and Lesbian Gay Bisexual Transgender (LGBT) initiatives. Both Freeman and Paisley report to K-PRIDE, the LGBT employee network of over 100 Kimpton employees from the company’s sales, marketing and human resources divisions, among others—evidence that the Red Ribbon Campaign is largely employee-driven.

While the two major parties in Kimpton’s public-private partnerships are the local Red Ribbon Campaign committees and the local non-profit HIV/AIDS organizations, many other stakeholders are involved in Kimpton’s initiatives, including Kimpton management and employees, larger private organizations (e.g., American Airlines), hotel vendors, and Kimpton customers.

Kimpton’s main criterion for evaluating partnerships with non-profit organizations is the potential to have a significant impact on a specific organization. The company aims for the partnership to not only improve the ability of a non-profit organization to accomplish its mission, but also to increase community awareness of the organization, with the goal of enticing other companies and funders to partner with the chosen non-profit organization.

CONCLUSIONS

Impacts from Kimpton’s Red Ribbon Campaign and other initiatives vary from city to city—chief among them, since 2008 Kimpton has raised upwards of \$90,000 for local non-profit organizations each year. Likewise, through its Red Ribbon Campaign, Kimpton realizes benefits on multiple levels: the company retains many of its employees because of its strong commitment to HIV/AIDS and the LGBT community broadly, and it has built a leading brand within the LGBT community and its allies.

After many years of experience, Kimpton has learned a number of key lessons about administering a unified philanthropic campaign in communities across the country, including the following:

- A centralized planning and coordinating process is essential to the success of the Red Ribbon Campaigns in each city.
- Using local resources and donating to local organizations have been crucial to the success of this volunteer-driven initiative, allowing internal and external stakeholders to see directly the impact of their contribution.

LEVI STRAUSS & CO.

A HISTORY OF LEADERSHIP

For more than 155 years, Levi Strauss & Co. has sought to bring the pioneering values of empathy, originality, integrity and courage to life in how it makes its products and takes bold stands on the issues of the times. The way the company cares for the environment, its employees, supply chain workers and the communities in which it operates reflects these values. Levi Strauss & Co. strives to take pioneering positions, occasionally supporting potentially unpopular causes, because the company knows it can make a difference and break new ground with best practices in corporate social responsibility.

Since its inception, the relationship between Levi Strauss & Co., its products, its employees and its customers has been deeply woven into the fabric of the company: shortly after opening his dry goods business, the company's founder, Levi Strauss, donated \$5 to a local orphanage, and in 1897, he went on to endow twenty-eight scholarships at the University of California, Berkeley which are still in place today.

Recognizing that meaningful change does not happen in a single business cycle, the Levi Strauss Foundation was created in 1952 to address the critical social issues of the times. Millions of dollars and hundreds of volunteer hours later, the Levi Strauss Foundation is an independent, private foundation working at the forefront for meaningful social change around the world. Through its grant partnerships, the Levi Strauss Foundation's current efforts focus on eradicating discrimination against people living with HIV/AIDS, helping marginalized individuals and families worldwide through asset building and ensuring that workers' rights are protected.

EMPLOYEE AND COMMUNITY ENGAGEMENT

Levi Strauss & Co. began its long history of action on HIV/AIDS at the first emergence of the epidemic in 1982 when a group of employees in San Francisco wanted to distribute educational materials to co-workers about an unknown but potentially deadly disease. These employees were afraid that they would be stigmatized because other employees would assume that they were gay. To reassure them, senior leaders—including Bob Haas, the CEO of the company at the time—distributed information in the lobby of the company's headquarters to alleviate fears and communicate the importance of educating the work force about HIV/AIDS. With this, the first major corporate response to HIV/AIDS was born.

The following year, the Levi Strauss Foundation made its first matching gifts to the Kaposi's Sarcoma Clinic at San Francisco General Hospital, and Levi Strauss & Co. headquarters formed its first AIDS support group. As community service organizations gained experience and knowledge, the company was able to transfer lessons and information from the community back into its workforce. Since these early days, the company and the foundation have provided more than \$40 million in grants to non-governmental organizations in more than 40 countries.

Levi Strauss & Co. continues to encourage employee engagement on HIV/AIDS through its matching grant program and by supporting employee volunteerism. In 2000, the company sponsored its first "Community Day"—an initiative designed to inspire employees in San Francisco to volunteer with local nonprofit organizations. Today, hundreds of Levi Strauss & Co. employees in more than 40 countries around the world participate in Community Day each year. During the rest of the year, "Volunteer Release Time" allows full-time, salaried employees in the United States to spend up to four hours per month, as paid time away from the office, to volunteer at the nonprofit organization of their choice. Additionally, the "AIDS Action Group," which consists of 25 core employees based at the company's San Francisco headquarters, focuses on encouraging employee participation in annual events such as AIDS Walk and World AIDS Day.

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¹⁴ Ibid.

In 2006, Levi Strauss & Co. joined with the Clinton Global Initiative to make a new commitment to revitalize and expand its employee HIV/AIDS workplace policies, education and benefits. The program provides innovative and interactive in-person and online HIV/AIDS prevention education, while striving to improve access to voluntary and confidential HIV testing, treatment and care.

The company's HIV/AIDS program is designed to reach all of our employees and their families in more than 40 countries where it operates. The goal is to ensure that employees have access to HIV/AIDS prevention, education, comprehensive treatment through the establishment of a global system for case management and reimbursement for HIV/AIDS services. Information is provided through the program website (www.hivaids.levi.com) that includes valuable information about available benefits.

Beyond its own operations, Levi Strauss & Co. is committed to sharing best practices in the development and implementation of HIV/AIDS workplace programs with other companies, particularly those in the apparel industry. To that end, the company is rolling out best practices in HIV/AIDS education to its supplier factories in select locations from Mexico to Africa.

SENIOR LEADERSHIP AND ADVOCACY

The hallmark of Levi Strauss & Co. senior leadership involvement and advocacy for HIV/AIDS programs began in 1982 under President and Chief Executive Officer Robert Grohman, who, along with other senior managers, supported comprehensive HIV/AIDS education and health services for Levi's® employees, their families and the community at-large.

Levi Strauss & Co. has long been a vocal advocate for nondiscrimination and the elimination of HIV/AIDS-related stigma. In 1986, still early in the HIV/AIDS epidemic, the company hosted an "AIDS in the Workplace" conference at the Levi's® Plaza in San Francisco. Participants included 200 people representing 100 different companies and the conference resulted in the first curriculum for HIV/AIDS education in the workplace which was ultimately adopted by various corporations nation-wide.

In 1990, the company's President and CEO, Bob Haas, continued the tradition established under Robert Grohman, by presenting the Levi Strauss & Co. HIV/AIDS workplace program to President George H. Bush. In 2008, current President and CEO John Anderson, along with representatives of more than 100 other companies, pledged to combat HIV/AIDS-related stigma and discrimination around the world in an effort to stop the spread of the disease.¹⁵

Since the advent of the HIV/AIDS pandemic, Levi Strauss & Co. has sought to influence policy makers and shape the global response to HIV/AIDS. The company continues its leadership agenda by focusing on education efforts and by fighting stigma and discrimination.

As the first global company focusing on HIV/AIDS in the workplace, Levi Strauss & Co. has participated with key global organizations, including the International Labor Organization (ILO), to help shape global recommendations on HIV/AIDS in the world of work. In the U.S. the company has assisted the Obama Administration in developing a National HIV/AIDS Strategy, and has advocated at the European Parliament in roundtable discussions on how stigma and discrimination impacts communities affected by HIV/AIDS.

In 2009, the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) presented Levi Strauss & Co. with its prestigious Richard Holbrooke Leadership Award in recognition of more than 25 years of leadership on fighting HIV/AIDS. The GBC put a spotlight on the company's pioneering and comprehensive approach to combating HIV/AIDS from employee treatment and prevention programs to public policy advocacy to consumer education and support for HIV/AIDS nonprofit organizations.

¹⁵ Levi Strauss & Co. Timeline, 2005.

PHILANTHROPY

While advocating for change requires visible leadership and action by company leaders, the Levi Strauss Foundation recognized early on that there is a need to create a supportive environment to combat the stigma and discrimination associated with HIV/AIDS, by using a “top-down, bottom-up” approach. This led to strategically focusing advocacy efforts and working with people living with HIV/AIDS—including men who have sex with men, drug users and sex workers.

In responding to HIV/AIDS over the past three decades, Levi Strauss & Co. and the Levi Strauss Foundation have followed several guidelines for selecting grantees:

- *Model adoption*: organizations that understand how innovative models work and what they need to succeed
- *Changing laws and policies*: partners who have mastered the skills required for effective advocacy
- *Consensus Building*: teams who can collaborate and communicate with government and public health officials as well as constituents around a focused and unified agenda

Merle Lawrence, Senior Manager of the Levi Strauss Foundation, articulates the foundation’s philosophy on philanthropy: “Our motto is ‘support the prophets, not the chorus.’ We try to find social innovators and entrepreneurs, visionaries.”¹⁶

SUPPORTING COMMUNITY-LEVEL ADVOCACY

In 1983, the Levi Strauss Foundation became the first U.S. corporate foundation to address the HIV/AIDS epidemic. Since then, the foundation has evolved its strategies, adapted lessons, and pioneered new approaches to address the changing face of this global epidemic. Levi Strauss & Co. and the Levi Strauss Foundation have contributed more than \$40 million in grants to HIV/AIDS service organizations in more than 40 countries.

Through its grant partnerships, the Levi Strauss Foundation’s current efforts focus on eradicating discrimination against people living with HIV and providing assistance to those who are most vulnerable to infection. The foundation supports policy advocacy, law reform and other efforts to ensure that people living with HIV/AIDS are treated with dignity and respect and have access to critical services. Some of these partnerships include:

- **Balm in Gilead & the Black AIDS Institute**: Partnerships with Balm in Gilead, national organization working to offer effective anti-homophobia messages and transform African American churches into centers of support for people living with HIV/AIDS, and the Black AIDS Institute, a Los Angeles-based think tank.
- **Black Brothers Esteem**: A branch of the San Francisco AIDS Foundation that works to empower African American men in San Francisco to confront issues that affect their communities including HIV/AIDS, racism, drug use, poverty, homophobia, violence and marginal housing conditions.
- **Syringe Access Fund**: A multi-year grant making initiative aimed at diminishing the risk of HIV infection in the United States and Puerto Rico by increasing access to sterile syringes for intravenous drug users.

Two examples of exemplary Levi Strauss Foundation grantees are Get Screened Oakland and the HIV Prevention Justice Alliance:

Get Screened Oakland

Fueled by homophobia, injection drug use, homelessness and poverty, Oakland is home to a severe HIV/AIDS epidemic among African Americans and Latinos. In 1998, with the help of U.S. Congresswoman Barbara Lee (D-Oakland), U.S. Secretary of Health and Human Services, Dr. Donna Shalala, and Shalala’s then-deputy, Dr. Marsha Martin, Oakland was

¹⁶ Merle Lawrence. Personal communication, April 14, 2010.

the first congressional district in the United States to declare that HIV/AIDS rates among black constituents constituted a state of emergency. In response to the crisis, and the disturbing fact that many HIV-positive Oakland residents had already advanced to the stage of AIDS before taking their first HIV test, Oakland Mayor Ronald V. Dellums, Dr. Marsha Martin, two local filmmakers, Abby Ginzberg and Dedocio Habib, and community foundation executives began looking for strategies to address this crisis. Their efforts resulted in the creation of “Get Screened Oakland,” a ground-breaking campaign to encourage Oakland residents aged 13 to 64 to get tested for HIV, which received its initial funding from the Levi Strauss Foundation. Since the launch of Get Screened Oakland in 2007, the program has demonstrated an increase of 20 percent in HIV testing rates.

The first citywide campaign began in June 2007, and the Levi Strauss Foundation, together with the Gilead Foundation and the Alameda County Department of Public Health/Office of AIDS, provided the start-up funding. The Levi Strauss Foundation has provided a total of \$250,000 since its first grant in 2006 to develop campaign messaging and outreach materials. The Foundation’s 2009 grant will allow the program to be replicated and expanded in other U.S. cities heavily impacted by HIV.

The HIV Prevention Justice Alliance

The HIV Prevention Justice Alliance, founded in 2009, is a network of more than 70 groups focused on establishing a unified, effective movement for HIV/AIDS prevention in the United States. The Levi Strauss Foundation provides general support to expand and enhance the Alliance and its efforts to ensure a robust and effective National AIDS Strategy. The main coordinator of the Alliance is the Community HIV/AIDS Mobilization Project, in collaboration with the AIDS Foundation of Chicago and SisterLove, an Atlanta-based reproductive and sexual health organization. The Alliance’s motto is: “HIV/AIDS is not just a disease; it’s proof positive of injustice.” As such, the group works to ensure that marginalized communities and issues are brought to bear on an effective HIV/AIDS advocacy effort and that human rights issues remain central to the HIV/AIDS response.

The HIV Prevention Justice Alliance focuses on policy goals in three main areas:

- The need for a paradigm shift in prevention efforts that addresses the social determinants, including poverty, that fuel the epidemic;
- Research methods as a means of framing and answering questions in neglected communities; and
- Cross-governmental collaboration (including the need for an operative national HIV/AIDS strategy) to coordinate federal, state and local HIV-prevention efforts.

Like Get Screened Oakland and the HIV Prevention Justice Alliance, the most successful Levi Strauss Foundation-funded domestic HIV/AIDS programs share the following characteristics:

- Collaboration at all levels;
- Understanding the unique role of private philanthropy vis-à-vis public sector responses;
- Scalability, as in the case of Get Screened Oakland, where Levi Strauss & Co. partnered extensively with local government; and
- A focus on helping the most marginalized and vulnerable populations,

CONCLUSIONS

More than 30 years of experience in addressing the HIV/AIDS pandemic has revealed that collaboration is essential for a sustained, long-term commitment:

- Government, community organizations and businesses work best together as partners.
- Government is an instrumental partner when it fosters genuine dialogue among key stakeholders including businesses, donors and community-based organizations.

- Clear direction from government on a national strategy for addressing the HIV/AIDS epidemic allows companies contribute their best resources.¹⁷

What started as a grassroots effort by Levi Strauss & Co. employees and executives to better educate their colleagues about HIV/AIDS has evolved into a comprehensive corporate response embracing the company's employees, their families, nonprofit organizations, public policy, supply chain partners, communities and consumers. Collaboration—above all else—is essential to stopping the HIV/AIDS pandemic.

¹⁷ Ibid.

MACY'S: PASSPORT PROGRAM

Macy's "Passport" began as an awareness-raising fashion show in a Macy's employee cafeteria in 1982, and since has grown into one of the largest and longest-running HIV/AIDS events of its kind. In the early 1980s, when HIV/AIDS was a new disease, the fashion and retail industries were losing important members of their community. Macy's created Passport to support friends and employees of the company who had been affected by the disease. In 1988, Passport became a fund-raising event for HIV/AIDS organizations, and often attracts the attention of national media and celebrity supporters. As a major U.S. retailer, a fashion show benefitting a cause that is close to many employees and customers has proved an appropriate and unique fit.

APPROACHES

Macy's has partnered with over 80 organizations to support care, services, education and research for people affected by HIV/AIDS. Many of these beneficiaries have long-term relationships with Macy's. To select beneficiaries, Macy's invites organizations to request funding, evaluates the requests, and then submits them for review by executives and independent grant-request readers, before choosing successful applicants. Macy's also works with many of its beneficiaries throughout the year on smaller events and projects. The partner organizations provide mutual and continued support on HIV/AIDS initiatives.

In addition to fundraising activities, Macy's engages in other related efforts. For instance, in the San Francisco Bay Area, Macy's holds a "Fashion Inform Teen Night" for high school students in conjunction with the main benefit night. During Teen Night, over 2,100 students see the same fashion show featured at the benefit. Following the Teen Night performance of the fashion show, HIV/AIDS organization partners lead HIV awareness and prevention activities for the teens.

Macy's plays to its strengths, and finds ways to leverage what it does well. As a fashion company, it has the knowledge and resources to successfully execute major events such as fashion shows, while HIV/AIDS beneficiaries have the expertise needed to provide tailored educational messages.

Macy's provides all of the resources for the Passport fashion show. Partner beneficiaries provide educational materials and HIV/AIDS messages for distribution at the event. Major beneficiaries also are asked to support the event by selling tickets, providing volunteers and garnering publicity. Smaller agencies are invited to sell tickets to shopping events to raise funds.

One Macy's Passport leader noted, "It is important to find causes and organizations to partner with that resonate with your brand and company culture. That creates a natural synergy. If the relationships support your brand values, the employees will want to support the organizations and the relationship can be expanded into events, fund-raising and volunteerism."¹⁸

IMPACTS

Through Passport and other programs, Macy's has donated ~\$30 million to date to HIV/AIDS organizations. In addition to the ~\$30M raised, Macy's has garnered substantial community support and positive publicity from its HIV/AIDS fundraising efforts. The company also sees Passport as a vehicle to support its employees and maintain strong relationships and goodwill in the communities it serves—a model that has been extremely successful for Macy's and the Passport beneficiaries, and one that has created many sustainable relationships.

¹⁸ Betsy Nelson. Personal Communication. March 30, 2010.

MTV: Get Yourself Tested

GYT (“Get Yourself Tested”) is part of “It’s Your (Sex) Life,” an ongoing public education partnership of MTV and the Kaiser Family Foundation that equips young people with information that empowers them to make responsible decisions about their sexual health. It is developed in partnership with the U.S. Centers for Disease Control and Prevention (CDC) and Planned Parenthood Federation of America (PPFA) and its health centers across the nation. Timed to coincide with National STD Awareness Month, GYT launched in April 2009 to normalize and encourage testing for sexually transmitted diseases (STDs) among sexually-active young people under age 25 by creating a youthful, empowering social movement that increases knowledge and promotes open communication with partners and health care providers.

Launching GYT

Confronting the difficulty of discussing testing for HIV and other STDs head-on, GYT sought to generate buzz through a “guerrilla-style viral marketing campaign” to pique the interest of the MTV audience with the phrase “WTF is GYT?” This was designed to showcase the GYT acronym and capture the interest of young Americans. The GYT launch included:

- Celebrity spokespeople promoted GYT via their online social networks, which extend to fans, critics and others. For instance, hip hop artist Soulja Boy tweeted “WTF is GYT?” to nearly 200,000 Twitter followers
- Celebrity viral videos, with spokespeople such as Perez Hilton (whose video generated over 100K streams) and Big Boi of Outkast trying to guess the meaning of GYT, were placed on social networking sites regularly visited by the target audience (including YouTube)
- MTV interns wearing GYT t-shirts swarmed the “Today Show” to generate national publicity

The meaning of GYT, and the GYT URL was revealed on April 1, 2009, at the top of the world premiere of “Pedro,” an MTV film about Pedro Zamora, the first HIV-positive gay person to appear in a reality show on MTV (“The Real World: San Francisco”). **These tactics led to more than 500,000 views of MTV’s GYT videos, and over 3,000 comments during the campaign launch.**

Following the launch, GYT was among the most-searched terms on Google, the most-discussed videos on YouTube, and the most-tweeted terms on Twitter. All GYT outlets—MTV, MTV.com, social networking sites, pop culture blogs, mobile devices, schools, and close to 900 Planned Parenthood clinics nationwide—directed people to the campaign’s informational resources, to learn more about STDs and find local testing centers via mobile phone or the Internet.¹⁹

The campaign kicked-off it’s second year in April 2010 with new creative, special promotions, expanded informational resources and increased community outreach and events across the nation. GYT is available year-round with heightened promotions during National STD Awareness Month (April) and other key dates (ie. National HIV Testing Day, June 27).

CAMPAIGN COMPONENTS

The GYT campaign includes:

- **On-air promotions:** Programming featuring popular talent and current artists developed with MTV and other MTV Network properties to normalize and promote STD testing, including public service ads, news and other shows, and more.
- **Sweepstakes and contests:** Special promotions produced by MTV and other GYT partners to incentivize testing and engage young people to get tested and to encourage their friends to do the same.
- **GYTnow.org:** A dedicated website with information about STDs and testing, an online testing center locator, videos that provide tips for talking about STDs with partners and health care providers and other resources.

¹⁹ MTV. *GYT Berger 500-word summary*. 2010.

- **GYTnow on Mobile:** A specially designed website for mobile phones, includes on-the-go information about protection, testing and communication, as well as an SMS testing center locator that allows users to find their nearest testing center by texting their zipcode to GYTNOW (498669).
- **GYT Nation:** An extensive on-the-ground outreach effort is taking GYT to communities cross the country. GYT promotional materials, including t-shirts, posters, buttons and stickers are being distributed to more than 4,000 health centers nationwide, including Planned Parenthood’s network of 840 health centers. The CDC is also working with state and local health departments, the American Social Health Association and the National Coalition of STD Directors to get out information about the campaign. And, the American College Health Association (ACHA) has joined the GYT campaign to spread the word and distribute GYT materials through college health centers.

Online Social Marketing Tactics

During its first year, from April 1, 2009 to March 31, 2010, there were more than 800,000 visits to the website. GYTnow.org offers tips on how to discuss STD testing with partners, and provides downloadable “banners” with GYT slogans. Users are also prompted to “enter your zip code to find the STD testing center nearest you,” which connects them to the CDC National HIV and STD Testing Resources page. The site also provides widgets and other special applications enabling viewers to share information through their preferred social networking sites. In addition, the site offers an online toolkit for people who want to customize posters, flyers and t-shirts to help promote the GYT campaign.

²⁰

Mobile Texting

In the first year, more than 40,000 people have texted their zip code to the campaign’s SMS service (GYTnow) or input their zip code on the GYT website to gain access to testing resources.

MTV’s market research shows that up to 90% of its audience has immediate access to a mobile phone, while just 40% have a computer nearby when watching MTV. For this reason, GYT public service announcements and all promotional materials direct viewers to a mobile messaging service, where users type in their zip code to get the location of the Planned Parenthood or CDC-recommended clinic closest to them. Both Planned Parenthood and the CDC provided their clinic databases to enable mobile access to testing sites (MTV worked with a mobile vendor to design this feature). College clinics also may be added to the database. A complimentary texting service also allows users to access the GYT mobile site, with some of the same information as the website, as well as the Planned Parenthood mobile site.²¹

Full-length Programming

Throughout the year, MTV integrates HIV/AIDS and STD-related information into existing MTV shows like “Sixteen and Pregnant”. MTV News segments also highlighted the impact of HIV and other STDs on young people. Message integration also took place at events such as MTV Spring Break.²²

Community Kits

GYT provides community tool kits to 880 Planned Parenthood clinics as well as to 2,500 state and local health departments (in collaboration with the CDC). MTV and the Kaiser Family Foundation coproduce the kits, which contain materials featuring the GYT logo and information, including posters for clinics and waiting rooms; t-shirts, featuring a link enabling the creation of more GYT t-shirts online; stickers; GYT buttons for clinicians to wear; and tips for clinicians

²⁰ Jason Rzepka and Lily Williamson. Personal communication, March 16, 2010; *GYT Berger 500-word summary*.

²¹ Ibid.

²² “MTV’s GYT campaign spurs national movement to ‘Get Yourself Tested.’” MTV *Think Press* blog, July 16, 2009 (available at <http://think.mtv.com/044FDEFFF00ED7CC70008009972EE/User/Blog/BlogPostDetail.aspx>).

²² Henry J. Kaiser Family Foundation website (www.kff.org/entpartnerships/mtv2/gyt.cfm) and the MTV/It’s Your (Sex) Life/GYT website (www.itsyoursexlife.com/gyt?utm_source=gyt09), both accessed on February 17, 2010;

on which tests to perform and how to screen patients for STD tests.²³ GYT also distributed Community Kits to more than 1,500 other clinics, youth organizations, public health departments and organizations nationwide.

RESOURCES

MTV contributes media-savvy elements as well as an ability to extend the reach of the campaign. The MTV Public Affairs team has three dedicated staff members for GYT, but practically department at MTV contributes to GYT in one way or another. For example, the MTV promo team creates concepts for public service announcements, the on-air programming team manages TV segments, the MTV marketing team ensures that GYT reaches a wide audience, and the digital team leads many of the technological aspects of GYT.²⁴

In addition to strategic and substantive staff support, Kaiser provides financial resources to support production of PSAs and other programming and the core informational resources that support the campaign (website, SMS service, community materials). The CDC provided funding to support development of tool kits for health centers and clinics and Planned Parenthood provides significant in-kind support. Specific elements of GYT promotions in 2010 were made possible by the financial contribution of Gilead Sciences, Inc. to MTV.

PARTNERSHIP

When GYT launched in April 2009, the primary partners were MTV, The Henry J. Kaiser Family Foundation (the organizations have been collaborating on sexual health campaigns since 1997), and the CDC and Planned Parenthood Federation of America. For GYT, Kaiser offers a deep understanding of health issues, messaging objectives and behavior change, as well as valuable processes for establishing key messaging priorities. MTV has the creative firepower and platforms to raise public understanding about STDs and testing on a massive scale, through popular social networking platforms (e.g., Twitter, Facebook and YouTube) and through the MTV online community. The CDC together with Planned Parenthood and its nearly 900 clinics across the country, provides services on the ground. The CDC and Planned Parenthood also provide valuable information about the on-the-ground response. Each partner collaborates on the development of campaign materials to ensure that the materials accurately capture public health messages and are appropriate for the target audience. Other supporting organizations include the American College Health Association, National Coalition of STD Directors, National Alliance of State and Territorial HIV Directors, among others.

“GYT is an unprecedented alignment and potent mix of partners with complementary capabilities.”

- Jason Rzepka, Vice President of Public Affairs,

OUTCOMES FROM YEAR 1 (APRIL 2009-MARCH 2010)

Table 1: Summary of the average changes from ten Planned Parenthood clinics when comparing selected statistics from April 2009 to the same statistics for April 2008.²⁵

Testing Characteristic	Change for men	Change for women
STD clients	+36%	+18%
STD visits	+36%	+16%
Gonorrhea tests	+49%	+20%
Tested positive for gonorrhea	+106%	+3%
Chlamydia tests	+55%	+17%
Tested positive for	+63%	+30%

²³ Henry J. Kaiser Family Foundation website (www.kff.org/entpartnerships/mtv2/gyt.cfm) and the MTV/It's Your (Sex) Life/GYT website (www.itsyoursexlife.com/gyt?utm_source=gyt09), both accessed on February 17, 2010; Stephen Massey, Associate Director, Entertainment Media Partnerships, Henry J. Kaiser Family Foundation Personal communication, February 18, 2010; Jason Rzepka and Lily Williamson. Personal communication, March 16, 2010.

²⁴ Jason Rzepka and Lily Williamson. Personal communication, March 16, 2010.

²⁵ MTV PowerPoint Presentation, 2010.

Chlamydia		
HIV initial tests	+55%	+53%
Tested positive for HIV	+1900%	-100%

In addition, the following outcomes were measured for the month of April 2009 compared to April 2008.²⁶

- Planned Parenthood Health Systems in North Carolina and South Carolina recorded an increase of more than 100 percent in both male and female clients. Planned Parenthood of St. Louis reported a 100 percent increase in the male clients who typically are less likely to present for testing, and a 61 percent increase in female clients.
- More than twice as many men were tested for HIV at Planned Parenthood of Greater Iowa in 2009 vs. 2008, while both Planned Parenthood of South Texas and Planned Parenthood of the Greater Memphis region recorded a nearly 40 percent increase in HIV testing among male clients. Female clients testing for HIV increased in numerous regions, including Planned Parenthood of Indiana, where the number of female clients presenting for HIV tests increased by 45 percent in April 2009 compared to April 2008.
- Gonorrhea testing for both men and women increased in numerous regions. In Georgia, Planned Parenthood recorded a 64 percent increase in the number of male clients tested for gonorrhea. A Planned Parenthood clinic in south central New York reported an increase of close to 70 percent in the number of female clients tested for gonorrhea. Planned Parenthood of the Rocky Mountains conducted 2,754 Chlamydia and gonorrhea tests in just two days, compared to the normal average of 156.

NEXT STEPS²⁷

The 2010 campaign, which kicked off April 6th again coinciding with National STD Awareness Month, is building on the power of the GYT brand and working to break down barriers of shame and embarrassment around asking a partner to get tested, or asking a health care provider to be tested while continuing to normalize and promote STD testing generally. The campaign aims to provide its audience with the tools to “Get Yourself Talking.” These include “talking tips” and videos available online about how to ask a partner to get tested and how to ask a doctor for about tests. GYT is also focusing its 2010 efforts on dispelling the myth that having taken a blood or urine test means that a person was automatically tested for HIV.

The 2010 GYT campaign includes an expanded community outreach component, including a special “Campus Challenge” to get college students to help spread the word about STD testing among their peers as well as get tested themselves. As an incentive for college students to engage with the campaign, GYT will reward the Facebook campus network that gets the largest percentage of enrolled students to take the pledge to get involved in GYT and to get tested. The top ten student GYT recruiters in the Campus Challenge win a free trip and tickets to attend a major MTV concert event during the summer.

Also, in 2010, GYT joined forces with Greater Than AIDS, a sister campaign of the Kaiser Family Foundation and a coalition of media partners with strong reach into the African-American community, to promote HIV and STD testing as part of a special promotion in 10 cities across the country in the week leading up to National HIV Testing Day (June 27, 2010). During *Be Greater Than AIDS: Get Yourself Tested Week*, targeted media promotions featuring Kelly Rowland, Ciara, MTV VJ Sway and others encouraged individuals to get tested for HIV and other STDs. Online resources directed to testing centers and highlighted local National HIV Testing Day activities. Planned Parenthood Federation of America worked to secure free testing for the week of June 19-27, and additional testing centers identified by the CDC, state & local health departments, and the Black AIDS Institute were also highlighted as part of the promotion. The promotion was coordinated with the National Association of People With AIDS (NAPWA), the creator and official organizer of

²⁶ “MTV’s GYT campaign spurs national movement to ‘Get Yourself Tested.’” July 16, 2009.

<http://think.mtv.com/044FDF00ED7CC70008009972EE/User/Blog/BlogPostDetail.aspx>

²⁷ Jason Rzepka and Lily Williamson. Personal communication, March 16, 2010.

National HIV Testing Day, as well as the National Alliance of State & Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors (NCSD). Results of the promotion will be available in Fall 2010.

CONCLUSIONS

Now entering year 2, GYT has continued to grow and experienced even greater audience response. Partnership has been key to this success. The results of this effort have included not only higher testing numbers, but substantial reinvestment and increased involvement among the GYT partners in 2010.²⁸

²⁸ Jason Rzepka and Lily Williamson. Personal communication, March 16, 2010.

OGILVY AND THE CDC: AMERICA RESPONDS TO HIV/AIDS

By the mid-1980s, thanks in part to willful public and government bias and neglect, HIV/AIDS in the U.S. had become a boiling health crisis. Yet, information about, and public understanding of, HIV/AIDS was inconsistent and limited. HIV/AIDS—and its devastating impact—were widely misunderstood. At the time, only seven percent of Americans reported personally knowing someone with HIV/AIDS, and many supported efforts to segregate and punish infected people.²⁹

Finally, Congress issued a mandate requiring the CDC to reach out to and educate the American people about HIV/AIDS. In 1987, the CDC responded with the launch of America Responds to AIDS (ARTA), the first-ever, federally-funded, national HIV/AIDS public service campaign. ARTA ran through 1996, and was recognized by PR Week as one of the top 20 public relations campaigns of the 20th century.³⁰

CREATING A PARTNERSHIP

As the first federally-funded national HIV/AIDS campaign, America Responds to AIDS (ARTA) aimed to raise HIV/AIDS awareness, promote prevention and clear up common fears and misperceptions. For decades prior to ARTA, the CDC had supported and created public education campaigns that were regionally-focused, community outreach efforts. Launching a national campaign involving mass media prompted the CDC to put out an RFP for communications support.

Staff and leaders at Ogilvy Public Relations had been impacted by the HIV epidemic and possessed deep, personal passion for being at the forefront of efforts to tackle this growing public health crisis. With these strong motivations, Ogilvy Public Relations and its sister advertising agency, Ogilvy & Mather, submitted a proposal for and won the CDC's contract to provide discounted communications support for the ARTA campaign.

THE CAMPAIGN

The theoretical model behind the ARTA campaign was to raise national attention about HIV/AIDS, increase understanding of personal relevance and drive individuals to take action. To accomplish this, the campaign was rolled out in several phases from 1987 through 1996. In the absence of existing data about the effectiveness of AIDS-related messaging and public service announcements, Ogilvy played an important role in both creating and testing advertising components with the public.

The creation of each phase involved comprehensive research and planning. Focus groups and research sessions were conducted across the country with community leaders, special interest groups, health professionals, and industry experts to help develop and fine tune each of the communication pieces. The phases were planned to build upon one another, and all materials were designed so that they could be adapted at the national, state and local levels. In this way, the ARTA infrastructure could facilitate parallel campaigns while maintaining a coordinated message.

²⁹ The Kaiser Family Foundation. Evolution of an Epidemic: 25 Years of HIV/AIDS Media Campaigns in the U.S. June

2006.

³⁰ Social Marketing. Ogilvy Public Relations Worldwide. <http://www.ogilvypr.com/en/practices/social-marketing>

THE PHASES OF THE AMERICA RESPONDS TO AIDS CAMPAIGN³¹

Phase	Name	Year	Target Audience	Goal
1	“General Awareness: Humanizing AIDS”	1987	General audience	Raise public awareness of HIV/AIDS while addressing fears and misperceptions
2	“Understanding AIDS”	1988	All U.S. households	Brochure designed to build on awareness raised through Phase I and further educate about HIV/AIDS transmission
3	“Women at Risk/Multiple Partner Sexually Active Adults”	1988	At-risk populations	Raise awareness of risky behaviors
4	“Parents and Youth”	1989	Parents	Encourage and support conversations between parents and youth about HIV/AIDS. “AIDS Prevention Guide” included age-appropriate handouts for teenagers and children
5	“Preventing HIV Infection and AIDS: Taking the Next Steps”	1990	General audience with some specific messaging	Build upon previous phases to deepen understanding. Also encouraged those possibly at risk to seek counseling, testing, or even treatment if appropriate
6	HIV Risk-Reduction Behaviors	1994	General audience	Encourage risk-reduction behaviors such as abstinence and condom use
7	Specific Populations	1995-1996	Audiences disproportionately impacted (primarily African Americans and Latinos)	PSAs to reach key populations

RESOURCES

Federal funding was critical to the development of the ARTA campaign. It is reported that within the first five years, federal government spending on ARTA development was about \$7.36 million. In addition to this federal investment, and the sweat equity of Ogilvy staff and leaders, one of the most substantial resources supporting this campaign was the free airtime donated by broadcasters.³² Ogilvy cultivated relationships with various networks that generated an estimated \$300 million worth of free broadcast time for the public service announcements across multiple channels and stations.

Additional support came from state and local health departments who lobbied local television and radio stations, pressing them to be at the forefront of health and education efforts. Further funding came from engaging public and private parties and garnering investment for various phases of the campaign. The CDC and Ogilvy cultivated meaningful partnerships with over 1,000 different organizations, resulting in strong relationships, as well as financial investments.³³

³¹ Woods, Davis, and Westover. “America Responds to AIDS”: Its Content, Development Process, and Outcome.”

Public Health Reports. November-December 1991, Vol. 106, No. 6.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1580341/pdf/pubhealthrep00187-0018.pdf>

³² The Kaiser Family Foundation. Evolution of an Epidemic: 25 Years of HIV/AIDS Media Campaigns in the U.S. June

2006.

³³ Interview with Tom Beall, Managing Director, Ogilvy Global Social Marketing Practice, April 2010.

RISKS AND BENEFITS

Early on, the campaign had to wrangle with a challenging environment of fear and misperceptions about HIV/AIDS, existent due to a lack of widespread information. The pressure and risks were great for both the CDC and Ogilvy. Answering the Congressional mandate required the CDC to step outside of its traditional outreach strategies and buck internal bureaucratic resistance to the use of mass media. Hiring a public relations agency was one way the CDC acted to mitigate this risk, but partnering with a private organization with which they had no prior experience certainly brought risks of its own.

Working with the CDC on ARTA was the starting point of Ogilvy's now-flourishing social marketing practice. New to the world of public outreach, Ogilvy learned how to work with a complex public-sector entity, and how to work effectively with different constituency groups. While Ogilvy was skilled at using research to develop the right programs and messages for diverse target audiences and knew how to build strategic alliances and organize comprehensive, nationwide efforts that involve a multitude of diverse partners, ARTA forced Ogilvy to operate in a delicate environment fraught with uncertainty.³⁴ Attempting to promote prevention through condom use without being able to talk about condoms in the mainstream media was just one of the many challenges they faced.³⁵

Accepting and confronting these risks allowed for great strides in HIV prevention and generated benefits for the CDC and for Ogilvy. With the help of Ogilvy, the CDC succeeded in overcoming the internal and political resistance to mass media. Now, mass media is a hallmark of CDC's work in the public education arena, far beyond HIV/AIDS, and the organization has a dedicated unit committed to health marketing. For Ogilvy, ARTA was a landmark campaign that stimulated their interest in social marketing projects and led to the creation of the company's social marketing practice.

OUTCOMES

Evaluation of ARTA was conducted in a few different ways. Ogilvy was responsible for tracking airplay and media attention generated by the PSAs. For advertising campaigns, message frequency and reach are key to captivating viewers' attention. By 1991, Ogilvy was able to determine that, on average, American adults between the ages of 18 and 54 had seen no fewer than 56 ARTA campaign ads.

Likewise, the CDC focused on measuring changes in public awareness as a result of the campaign phases. One element of the campaign involved referring individuals to a national hotline number to receive information about available resources and materials. Monitoring how much traffic was driven to these resources after the launch of each phase provided just one measure of the impact of the campaign elements.

Additionally, the National Health Interview Survey (NHIS) employs personal household interviews to monitor the health of the U.S. population. The CDC tracked results from this survey to measure changes in public attitudes and knowledge about HIV/AIDS. Questions included in the survey were designed to understand the following (among other issues):

- Were individuals becoming more informed about HIV/AIDS?
- Were individuals accurate in assessing risk, given their own behaviors?
- Were individuals engaged in fewer "risk behaviors"?
- Were myths around HIV/AIDS becoming less prevalent?

The CDC and Ogilvy continually assessed the progress of the campaign (although specific results from the surveys are no longer available).

³⁴ Social Marketing. Ogilvy Public Relations Worldwide. <http://www.ogilvypr.com/en/practices/social-marketing>

³⁵ Interview with Tom Beall, Managing Director, Ogilvy Global Social Marketing Practice, April 2010.

CONCLUSION

Through ARTA, the CDC and Ogilvy were able to relay educational messages about HIV/AIDS to the entire nation at a time when coordinated communication at-scale was critical to stem public misconceptions and hysteria, and ultimately begin to stem the spread of the epidemic. By working together as true partners throughout the campaign, and utilizing the unique skills that each party provided, CDC and Ogilvy were able to fulfill their ambition to raise national attention about HIV/AIDS, change public perceptions, and ultimately influence behavior change.

HIV/AIDS WORKPLACE POLICIES

An HIV/AIDS workplace policy provides the basic framework for company action to reduce the spread of HIV/AIDS and to manage its impact. Developing an HIV/AIDS workplace policy is often the first step for any company committed to addressing HIV/AIDS. An HIV/AIDS workplace policy clearly states the company's position on the issue and articulates the responsibilities, rights, and expected behavior for management and employees.

Most HIV/AIDS workplace policies are based on the International Labour Organization (ILO) "Code of Practice on HIV/AIDS and the World of Work". The ILO developed its Code of Practice in 2001 (and updated it in 2010) in response to the initiative taken by small and medium enterprises and subsidiary companies in sub-Saharan Africa to develop their own HIV/AIDS workplace policies and programs due to the epidemic's impact on their workforce and communities. The ILO Code of Practice promotes the following key principles for HIV/AIDS workplace policies:

- Make an explicit promise for corporate action;
- Commit to confidentiality and non-discrimination for all employees;
- Assure consistency with appropriate national laws;
- Lay out a standard of behavior for all employees (whether HIV-infected or not);
- Provide guidance to supervisors and managers;
- Explain to employees living with HIV/AIDS the type of support and care they will receive, so they are more likely to come forward for counseling and testing;
- Help stop the spread of the virus through prevention programs;
- Be made available to all employees, in a format that is easily understood; and,
- Manage the impact of HIV/AIDS with the ultimate aim of cutting business costs.

The Code also covers general rights and responsibilities (of governments, employers, and employees); HIV/AIDS-related training at multiple levels; and HIV testing.³⁶

The following companies are among those that have adopted comprehensive global HIV/AIDS workplace policies (See Appendix B for example policies). These policies apply equally to employees around the globe—including, of course, in the U.S., where nearly all of these companies are headquartered.

- The Brink's Company (specializing in services such as armored car transportation, ATM servicing, and currency and coin processing)
- Chevron Corporation (providing a wide range of energy sources)
- The Coca-Cola Company (a global beverage company)
- Colgate-Palmolive (products for oral care, personal care, home care and pet nutrition)
- Levi Strauss & Co. (clothing manufacturer)
- Merck & Co. Inc. (health care and pharmaceuticals)
- Pfizer, Inc. (health care and pharmaceuticals)
- Virgin Group (in travel, music, media, and mobile telephone service).

³⁶ International Labour Organization. *Code of Practice on HIV/AIDS and the World of Work*. ILO: Geneva, 2001.



August 17, 2009

By electronic mail

Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
United States Department of Health and Human Services
Attn: Part 34 NPRM Comments
1600 Clifton Road, NE, MS E-03
Atlanta, Georgia 30333

Email: Part34HIVcomments@cdc.gov

Docket No: Docket No. CDC-2008-0001
Docket Title: Medical Examination of Aliens – Removal of Human Immunodeficiency Virus (HIV) Infection from Definition of Communicable Diseases of Public Health Significance

Dear Director Frieden and Centers for Disease Control and Prevention Staff:

Lambda Legal submits these comments in support of the proposed regulations to amend 34 C.F.R. § 34.2 to remove the human immunodeficiency virus (“HIV”) from the list of “communicable diseases of public health significance” and to amend 34 C.F.R. § 34.3 to eliminate mandatory HIV testing in the routine medical examination of foreign nationals.¹

For over two decades, the United States (“U.S.”) policy of barring people with HIV from entering this country for purposes of travel or immigration (the “HIV travel and immigration ban”) has violated the fundamental rights of foreign nationals living with HIV; impeded HIV prevention, care and treatment; and fostered stigma and discrimination against people living with HIV, both in the U.S. and abroad. If this policy ever truly served any legitimate governmental goal or interest – and Lambda Legal submits that it did not – that time has long since passed. Lambda Legal strongly urges the Department of Health and Human Services, through the Centers for Disease Control and Prevention (“HHS/CDC” or “the agency”) to move swiftly to finalize and implement the proposed regulations, thereby ending the discriminatory and disgraceful HIV travel and immigration ban and allowing the United States to more fully assume its role as a leader in the global fight against HIV/AIDS.

Lambda Legal Defense and Education Fund, Inc. (“Lambda Legal”) is a national nonprofit organization committed to achieving the full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those living with HIV through impact litigation, education and

¹ Medical Examination of Aliens – Removal of Human Immunodeficiency Virus (HIV) Infection From Definition of Communicable Disease of Public Health Significance, 74 Fed. Reg. 31797 (proposed Jul. 2, 2009) (to be codified at 34 C.F.R. §§ 34.2, 34.3) (“NPRM”).

public policy work. Lambda Legal has represented the interests of people living with HIV since the beginning of the epidemic, and our work has ensured access to treatment, promoted effective prevention policies, and helped combat discrimination, bias and stigma.

Lambda Legal supports adoption of the Proposed Rule for the reasons set forth below.

The HIV Travel and Immigration Ban Violates Fundamental Human Rights

This country was founded on principles of freedom, equality and respect for the human rights of the individual. For the United States to live up to these principles on the world stage, we must stop barring individuals living with HIV from visiting or immigrating to this country. The current policy restricting the ability of people living with HIV to enter, remain and reside in the United States runs afoul of international human rights provisions prohibiting state-sponsored discrimination and mandating equal treatment under the law for all individuals. For instance, the International Covenant on Civil and Political Rights (“ICCPR”) – to which the U.S. is a party – guarantees all persons the right to equal protection of the law without discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.² “Other status” under the ICCPR has been interpreted to include actual or perceived HIV/AIDS status.³ As a signatory to this treaty and a world leader with respect to human rights, the United States has an obligation not only to respect this right for all individuals within its territory and subject to its jurisdiction, regardless of citizenship, but also to avoid discriminating against those who seek entry or residence.⁴

Restrictions against entry, stay, and residence based on HIV status interfere with governmental obligations to protect the integrity of families, as well as the best interests of the child, and run contrary to numerous related human rights principles, including freedom of movement, freedom of association, the *non-refoulement* (unlawful return) of refugees, and the right to privacy.⁵ Such

² International Covenant on Civil and Political Rights, art. 26, Dec. 16, 1966, A-14668 U.N.T.S. 999.

³ United Nations High Commissioner for Human Rights (“UNHCHR”), *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)*, Resolution 1995/44 (March 3, 1995), *available at* <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/47a2677e0c36688c8025676300599ece?Opendocument> (last visited Aug. 17, 2009).

⁴ *See, e.g.*, UNHCHR, U.N. Human Rights Committee, General Comment 18, Non-discrimination (1989), *available at* <http://www.unhchr.ch/tbs/doc.nsf/0/3888b0541f8501c9c12563ed004b8d0e?Opendocument> (last visited Aug. 17, 2009); UNHCHR, U.N. Human Rights Committee, General Comment 15, The Position of Aliens Under the Covenant (1986), *available at* [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/bc561aa81bc5d86ec12563ed004aaa1b?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/bc561aa81bc5d86ec12563ed004aaa1b?Opendocument) (last visited Aug. 17, 2009).

⁵ *See, e.g.*, Office of UNHCH (“OHCHR”) & Joint United Nations Programme on HIV/AIDS (“UNAIDS”), *International Guidelines on HIV/AIDS and Human Rights* (2006), *available at* http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (last visited August 17,

restrictions interfere with the individual's ability to pursue educational opportunities, to become maximally employed, to attain the highest standard of health, to seek asylum, and to live with the full dignity and respect that we, as a country, believe should be accorded every human being.

Only a dozen countries – countries such as Libya, Qatar, the Russian Federation, Saudi Arabia, South Korea and Sudan – impose immigration restrictions similar to those imposed under current U.S. policy.⁶ Being counted among these countries has been denounced as shameful for our country.⁷ Because the HIV travel and immigration ban cannot be justified based on public health concerns or economic considerations (both of which are discussed below), it would be unconscionable for the United States to continue this discriminatory policy, to perpetuate the violation of human rights it entails or to stand in the way of the individual's ability to reach full potential – based solely upon the fact that individual is living with HIV. Removing this discriminatory ban from U.S. immigration policy is a crucial step toward strengthening our nation's leadership in the global fight against HIV/AIDS.⁸

The HIV Ban Cannot Be Justified on Public Health Grounds

As HHS/CDC has recognized in its proposed regulations, the HIV travel and immigration ban cannot be justified on the grounds that it protects the public health.⁹ For decades now, public health officials and medical professionals have known that HIV is not transmitted through casual contact and does not present the type of threat posed by diseases that are communicable through aerosol or

2009); UNAIDS & International Organization for Migration (“IOM”), *UNAIDS/IOM Statement on HIV/AIDS-Related Travel restrictions* (2004), available at http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/activities/health/UNAIDS_IOM_statement_travel_restrictions.pdf (last visited August 17, 2009).

⁶ NPRM, 74 Fed. Reg. at 31800.

⁷ International AIDS Society (“IAS”), *IAS Policy Paper: Banning Entry of People Living with HIV/AIDS* (2007), available at http://www.iasociety.org/Web/WebContent/File/ias_policy%20paper_07%2012%2007.pdf (last visited Aug. 17, 2009).

⁸ For example, since 1993, the IAS has refused to hold its biannual International AIDS Conference, which brings together the leading medical experts in the field and generally draws 25,000 participants, in the United States because of the U.S. HIV travel and immigration ban. The IAS is considering holding this conference in Washington, D.C. in 2012, but only if the U.S. first changes its discriminatory policy. IAS, *supra* note 7.

⁹ As stated in the discussion of “Current Scientific Knowledge for HIV Transmission” in the Notice of Proposed Rulemaking, “[w]hile HIV infection is a serious health condition, it does not represent a communicable disease that is a significant threat for introduction, transmission, and spread to the United States population through casual contact, as is the case with other serious conditions such as tuberculosis. An arriving alien with HIV infection does not pose a public health risk to the general population through casual contact.” NPRM, 74 Fed. Reg. at 31800.

respiratory droplets.¹⁰ It is well understood that, as the agency notes, HIV is transmitted “almost exclusively” by unprotected sexual activity, the sharing of contaminated needles and syringes, and mother-to-child transmission.¹¹ In light of the modes of transmission of HIV, public health officials and medical professionals have asserted for years that allowing foreign nationals living with HIV to enter the United States to visit or immigrate does not pose a discernible risk of exacerbating the HIV endemic that already exists in this country.¹²

In fact, many public health officials believe that ending the HIV travel and immigration ban will have a net positive overall effect on public health across the world. For far too long, the United States has been sending contradictory messages with respect to HIV care, treatment and prevention. Through our public health initiatives at home and foreign aid programs abroad, we encourage people to get tested and learn their HIV status, asserting that effective treatments are available for those who are already infected and that public health officials know how to prevent transmission to those who are not currently infected. Yet at the same time our own immigration policy is premised upon entirely outdated and thoroughly discredited misconceptions about the transmission of HIV and, in fact, provides incentives for foreign nationals to remain unaware of their HIV status, to engage in deceitful behavior when interacting with immigration officials, and even to forego treatment while visiting or residing in the United States.¹³ Lifting the HIV travel and immigration ban will end the schizophrenic messages being sent across the world via our contradictory immigration, public health and foreign aid policies and will allow the United States to speak with one, clear voice in its efforts to prevent the further spread of HIV.

¹⁰ See, e.g., NPRM, 74 Fed. Reg. at 31800-01; CDC, *HIV and Its Transmission* (last revised Mar. 8, 2007), available at <http://www.cdc.gov/hiv/resources/factsheets/transmission.htm> (last visited Aug. 17, 2009).

¹¹ NPRM, 74 Fed. Reg. at 31800-01; see also CDC, *supra* note 10.

¹² See, e.g., NPRM, 74 Fed. Reg. at 31800; OHCHR & UNAIDS, *supra* note 5; World Health Organization (“WHO”), *Report: Consultation on International Travel and HIV Infection*, WHO/SPA/GLO/787.1 (1987), available at <http://unesdoc.unesco.org/Ulis/cgi-bin/ulis.pl?catno=76034&gp=o&lin=1> (last visited Aug. 17, 2009); CDC, *Technical Questions and Answers Proposed Removal of HIV Entry Ban* (2009), available at http://www.cdc.gov/ncidod/dq/laws_regs/fed_reg/remove-hiv/hiv-faq-technical.pdf (last visited Aug. 17, 2009).

¹³ Because individuals who seek to visit or temporarily reside in the United States are required to disclose that they have HIV, foreign nationals living with HIV have an incentive not to get tested for HIV. Moreover, foreign nationals who learn they do have HIV have an incentive, under current policy, to conceal their status – in order to travel to or remain here and avoid the cumbersome waiver process and intrusive questions into their personal and private health information required by that process – which may cause them to forego necessary treatment while visiting or residing in the United States. Lifting the HIV travel and immigration ban will eliminate this Hobson’s choice between optimal health, integrity and personal privacy for foreign nationals living with HIV who intend to travel to the United States or are currently residing here under a lawful visa.

Lifting the HIV Ban Will Help Reduce the Stigma, Bias and Discrimination Faced by People Living With HIV

In addition to improving public health abroad, the proposed change will improve public health in the United States by helping to reduce the stigma, bias and discrimination associated with having HIV. Much of the stigmatization of and discrimination against people living with HIV stems from a lack of understanding about HIV and the limited ways in which it can be transmitted. The HIV travel and immigration ban sends a clear – and incorrect – message to the general public that admission of people living with HIV to the U.S. poses a threat to public health. Eliminating that false and harmful message should help decrease stigma and discrimination.¹⁴ In turn, decreased stigma and discrimination should lead to public health benefits, such as a greater willingness to be tested for HIV (which may result in earlier detection of the virus if the person has HIV); a greater willingness to initiate and remain in care; reduced infectiousness for those receiving treatment; a reduced rate of transmission, and better overall health outcomes for people living with HIV.¹⁵ Recognizing the benefits with respect to public health, the United States has for years – through various laws and policies – attempted to reduce the stigma, bias and discrimination faced by people living with HIV. One glaring omission in those efforts, however, has been U.S. immigration policy. As the agency notes, ending the HIV travel and immigration ban and associated HIV testing “will remove stigmatization of and discrimination against HIV-infected people who have long been denied entry into the U.S. based only on a treatable and preventable medical condition.”¹⁶ Maintaining the current policies hurts this country’s efforts to reduce stigma and discrimination for people living with HIV; by ending those policies, the U.S. government will be furthering its important obligation to help end stigma, bias and discrimination against people living with HIV.¹⁷

¹⁴ See e.g., IAS, *supra* note 7.

¹⁵ See, e.g., UNAIDS & IOM, *supra* note 5.

¹⁶ NPRM, 74 Fed. Reg. at 31804. The stigmatizing and discriminatory impact of the current policy is not limited to those denied entry, but extends to U.S. citizens living with HIV. These individuals not only suffer the stigmatizing consequences of the misleading message the policy sends about HIV, but also suffer in the awareness that their own government engages – without any valid justification – in discrimination against people living with HIV.

¹⁷ The current system of a blanket ban against people living with HIV and individual waivers imposes yet another particularized harm against individuals in same-sex relationships. Individual waivers, though obtained through a cumbersome and intrusive process, allow foreign nationals with specific types of familial ties to a U.S. citizen or Legal Permanent Resident to immigrate despite the HIV travel and immigration ban. Because, however, the U.S. government does not recognize the validity of marriages of same-sex couples, the waiver process is not available to foreign nationals living with HIV who are married to members of the same sex. Therefore, even in situations in which a foreign national could obtain lawful immigration status through some means that does not rely on a familial relationship (e.g., an Employment-Based visa), that individual is currently not able to obtain the necessary HIV waiver to immigrate to the U.S. based on his or her marriage to someone of the same sex.

Mandatory Testing for HIV Must Also Be Discontinued

Lambda Legal strongly agrees with HHS/CDC that eliminating HIV testing as part of the immigration medical examination is the best approach. The medical examination should be limited to screening and testing for those diseases that are on the list of “communicable diseases of public health significance.”¹⁸ At the same time that HHS/CDC implements the proposed rule change to remove infection with HIV from that list, it should remove HIV testing from the routine medical exam for foreign nationals. To continue to require HIV testing as part of the medical examination for immigration purposes would be unnecessary and harmful.

As the agency notes, testing is not generally required for medical conditions, but only for those conditions on the list of “communicable diseases of public health significance.” Although a person may gain some advantages from finding out that they have a particular medical condition, mandatory testing should not be imposed on any individuals, as a general principle. In the immigration context, with the removal of HIV as an issue in the admission process, there is no justification for requiring HIV testing; rather, HIV should be treated the same as other health conditions – including other serious and infectious diseases – which are not inadmissible health conditions.¹⁹ That is, HIV testing should not be required as part of the medical examination, nor should it be suggested as part of that examination process.

To require HIV testing or even to suggest HIV testing (on either an “opt in” or “opt out” basis) would actually contribute to the HIV-related stigma and discrimination that the proposed rule seeks to end. As noted, tests for other health conditions not on the list of “communicable diseases of public health significance” are not required or suggested as part of the medical examination. Requiring or suggesting testing for HIV after it is removed from that list would continue different treatment of HIV, thus perpetuating the mistaken – and harmful – idea that the public health is put at risk if people living with HIV immigrate to the U.S.

Additional harms would be likely to flow from including a requirement related to HIV testing. Unfortunately, HIV testing raises serious concerns not present with testing for some other health conditions, due to the continuing stigma associated with an HIV diagnosis in this country and others and the discrimination that people living with HIV face here and in other countries. With respect to other countries, as the agency notes,²⁰ HIV test results might not be kept confidential, thus putting individuals found to have HIV at great risk of experiencing discrimination and/or stigmatization.

¹⁸ See NPRM, 74 Fed. Reg. at 31801, 31809.

¹⁹ As the agency notes, testing is not mandated, as part of the immigration process, for infectious diseases such as hepatitis, malaria, and West Nile virus and chronic conditions such as diabetes and heart conditions. NPRM, 74 Fed. Reg. at 31801. We question whether HHS/CDC even has the legal authority to mandate HIV testing (or even mandate an offer of HIV testing) once HIV is removed from the list of “communicable diseases of public health significance.”

²⁰ NPRM, 74 Fed. Reg. at 31802.

Moreover, the persons who conduct the required medical examination might not be qualified or trained to provide necessary information to ensure that informed consent for an HIV test is obtained or to provide the necessary counseling and linkage to care if the individual tests positive for HIV.

In our own country, people living with HIV still face significant stigma and discrimination.²¹ The agency notes the risk that information that a foreign national has HIV might be used by the Department of Homeland Security in evaluating whether the foreign national would become a public charge,²² reflecting the agency's recognition that misunderstanding of the significance for a particular individual of having HIV is widespread and that people with HIV in this country have to counter stigmatizing assumptions made about them based solely on their HIV test results. That reality underscores the importance of HIV testing being performed on a voluntary, informed basis. The coercive atmosphere of a required medical examination is not conducive to obtaining informed consent and ensuring voluntariness.

Lambda Legal opposes incorporating an offer of HIV testing into the medical examination process.²³ If HIV testing is offered in that process, meaningful safeguards must be imposed, requiring that the testing is conducted in a manner which ensures it is confidential, voluntary, and informed and that appropriate steps are taken (including post-test counseling and linkage to care) if the individual tests positive for HIV.²⁴

²¹ See, e.g., Katherine R. Waite et al., *Literacy, Social Stigma, and HIV Medication Adherence*, 23 J. Gen. Internal Medicine 1367, 1367 (2008); Kaiser Public Opinion Spotlight, *Attitudes About Stigma and Discrimination Related to HIV/AIDS* (Aug. 2006), at pp. 7-8, available at http://www.kff.org/spotlight/hivstigma/upload/Spotlight_Aug06_Stigma.pdf (last visited Aug. 17, 2009); Lambda Legal, *The State of HIV Stigma and Discrimination in 2007: An Evidence Based Report* (Feb. 2007), available at <http://www.lambdalegal.org/our-work/publications/general/2007-hiv-stigma-discrimination.html> (last visited Aug. 17, 2009)

²² NPRM, 74 Fed. Reg. at 31802.

²³ The agency's reference to "all immigrants, refugees, and status adjusters [having] the opportunity . . . to be tested in the United States as recommended by the [2006 CDC recommendations for HIV testing]," 74 Fed. Reg. at 31802, is a bit puzzling. The referenced recommendations relate to HIV testing in health-care settings. To the extent that immigrants, refugees, and status adjusters seek medical care in health-care settings, they should be treated the same as other individuals with respect to HIV testing.

²⁴ See Lambda Legal, et al., *Expanding the Availability and Acceptance of Voluntary HIV Testing: Fundamental Principles to Guide Implementation* (Oct. 2007), available at <http://www.lambdalegal.org/our-work/publications/general/voluntary-hiv-testing.html> (last visited Aug. 17, 2009); see also Lambda Legal & American Civil Liberties Union, *Increasing Access to Voluntary HIV Testing: The Importance of Informed Consent and Counseling in HIV Testing* (Mar. 2007), available at <http://data.lambdalegal.org/pdf/publications/hiv/informed-consent-counseling.pdf> (last visited Aug. 17, 2009).

The Economic Impact of the Rule Change Is Likely Not as Significant as the NPRM Suggests

The economic impact of the proposed rule change, which happens to be the most quantifiable aspect of the agency's cost-benefit analysis, must be placed in context relative to the almost entirely unquantifiable – and tremendously important – benefits of ending this stigmatizing and discriminatory policy. While Lambda Legal recognizes that the agency has an obligation pursuant to Executive Order 12866 to assess the proposed rule change to determine if it is “economically significant,” we must point out that the original decision to place HIV on the list of “dangerous contagious diseases” was, at least purportedly, driven by concerns regarding the public health and not by economic considerations.²⁵ For over two decades now, individuals living with HIV have endured this discriminatory policy – one that is not applied to persons with almost any other medical condition which, like HIV, does not pose a public health risk to the general public through casual contact.²⁶ Lambda Legal notes the paradox of the economic scrutiny that is now required by the rulemaking process in order to lift a policy that should not have been imposed in the first place. This rulemaking process forces the agency to engage in one final act of discriminatory treatment, seeming to require economic justification for foreign nationals living with HIV merely to obtain the same treatment under our immigration laws accorded to individuals suffering from other chronic illnesses. The fact that the proposed rule change seeks to end an admittedly stigmatizing and discriminatory policy should significantly reduce the weight given to possible economic aspects when evaluating the “costs and benefits” of the proposed rule change.²⁷

To assist it in evaluating the reasonableness of the model used to assess the economic impact of lifting the HIV travel and immigration ban, Lambda Legal (along with the Whitman-Walker Clinic (“WWC”) in Washington, DC) retained the services of economic consultants at Deloitte Financial Advisory Services LLP (“Deloitte FAS”). As a *pro bono* service, Deloitte FAS provided to Lambda Legal and WWC a report regarding HHS/CDC's economic model and analysis of the economic impact of the proposed rule change (the “Deloitte FAS Expert Report”), and that report is attached to these comments as Exhibit A. The following comments are, however, solely Lambda Legal's comments and are not intended to reflect the views of Deloitte FAS regarding the proposed policy

²⁵ Of course, individuals with HIV have been and will remain subject to the immigration restrictions that seek to bar the entry of *any* foreign national who may become a “public charge” and, thereby, drain resources from the U.S. economy. *See* 8 U.S.C. § 1182(a)(4).

²⁶ Lambda Legal notes that the list of “communicable diseases of public health significance” continues, even with the changes proposed in the NPRM, to include a few other diseases – notably gonorrhea and syphilis – that are not transmissible through casual contact. *See* 34 C.F.R. § 34.2. Continued inclusion of those diseases on the list lacks public health justification and should be ended by regulatory change.

²⁷ HHS/CDC appears to acknowledge this point. *See* NPRM, 74 Fed. Reg. at 31801 (“This proposed rule is not intended to correct any market failure, but to remove a government-imposed barrier that does not appear to provide a significant public health benefit and it at odds with human rights considerations.”).

change. Rather, Lambda Legal's comments in this section are based on its understanding and interpretation of the analysis contained in the "Deloitte FAS Expert Report."

Lambda Legal notes that the Notice of Proposed Rulemaking ("NPRM") could provide greater clarity as to what the economic impact analysis in the proposed rule is in fact assessing.²⁸ In particular, it is worth noting that the estimate of the "cost" to the economy described in the NPRM is *not* the costs HHS/CDC believes will be borne by the federal government after the rule is implemented. Rather, the portion of the healthcare costs in the "economic impact" analysis for which the federal government might be directly responsible is subsumed within the figure representing the overall "costs" to the economy, because such "costs" are calculated regardless of payer. It would be helpful if the agency explicitly states that the costs to be borne by the federal government are but a fraction of the figure described as "costs" in the NPRM.

Furthermore, the comments to the proposed rule change should acknowledge that, before passing the legislation that returned to HHS/CDC the authority to determine whether HIV should be on the list of "communicable diseases of public health significance"²⁹ Congress assessed, through the Congressional Budget Office ("CBO"), the potential costs *to the federal government* of removing HIV from the list.³⁰ Subsequently, Congress amended the legislation to offset those potential costs to the federal government by increasing the visa application fees to be paid by foreign nationals seeking to visit or immigrate to the United States.³¹ While HHS/CDC may not be allowed to include those offsetting monetary benefits in its analysis of the "economic impact" of the rule change,³² the agency should at least have noted in the NPRM that Congress has already identified and evaluated the

²⁸ For instance, Lambda Legal questions whether all expenditures on HIV-related healthcare for immigrants living with HIV, regardless of payer, may accurately be characterized as a "cost" *to the economy*. As noted in the Deloitte FAS Expert Report, the concept of healthcare expenditures as solely a drain on or cost to the economy may not be accurate. *See* Deloitte FAS Expert Report at 8.

²⁹ *See* Tom Lantos and Henry Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, Pub. Law 110-293, 122 Stat. 2963 ("PEPFAR II").

³⁰ While the NPRM does describe the differences between the models used by the CBO and HHS/CDC in their respective analyses, the NPRM does not make adequately clear the completely different purposes each of the analyses serves. *See* NPRM, 74 Fed. Reg. at 31804-05.

³¹ CBO, Cost Estimate for H.R. 5501 (Oct. 2008), *available at* <http://www.cbo.gov/ftpdocs/98xx/doc9866/hr5501.pdf> (last visited Aug. 17, 2009).

³² HHS/CDC could also clarify why it cannot include the increased revenue from visa application fees as part of the economic benefits resulting from this process of lifting the HIV travel and immigration ban. Lambda Legal believes that the reason may be that the statutory increase in visa application fees will go into effect regardless of whether HIV is now removed from the list, as Congress contemplated and HHS/CDC is now proposing, but HHS/CDC should explicitly explain in the NPRM the reasons behind its decision not to discuss the visa application fee offset placed in the legislation by Congress.

potential costs to the federal government and has implemented a mechanism for recovering those costs (as calculated by the CBO), which will therefore not be borne by the U.S. taxpayer.³³

Lambda Legal also wishes to acknowledge the difficult task the agency faced in attempting to assess the economic impact of lifting the HIV travel and immigration ban. Because the policy created a disincentive for foreign nationals living with HIV to even consider immigrating to the United States, HHS/CDC lacks data regarding the population of individuals who might attempt to immigrate to the U.S. once the ban is lifted. Other factors – including but not limited to shifts in the demographics of the global epidemic, medical advances in the treatment of HIV, the availability of care and treatment abroad (in many countries, often at a lower cost than in the United States), changes in the standard of care within the United States itself, and improvement in public education regarding modes of transmission – continue to complicate any analysis that may be conducted. With each passing year that the HIV travel and immigration ban has been in place, it has become more difficult to develop an accurate analysis of what the economic impact would be of ending that discriminatory policy.

Given the limitations imposed by the lack of reliable data on many crucial points, Lambda Legal believes that the economic model presented in the NPRM is, in most respects, a reasonable analysis of the potential economic impact of lifting the HIV travel and immigration ban.³⁴ As Deloitte FAS notes, for the most part, where the agency lacked solid data and was forced to make assumptions, it made clear on what information those assumptions were based, pointed out the effects adjusting those assumptions might have, and conducted sensitivity testing to provide a range of values within which the actual figures might fall.³⁵ It appears that HHS/CDC has been as transparent as possible in evaluating the economic impact of the proposed rule change and has affirmatively sought comment with respect to specific choices it has made and assumptions it has been forced to draw in the face of a paucity of data on certain topics.³⁶

Benefiting in large part from the analysis conducted by Deloitte FAS, Lambda Legal can identify several choices and assumptions that it believes result in some degree of overestimation of the economic costs and an underestimation of the economic benefits involved in lifting the HIV travel and immigration ban. For instance, the assumption that the prevalence of HIV among those immigrating to the U.S. will be the same as the prevalence in the general population of a particular region seems questionable. As HHS/CDC admits, “[t]here are several possible reasons as to why

³³ See Deloitte FAS Expert Report at 8.

³⁴ See Deloitte FAS Expert Report at 4.

³⁵ See *id.*

³⁶ Based on the work of the economic consultants at Deloitte FAS, Lambda Legal learned that a calculation error and a transcription error were made in the NPRM, resulting in cost overstatements of approximately \$3 million and \$81 million, respectively. See Deloitte FAS Expert Report, at 5-6. Although it is important for HHS/CDC to review this data and correct any errors it confirms, it should be noted that Deloitte FAS believes that the HIVEcon model remains sound. See *id.* at 6.

the proportion of HIV-infected immigrants could be less or more than the prevalence of HIV-infected persons in the region of origin.”³⁷ Nonetheless, given the lack of reliable data on the subject, the choice HHS/CDC made in this regard – perhaps to overestimate somewhat the number of individuals living with HIV who would seek to immigrate to the U.S. – was not outside the range of what might be considered reasonable. Furthermore, the sensitivity testing conducted in the model – and set forth in the NPRM – reveals what the resulting economic impact would be if the assumption was changed to reflect both higher and lower prevalence rates among those seeking to immigrate to the United States from a particular region.

In the HHS/CDC model and analysis, there does exist however one suspect foundational assumption for which no sensitivity testing was conducted. As noted in the Deloitte FAS Expert Report, HHS/CDC has based its analysis on the total number of immigrants to the United States for 2007 and has assumed that lifting the HIV travel and immigration ban will not by itself result in any increase in the number of immigrants to the U.S.³⁸ A flaw in that assumption, however, is that it ignores the fact that immediate relatives – which according to the Deloitte FAS Expert Report account for 40-47% of all immigrants to the U.S. – are not subject to numerical caps. Therefore, immediate relatives with HIV would not simply replace (or “crowd out”) an immigrant who is not HIV-positive, as the HIVEcon model assumes. The model captures HIV-related healthcare expenditures for these new immigrants, but the model fails altogether to account for the economic *benefits* – such as increased productivity and additional tax revenue – of these immediate family member immigrants.³⁹ Lambda Legal submits that one cannot conduct an accurate cost-benefit analysis while looking only at the debit side of the ledger sheet. In order to assess the economic impact of lifting the HIV travel and immigration ban, the economic benefits of the incremental increase in the total number of immigrants must also be taken into account.⁴⁰ Lambda Legal believes that including such benefits in the analysis would have reduced the HHS/CDC’s assessment of the degree of economic impact resulting from its decision to lift the HIV travel and immigration ban.⁴¹

³⁷ NPRM, 74 Fed. Reg. at 310803.

³⁸ Deloitte FAS Expert Report at 7-8.

³⁹ *See id.*

⁴⁰ Although HHS/CDC acknowledges that immigration “produces net economic gains for the U.S.,” citing a study finding that “immigrants, in general, create an annual economic impact of between \$1 billion and \$10 billion,” NPRM 47 Fed. Reg. at 31804, the agency completely ignores these incremental benefits because of the assumptions discussed above.

⁴¹ Even if the figure at which the HHS/CDC model arrives in terms of HIV-related healthcare costs for immigrants living with HIV is accurate, the figure must be viewed in context. When viewed in an “apples to apples” comparison with the total spent on healthcare in the U.S. (*i.e.*, all expenditures, regardless of payer), the incremental amount spent on healthcare for immigrants living with HIV is dwarfed to the point of being insignificant. *See* Deloitte FAS Expert Report at 10.

Additional Steps That Should be Taken Once the Proposed Rule is Adopted

Once, as HHS/CDC proposes and Lambda Legal urges, the HIV travel and immigration ban is lifted, the agency should work with other relevant U.S. agencies to ensure that these changes are well publicized. In order to ensure that this significant change in long-standing policy is properly administered, policy guidance and training of consular personnel and other immigration processors is crucial, and the agency should work closely with the Department of Homeland Security and Department of State to ensure that occurs promptly. Finally, the agency needs to take effective measures to ensure that persons who have been denied entry, stay, or residence because they are living with HIV do not face bias or discrimination if they reapply for admission, stay or residence.

Conclusion

Although difficult to quantify, the benefits – both at home and abroad – that will accompany the lifting of the HIV travel and immigration ban are very substantial. Lifting the ban, and the related requirement for HIV testing, will end requirements that lack medical or public health justification and are harmful to individuals, U.S. society, and the global community. Lambda Legal commends HHS/CDC for proposing these regulatory changes and urges the agency to adopt promptly the Proposed Rule and then to take the additional steps outlined above to ensure that the U.S. government's discrimination against foreign nationals living with HIV is brought to a complete halt.

Respectfully submitted,



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Exhibit A



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Re: Medical Examination of Aliens--Removal of Human Immunodeficiency Virus (HIV)
Infection From Definition of Communicable Disease of Public Health
Significance.

Dear Gentlemen:

Pursuant to an engagement letter dated July 21, 2009, Deloitte Financial Advisory Services LLP ("Deloitte FAS") was asked to evaluate a model included in the Notice of Proposed Rulemaking ("Notice") issued by the Centers for Disease Control and Prevention ("CDC") within the U.S. Department of Health and Human Services ("HHS") entitled "Medical Examination of Aliens--Removal of Human Immunodeficiency Virus (HIV) Infection From Definition of Communicable Disease of Public Health Significance."¹ That model estimates the potential healthcare costs and benefits to the American economy associated with eliminating the ban on immigration of persons with HIV/AIDS.

Our evaluation was performed by Thomas Dunn, a Ph. D. economist and Senior Manager in the Economic and Statistical Consulting group in collaboration with his colleagues.

¹ See *Federal Register*, Volume 74, Number 126 (July 2, 2009), pp. 31797-31809.

Executive Summary

Our observations are as follows:

- Overall, the model appears to be a reasonable attempt to estimate future healthcare expenditures attributable to the elimination of the ban on immigration for HIV-positive persons. The model appears to be thoughtfully constructed; it is well-documented and easy to use; it incorporates “real world” data from reputable sources; it appears to perform the required mathematical operations reliably; it clearly states assumptions; and it can accommodate alternative values for key parameters.
- Without challenging the choice of parameter values in the model, there are reasons to believe that the estimates presented in the Notice overstate the potential net costs to the U.S. economy.
 - An apparent transcription error overstates the total annual HIV-related healthcare expenditures by \$81 million or 22%.
 - Benefits (labor productivity, tax payments) associated with incremental immigrants are not counted against the incremental healthcare costs.
 - Healthcare expenditures, like other expenditures, can be expected to generate additional economic activity through a multiplier effect on the order of 2.3 to 2.7 that would act to offset the incremental costs.
- As calculated by the model, the total annual healthcare expenditures attributable to the removal of the ban on immigration of HIV-positive would amount to 0.16% of U.S. healthcare expenditures in calendar year 2007.

Subsequent sections of this report describe Deloitte FAS’ assessment approach and conclusions in more detail.

Assessment of the Healthcare Cost-Benefit Model

Our assessment of the CDC’s HIVEcon healthcare expenditure model has five main parts: a description of the purpose of the model; an evaluation of the model’s structure, assumptions, and calculations; discussion of two potential errors in calculations; a comparisons of the draft and final versions of the Notice; and an overall assessment of the model and comments on the cost and benefit concepts used in the model.

Purpose of the HHS model

The HIVEcon model is designed to estimate the potential expenditures to the U.S. economy, pursuant to Executive Order 12866, from changing the Part 34 regulation that would effectively allow the immigration of HIV-infected persons. The model focuses on healthcare expenditures and compares the expenditures to a baseline case, under which HIV-infected persons are not admitted or not allowed to adjust their status to permanent resident. The benefits of allowing the immigration of HIV-positive persons are characterized as either non-pecuniary or difficult to quantify: family reunification, acquisition of highly-demanded skilled labor, increased life expectancy, reduction of

stigma and discrimination, and reputational effects to the U.S.² As described below, the pecuniary benefits (such as labor productivity or taxes paid) generated by admitting HIV-positive immigrants are assumed to be identical to those that would be generated by HIV-negative immigrants if the HIV immigration ban were to remain in place.

We obtained the HHS' Notice published in the *Federal Register* on July 2, 2009 and the draft version dated June 16, 2009. We also obtained from the CDC's webpage, its Excel-based model that calculates potential healthcare costs ("HIVEcon") and its accompanying technical appendix.³

Model Structure and Assumptions

The HIVEcon model has five key components:

1. *Estimates for the number of potential HIV-infected immigrants that may arrive in the U.S. or be adjusted to permanent resident status within the U.S. under the new proposed rule.* This calculation relies on data from the Department of Homeland Security, Office of Immigration Statistics on the number and region-of-origin mix of legal permanent residents to the U.S. in 2007; data on HIV prevalence rates in regions of the world drawn from various United Nations reports; and assumptions about the number and regional mix of immigrants to the U.S. and HIV-prevalence rates among immigrants, and assumptions about changes in these values over time. The discussion in the Notice provides Primary, High and Low Estimates corresponding to various values of HIV prevalence among immigrants. The HIVEcon model allows the user to change the regional mix, the HIV-prevalence rates, and the growth in immigration over time.
2. *Life expectancy tables of HIV-infected persons.* These tables are based on research using national HIV surveillance data and assumptions about the average age at immigration. The HIVEcon model allows the user to change the average age at immigration.
3. *Onward transmission rate of HIV infections.* Most of the Notice assumes an average onward transmission rate of 1.51 per 100 among HIV-infected immigrants based on scholarly research and an assumption about the social behavior of immigrants.⁴ Estimates assuming a low value of 0% and a high value of 4.53% are also provided. The HIVEcon model allows the user change the onward transmission rate..
4. *Annual cost of treatment.* Most of the discussion in the Notice assumes an annual cost of treatment of \$25,200 per year based on research published in a medical journal.⁵ The model allows the user to change the annual cost of treatment.

² See Notice, pages 31803 and 31804.

³ See www.cdc.gov/ncidod/dq/laws_regs/part34/hivecon.html.

⁴ The average rate onward transmission rate due to sexual activity in the U.S. is 3.02 per 100 HIV-infected persons Pinkerton, S.D. "How many sexually-acquired HIV infections in the USA are due to acute-phase HIV transmission?" *AIDS*. 21(12, July 31, 2007) : 1625-1629.

⁵ Schakman et al., "The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States," *Medical Care* 44, 11 (November 2006): 990- 997.

5. *Discount rate for converting dollar values in the future to their present value.*
Most of the discussion in the Notice assumes a discount rate of 3%. The HIVEcon model allows the user to input a value for this parameter.

The model relies on a number of parameters that reflect national immigration policy, the prevalence of HIV around the world, HIV transmission patterns, and the annual costs and lifetime benefits of HIV treatments and how these things change over time. The model appears to have relied on reputable data sources for baseline parameter estimates. The assumptions are clearly stated, the sources are cited, and the choice of a particular value is justified. The future time paths for the number and mix of immigrants, the HIV-prevalence rates and onward transmission rates, and annual HIV-related healthcare costs are assumed to be flat at the most recent value to avoid having to make additional assumptions about the evolution of the parameters over time.

The HIVEcon model allows flexibility in specifying parameter values. In the discussion of results in the Notice, lower and upper bounds for some of the key parameters are provided, which allow for reader to determine which parameters have the largest influence on the results. Finally, in the Notice the CDC explicitly requests guidance from subject matter experts on the reasonableness of its assumptions and more realistic parameter values.

The HIVEcon model compares favorably to forecasting models that are commonly used in litigation and business consulting engagements. The HIVEcon model is thoughtfully crafted and contains all of the relevant components necessary to produce a reasonable range of estimates of HIV-related healthcare expenditures induced by the proposed rule change. The HIVEcon model is well-documented with citations of data sources and clear user instructions. The model is transparent in that assumptions are clearly explained and the sensitivity of the results to assumptions on key parameter values can be tested quite easily from the input “dashboard.” The model calculates expenditures in the first, fifth, tenth, twenty fifth and fiftieth year after promulgation of the rule.. Additionally, the model is constructed in a way that would allow for easy alteration to accommodate alternative specifications of the model components.

Model Calculations

As part of our assessment, we “looked under the hood” to test the soundness of the construction of the model. While we did not fully deconstruct the model and verify the accuracy of every data element, formula and calculation, we conducted the following validation tests:

- Check that key data from external sources was accurately entered (the number of legal permanent residents in 2007 by region of origin, number of HIV cases by region, annual cost of HIV-related treatment)
- Check that formulas were accurately coded (for example, formulas for calculating weighted averages, discounting future values, and converting number of cases to dollars of treatment costs)

- Check that references to values from one part of the model to another part of the model were coded correctly and were operational.

Our inspection detected no errors in transcription from data sources, no mistakes in formulas, and no faulty cell references.

We also ran the HIVEcon model under several dozen scenarios using various combinations of values for key parameters, such as HIV prevalence rates, onward transmission rates, annual HIV-related healthcare costs, discount rate, immigration growth rate, and age at immigration. In this testing, the model output changed in expected directions and with expected magnitudes. We were also able to reproduce key results presented in the Notice and in the model's technical appendix, with the two exceptions that are described below.

Reconciliation of Expenditure Estimates Presented in the Notice

In the reconciliation of the healthcare expenditure estimates reported in the Notice to the calculations in the HIVEcon model, we identified two potential calculation errors. The first one only affects the expository flow of the discussion of the sensitivity of the estimates to a specific parameter assumption. The second instance, on the other hand, results in a significant overstatement of the potential healthcare expenditures presented in the Notice.

First, the discussion on page 31806 of the Notice of the sensitivity of the model to the choice of onward transmission rates appears to contain a calculation error. The "upper bound" scenario is described as an onward transmission rate of 4.53 per 100 HIV-infected persons. The number of onward transmitted cases is presented as 261 with an associated expenditure of \$8.1 million. We believe the correct calculation for an onward transmission rate of 4.53% applied to the 4,275 annual new HIV-positive immigrants is 194 new cases ($4,275 \times .0453$) with an associated expenditure of \$4.9 million ($194 \times \$25,200$).⁶

The second potential calculation error is in the lower panel of Table 2, the Annualized Monetized Healthcare Expenditures for cases of onward transmission. It appears that the expenditure estimate was incorrectly transcribed from the HIVEcon model. Table 2 shows the Primary Estimate of 676 HIV-positive cases due to 1.51% onward transmission. This number of cases can be confirmed using the HIVEcon model with the "Primary Estimate" set of assumptions. At an annual treatment cost of \$25,200 per case, the discounted annual expenditures in the fifth year after the rule promulgation should be \$15 million, not \$96 million as displayed in Table 2.

⁶ The 261 figure is consistent with a rate of 6.09%, a value that is mentioned elsewhere in the Notice as the upper bound for HIV-prevalence rate among immigrants, rather than the upper bound on the onward transmission rate.

This calculation is confirmed by the HIVEcon model's estimate of total expenditures under the Primary Estimate set of assumptions. That total is \$357 million for the combined 16,431 HIV-positive immigrants and onward transmission cases, not \$438 million as stated on page 31806 in the Notice. This difference of \$81 million represents a 22% overstatement of the actual total expenditures in the fifth year after the rule promulgation.⁷ This potential error in the Notice does not undermine our opinion of the robustness of the HIVEcon model, rather it appears to be simply a mistake in transcribing output from the model to the Notice.

Draft versus Final Version of Notice

Another element of our assessment is a comparison of the calculations and the description of methods and results in the draft version of the Notice to the final version of the Notice. Both versions are based on calculations from the HIVEcon model and employ the same set of assumptions about parameter values and their evolution over time. Where the two versions differ is in the choice of the time horizon at which expenditures are measured.⁸ Specifically, the draft version of the Notice highlights expenditures in year 20 after the rule is promulgated, while the final version focuses on the expenditures in the fifth year after the rule is promulgated. The final version of the Notice argues that the shorter time horizon is more appropriate to mitigate the uncertainty about the future time paths of the key inputs to the model citing the “rapid pace of change in HIV treatment, HIV prevalence in other countries, as well as potential changes in overall immigration policy.” (p. 31806)⁹

Given that the model results are highly sensitive to these and other parameters and assumptions— as demonstrated by the range of estimates presented in the Notice— and given the uncertainty about the future values of these parameters and given that Executive Order 12866 provides no specific guidance on the time horizon to be used in a cost-benefit analysis and given that estimates for other time horizons are available in supporting documents, the selection of the five-year time horizon in the final version of the Notice is a reasonable choice.

Overall Assessment

Notwithstanding the apparent errors in exposition or transcription of results in the Notice, the HIVEcon model can be viewed as a reasonable attempt to estimate the healthcare expenditures associated with eliminating the ban on immigration for HIV-infected persons for the reasons given above. The estimates depend critically on the parameter and baseline assumptions on immigration patterns, HIV prevalence, HIV transmission, and HIV-related healthcare costs and treatment options.

⁷ Similarly, the Low Estimate in Table 2 should be \$4 million, not \$24 million and the High Estimate should be \$22 million, not \$145 million.

⁸ The draft version also presents more sensitivity analyses, most of which now appear in the Technical Appendix to the HIVEcon model.

⁹ The CBO cost estimate uses a ten-year horizon.

The model is flexible enough to accommodate changes to these parameters and baseline assumptions and it is to be expected that different assumptions will have significant impacts on the number of cases of HIV infection and the total expenditures resulting from elimination of the ban on immigration of HIV-positive persons.

For example, the model assumes all HIV-infected immigrants and persons who acquired HIV through onward transmission receive the “optimal” standard of care for all the remaining years of their lives, which comes at a cost of \$25,200 per year for every remaining year of life, at every age, and in all years in the future.¹⁰ In the model, this cost per year enters the expenditure calculation as a simple scalar to the number of HIV-infected immigrants; this means that a 10% decrease (or increase) in the treatment cost per year will reduce (increase) the total (undiscounted) expenditures in any year by exactly 10%. If not all persons seek or receive this level of care or if the average cost of care is lower than the “optimal” treatment costs, then the total healthcare expenditures estimated in the model would fall.

Comments on Cost and Benefit Concepts

Our assessment of the model also includes a consideration of the concepts of costs and benefits in the model.

Fixed Number of Immigrants and Omitted Benefits

The model assumes that the number of immigrants is held fixed at the 2007 level for each year in the future and that that each HIV-positive immigrant replaces an HIV-negative immigrant. Furthermore, the HIV-positive immigrants incur HIV-related healthcare expenditures that are estimated in the model, but on all other aspects of productivity, other healthcare expenditures, and costs to the government, the HIV-positive immigrants are identical to the HIV-negative immigrants they replace.

This assumption that the HIV-positive immigrants “crowd out” HIV-negative immigrants may make sense if there are annual numerical caps on immigration so that there is “competition” for the available slots. However, a large percentage of immigrants, some 47% in 2007 (and around 40% historically), were immediate relatives of U.S. citizens, a category of immigrants that is exempt from annual numerical limits.¹¹

In the HHS model, HIV-positive immediate relatives would currently be excluded from immigration; when the ban is lifted, in the absence of annual numerical limits, they would not “crowd out” HIV-negative immigrants, rather they would be incremental to the 2007 number of immigrants. All the HIV-related healthcare expenditures for these new

¹⁰ The \$25,200 figure (in 2004 dollars) and the description of the care as “optimal” is from Schakman et al., “The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States,” *Medical Care* 44, 11 (November 2006): 990- 997. The application of this cost in all future years is an assumption made in the HIVEcon model.

¹¹ Jeffreys, K. and R. Monger, “U.S. Legal Permanent Residents: 2007” Annual Flow Report, Office of Immigration Statistics, U.S. Department of Homeland Security, March 2008.

immigrants are already captured in the model, whether the HIV-positive immigrants replace HIV-negative immigrants or they are incremental. However, if the immediate family members are incremental to the total number of immigrants, the benefits that they generate— in the form of labor productivity or tax revenues— should be modeled and counted as an offset to their healthcare expenditures. While we have not attempted to calculate the value of these benefits, it is likely that they would offset a considerable portion of the healthcare expenditures and reduce the net cost to the U.S. economy.

Cost Concept

In the Notice healthcare expenditures are characterized as a cost to the economy. While a topic of great concern these days, healthcare expenditures should not be viewed solely as a drain on or cost to the economy. It is a tenet in economics that an expenditure has ripple effects in the economy as the new expenditure is a source of income for the recipient that then induces a further expenditure elsewhere in the economy, and so on. Models that measure the economic impact of infrastructure projects and other expenditures typically estimate the effects on economy-wide employment and output, known as “multipliers”, generated by additional expenditures in specific industries in the economy.

IMPLAN, a widely used economic impact model, contains output multipliers that have been estimated for hundreds of industries.¹² The 2007 IMPLAN output multipliers for subsectors of the healthcare industry range from 2.37 to 2.71.¹³ This means that each additional \$1,000,000 of healthcare expenditure in these subsectors eventually generates \$2.37 million to \$2.71 million of output in the U.S. economy. This compares to multipliers in road construction of 2.82 and in public education of 2.24.

Not All of the Expenditures are a Cost to the Federal Government

Not all the healthcare expenditures presented in the Notice are costs to be borne by the U.S. government; rather, the figure includes expenditures paid by other sources including private health insurance, personal funds, state and local governments. The Congressional Budget Office (“CBO”) calculated the cost to the federal government of eliminating the ban on immigration of HIV-positive persons, under a different set of assumptions, in October, 2008 in the cost estimate for HR 5501, “Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.” The CBO estimated additional government expenditures over ten years of \$83 million (through Medicare, Medicaid, and other programs) which were more than offset by \$104 million of additional revenue generated from an increase in visa application fees.

Expenditures in Context

¹² IMPLAN is a proprietary software package produced by Minnesota IMPLAN Group, Inc. and requires a subscription to access its data and documentation. The company’s website is www.implan.com.

¹³ This includes these industry codes: 394 Offices of physicians, dentists, and other health practitioners; 395 Home health care services; 396 Medical and diagnostic labs and outpatient and other ambulatory care services; 397 Hospitals; 398 Nursing and residential care facilities.

The incremental healthcare expenditure estimate can be viewed in the context of recent healthcare expenditures for HIV-related treatment and care. The estimate of incremental annual healthcare expenditures in the fifth year after promulgation of the rule is \$357 million (corrected from \$438 million in Notice as described earlier), which includes all payer sources: private insurance, charities, and federal and state governments.

According to the Kaiser Family Foundation summary of recent U.S. federal funding of HIV/AIDS, the FY 2009 expenditures on treatment and care paid by the federal government (through the Ryan White Program, Medicare and Medicaid) was \$11.4 billion.¹⁴ Data for HIV-related healthcare paid by private insurance, charities, and state governments in FY 2009 were not readily available for this assessment, which prevents an “apples to apples” calculation, but does provide a kind of upper bound: the annual expenditures modeled in the Notice account for about 3% (\$357 million/\$11.4 billion) of the federal government outlays for HIV-related healthcare in FY 2009. In another comparison of healthcare expenditures by all payer sources, the annual expenditures modeled in the Notice account for 0.16% of the total (\$2.2 trillion) healthcare spending in the U.S. in calendar year 2007.¹⁵

Summary

Our assessment of the healthcare expenditure model presented in the Notice can be characterized as follows:

- The HIVEcon model appears to be reasonable attempt to estimate future healthcare expenditures that are very sensitive to parameters that reflect national immigration policy, the prevalence of HIV around the world, HIV transmission patterns, and the annual costs and lifetime benefits of HIV treatments.
- The model relies on actual, recent values for parameters when they are available and clearly states its assumptions about the evolution of the parameters over time.
- The CDC recognizes that its choices for parameter and baseline values are “best guesses” and provides high and low values to demonstrate the sensitivity of the results and the importance of the assumptions.
- The CDC specifically solicits expert opinion on the reasonableness of the values and seeks more accurate values. Furthermore, the model appears to be able to handle changes in parameter and baseline values easily and is capable of generating new expenditure estimates with the new parameter values.
- The Notice presents what appears to be an error in the transcription of the treatment expenditures for onward transmitted HIV infections that potentially overstates the Primary Estimate of expenditures by \$81 million or 22%.

¹⁴ “U.S. Federal Funding for HIV/AIDS: The President’s FY 2010 Budget Request”, *HIV/AIDS Policy Fact Sheet* (publication #7029-05), The Henry J. Kaiser Family Foundation, May 2009.

¹⁵ Source for U.S. healthcare spending in 2007: National Health Expenditures Fact Sheet, “Historical NHE, including Sponsor Analysis, 2007”, www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp, accessed August 13, 2009.

- The total annual healthcare expenditure figure, \$357 million in the fifth year after the rule promulgation, is characterized as a cost to the economy. However, the incremental healthcare expenditures, like other expenditures, can be expected to generate additional economic activity through a multiplier effect on the order of 2.3 to 2.7.
- In the context of overall health care expenditures, the total annual healthcare expenditures attributable to the removal of the ban on immigration of HIV-positive persons, \$357 million in the fifth year after the rule promulgation (corrected for an apparent calculation error), amount to 0.16% of U.S. healthcare expenditures attributable to all payers in calendar year 2007.

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My Deloitte FAS colleagues and I appreciate the opportunity to work in support of Hogan & Hartson, Whitman-Walker Clinic and Lambda Legal as they prepare their responses to the Notice of Proposed Rule Making.

Yours truly,



Thomas A. Dunn
Senior Manager, Economic and Statistical Consulting
Deloitte Financial Services LLP



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August 17, 2009

Division of Migration and Quarantine
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
Attn: Part 34 NPRM Comments
1600 Clifton Road, NE, MS E-03
Atlanta, Georgia 30333

Re: Docket # CDC-2008-0001
Docket Title: Medical Examination of Aliens – Removal of Human Immunodeficiency Virus (HIV) Infection from definition of Communicable Diseases of Public Health Significance
RIN: 0920-AA26

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LEGAL COUNSEL
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The Global Business Coalition (GBC) is pleased to submit the following comments in support of the Department of Health and Human Resources' (HHS) proposed rule to revise the Part 34 regulation to remove Human Immunodeficiency Virus (HIV) from the definition of "communicable diseases of public health significance" and remove references to "HIV" from the scope of examinations in its regulations.

The United States Congress took an important and overdue first step last year when they enacted Public Law 110-293, which finally removed the statutory ban on HIV and restored the jurisdiction to HHS to make a medical and scientific determination of whether or not HIV constitutes a "communicable disease of public health significance." In doing so, Congressional leaders sought to correct one of our nation's most unjust and troubling health policy provisions. We are happy to see that HHS now seeks to remove the HIV regulatory ban, which will eliminate the unnecessary stigma and discrimination that foreign nationals living with HIV face when trying to enter the United States.

At present, people living with HIV/AIDS are barred from entering the United States without disclosing their HIV status, and also must apply for a special immigration waiver. This burdensome policy violates the right to privacy, freedom of movement, and freedom from discrimination for people with HIV/AIDS, with adverse implications for civil society, for America's standing in the world – and for U.S. and multi-national companies, whose HIV-positive employees and executives face significant and undue hurdles to entering the United States even for routine business purposes.

In many cases, the current HIV ban policy also requires that companies disregard their own policies prohibiting HIV status discrimination in the workplace. For instance, the Chevron Corporation's workplace policies affirm that the company's HIV infected and affected employees worldwide are protected by the company's existing policies on discrimination and

GBC is the official Private Sector Focal point for the Global Fund to Fight AIDS, Tuberculosis and Malaria.



harassment. Chevron's policy also includes a non-discrimination clause and guarantees employee HIV/AIDS status confidentiality – a guarantee undermined by current U.S. policy.

Global firms with major U.S. operations also have implemented non-discrimination policies, and fought discrimination against people with HIV/AIDS in the workplace. Accor, which operates hotel properties, such as Sofitel and Motel 6, in 90 countries including the United States, too has a global HIV/AIDS policy that includes a non-discrimination clause – as do many other multi-national firms that do business in the U.S.

On World AIDS Day 2008, over 120 CEOs of GBC member companies signed a public pledge declaring their commitment to HIV non-discrimination in the workplace. These important workplace statements and policies are indicative of the corporate community's commitment to HIV non-discrimination. Yet, the spirit of these statements and policies is undermined by the U.S. government's own immigration policies.

The existing ban sends a signal, globally and domestically, that HIV status is fair grounds for discrimination, a message that encourages silence and secrecy, and runs directly counter to global and domestic efforts to destigmatize HIV and encourage HIV testing and care. Removal of HIV from the list of "communicable diseases of public health significance" in immigration guidelines would not only reduce stigma and discrimination, themselves leading causes of HIV ignorance and, ultimately, transmission, but also bring U.S. immigration policy in line with that of our allies and trading partners, and send a strong signal that the U.S. is committed to ending the HIV/AIDS crisis through research, compassion, and sound public policy.

Furthermore, if a foreign national does not have a qualifying relative, s/he cannot even apply for an HIV waiver under current policy. This means that highly skilled workers, whom the Department of Labor has determined will benefit the U.S. labor market; who are likely to be highly-educated; and who have private health insurance through their employers, still are ineligible to seek a waiver, and are needlessly excluded from permanent residence in the U.S.

In regards to the cost projections presented in the proposed rule, external analyses suggest that the Department's conclusions are reasonable, and that the costs may in fact prove lower than the estimate included in the regulation.

Again, we commend and support HHS for developing this proposed rule, and we urge you to move expeditiously in finalizing guidelines on this important issue.

Sincerely,

John Tedstrom, Ph.D.



Pfizer Inc
235 East 42nd Street
New York, NY 10017
Tel 212 733 4935 Fax 212 808 8924
Email jeff.kindler@pfizer.com



Jeffrey B. Kindler
Chairman of the Board
Chief Executive Officer

August 24, 2009

Division of Migration and Quarantine
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
Attn: Part 34 NPRM Comments
1600 Clifton Road, NE, MS E-03
Atlanta, Georgia 30333

Re: Docket # CDC-2008-0001
Docket Title: Medical Examination of Aliens – Removal of Human
Immunodeficiency Virus (HIV) Infection from definition
of Communicable Diseases of Public Health
Significance
RIN: 0920-AA26

Dear Sirs/Madams:

Pfizer commends the Department of Health and Human Resources for its proposed rule to revise the Part 34 regulation to remove “Human Immunodeficiency Virus (HIV) from the definition of “communicable diseases of public health significance” and remove references to “HIV” from the scope of examinations in its regulations.

Pfizer supports bringing U.S. health and immigration policy in line with the policies our company has made in the fight against HIV stigma and discrimination in the workplace. Ending the travel and immigration ban would send a strong signal that the U.S. is committed to ending the HIV/AIDS crisis through affirming and non-discriminatory public policy. In fact, on World AIDS Day 2008, Pfizer joined over 120 CEOs of other U.S. and multi-national companies in signing a public pledge declaring their commitment to HIV non-discrimination in the workplace. We are concerned that the spirit of these statements and policies is undermined by the U.S. government’s own immigration policies. Moreover, as stated

August 24, 2009
Page 2

by the Centers for Disease Control within their own justification for the proposed rule, there is no evidence that a travel ban based on HIV status is an effective public health strategy.

Accordingly, we are forwarding comments submitted by the Global Business Coalition (see attachment), and we ask that you fully consider the comments in promulgation of the rule and ask that you finalize the process as quickly as possible.

Sincerely,

A handwritten signature in blue ink that reads "Jeff Rudler". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke at the end.

August 17, 2009

Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
Attn: Part 34 NPRM Comments
1600 Clifton Road, NE, MS E-03
Atlanta, GA 30333

RE: Medical Examination of Aliens – Removal of HIV Infection from Definition of Communicable Disease of Public Health Significance (Docket # CDC-2008-0001)

To Whom It May Concern:

I am writing on behalf of Levi Strauss & Co. (LS&CO.) to urge the Department of Health and Human Services (HHS) to adopt the proposed rule, published in the July 2, 2009 *Federal Register*, that would end the ban on HIV-positive visitors and immigrants to the United States. The much over do end of this ban will eliminate the unnecessary discrimination and stigma that people living with HIV/AIDS face when trying to enter the United States.

LS&CO. is one of the world's leading branded apparel companies, marketing its products in more than 100 countries worldwide. The company designs and markets jeans-related pants, casual and dress pants, shirts, jackets and related accessories for men, women, and children under the Levi's®, Dockers®, and Signature by Levi Strauss & Co.™ brands. Based in San Francisco, California, LS&CO. is a global corporation with roughly 11,000 employees worldwide.

Since 1982, LS&CO. has been at the forefront of HIV/AIDS education, policy change and consumer education. We have advised businesses and multilateral organizations such as the International Labor Organization (ILO) on HIV/AIDS workplace practices, including business approaches to curb discrimination and stigma and improve access to much needed prevention, treatment and care. We also have been key partners with HHS and the Center for Disease Control and Prevention (CDC) in shaping the U.S. response to HIV/AIDS.

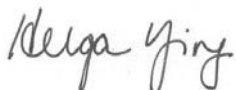
We recently signed a commitment alongside 120 companies to end HIV/AIDS stigma in the workplace, and we are extending comprehensive HIV/AIDS prevention, treatment and care -- including access to antiretroviral medication, counseling, preventive care, and education -- to all LS&CO. employees and their families worldwide. Wherever we have a business presence, at home in California and abroad, we consistently bring a disciplined and courageous approach to the ultimate eradication of the HIV/AIDS epidemic.

The current U.S. travel restrictions not only have public health and human rights implications, but also impact the ability for businesses to access talent and thrive in the global marketplace. Global businesses working to fight HIV/AIDS -- that confidentially support employees with their needs and assist impacted employees to remain productive in the global marketplace -- depend on policies that allow for safe and nondiscriminatory freedom of movement across borders.

We commend HHS for proposing changes to U.S. travel regulations that will end the ban against people living with HIV/AIDS. This proposal is the right thing to do, and we urge you to finalize and adopt the rules change as soon as possible.

Thank you for your consideration and please do not hesitate to contact me at (415) 501-3974 if you have any questions and/or need additional information regarding our position on this issue.

Sincerely,



Helga Ying
Director, Worldwide Government Affairs and Public Policy



OraSure Technologies, Inc.

September 23, 2009

The Honorable Daniel K. Inouye
Chairman,
Committee on Appropriations
United States Senate
S-131 U.S. Capitol
Washington, DC 20510

The Honorable David Obey
Chairman,
Committee on Appropriations
U.S. House of Representatives
H-218 U.S. Capitol
Washington, DC 20515

The Honorable Thad Cochran
Vice Chairman,
Committee on Appropriations
United States Senate
S-146A U.S. Capitol
Washington, DC 20510

The Honorable Jerry Lewis
Ranking Member,
Committee on Appropriations
U.S. House of Representatives
1016 Longworth House Office Building
Washington, DC 20515

Dear Chairmen Inouye and Obey and Ranking Members Cochran and Lewis:

I write to you as Vice President of Government and External Affairs of OraSure Technologies, Inc. Based in Bethlehem, Pennsylvania, OraSure Technologies develops, manufactures and markets point-of-care, oral fluid specimen collection devices that leverage proprietary oral fluid technologies, diagnostic products, including immunoassays and other *in vitro* diagnostic tests, and other medical devices.

These products include tests for the detection of antibodies for the HIV virus, including OraQuick *ADVANCE*® Rapid HIV-1/2 Antibody Test and the OraSure HIV-1 Oral Specimen Collection Device, and oral fluid testing solutions for drugs of abuse testing, including Intercept® Oral Fluid Drug Testing System and Q.E.D.® Saliva Alcohol Test.

As a member of the US and global business community – a community committed to empirical analysis, science, and data-based decision making – we join with the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) in urging Congress to rescind the ban on federal funding for syringe exchange programs (SEPs) and to remove restrictions on funding these programs to allow localities and states the flexibility to implement evidence-based HIV prevention initiatives.

According to the US Centers for Disease Control and Prevention (CDC), injection drug users (IDUs) account for one-fifth of the 1 to 1.5 million Americans living with HIV/AIDS and 16% of new HIV infections. Fortunately SEPs have proven to be an effective public health approach to reducing the spread of HIV and other life-altering diseases. Numerous scientific studies, including several funded by

the federal government, demonstrate that SEPs, when implemented as part of a comprehensive HIV/AIDS prevention strategy, do not increase rates of drug use among existing users or encourage initiation of drug use; and do decrease the number of new HIV infections; increase the number of injection drug users referred to and retained in substance abuse treatment; provide opportunities for multiple prevention services, referral and entry into medical care.

Likewise, numerous scientific, health, and law enforcement leaders, including the Institute of Medicine, the American Medical Association, the American Bar Association, three former US Surgeons General, and many public safety and law enforcement organizations across the US support SEPs as an effective health and humanitarian intervention, helping people avoid contracting and transmitting HIV and other life-altering diseases.

As such, we commend the Congress' determination to remove the ban on the use of federal funds for SEPs, and also support proposals to remove language restricting federal funding to SEPs that operate within 1,000 feet of selected establishments. The 1,000-foot restriction, if it stands, would infringe on local autonomy, make it nearly impossible for local governments and agencies to utilize federal resources for SEPs, and severely hamper efforts to implement such programs, particularly in urban areas, where public health officials say they are needed most.

We urge the US Congress to work for full removal of the federal funding ban on syringe exchange programs, in turn reducing HIV transmission in the US. We at OraSure Technologies would appreciate the opportunity to meet with you and your staff during the coming weeks, to discuss the above. Please let me know when you might be available to meet in person in the coming weeks.

Thank you and we look forward to speaking with you soon.

Regards,



Debra Fraser-Howze
Vice President Government and External Affairs
OraSure Technologies, Inc.

APPENDIX B
HIV/AIDS Workplace Policies

HIV/AIDS is a substantial worldwide threat with enormous human impact and attendant social, economic, and political risks that directly affect our employees and our business. Consistent with our values, Chevron will strive to meet the challenge this threat presents to our business through strategic leadership in our industry and in the communities where our employees live and work.

Further Guidance

Counsel on this policy may be obtained from Human Resources, Regional Shared Services as well as Corporate Law and the Health and Medical Services Staff as appropriate. Employees and supervisors based outside the U.S. with additional questions should contact their Regional Medical Directors for additional local policy information and procedures where they may exist.



Chevron Corporation
Health and Medical Services
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3M IDC 4563 11/05



Policy 260 HIV/AIDS



We're determined to make a difference.

Keeping people healthy is The Chevron Way.

Scope

This policy applies to all Chevron employees worldwide.

Non-discrimination

Employees with HIV/AIDS are fully protected by the company's existing harassment and discrimination policies (e.g., Policy 200 – Employment and Policy 202 – Harassment).

Pre-employment HIV Testing

The company will not conduct pre-employment HIV testing except as required by national and/or local laws. If pre-employment HIV testing is required by national or local laws, employment decisions will not be based on the results of the HIV testing. Applicants will not be asked about their HIV status when applying for a job.

Employment Benefits

Employees who become ill with HIV/AIDS will be treated like any other employee with a life-threatening illness and will be administered under the terms of the rules of their respective benefit plans.

Confidentiality

Confidentiality regarding the HIV/AIDS status of an employee shall be maintained at all times consistent with company policies as

described in the *Business Conduct and Ethics Manual*.

Treatment and Support

The company's intent and long-term goal is to secure treatment for employees and covered dependents, in the presence of accepted medical practice, appropriate medical expertise and infrastructure, pharmaceutical logistics, and national laws in their country or region of employment.

Partnerships

The company will strive to engage and work with national and local governments, public and non-governmental organizations, and multilateral agencies to deploy best practices in the prevention, care, treatment and support of HIV/AIDS in areas where the company operates.

Workplace and Community Programs

Consistent with need, workplace and community programs of education, awareness, prevention and treatment will be promoted in areas where the company operates.

Policy Review

This policy will be reviewed on a regular basis and amended as deemed appropriate.

Responsibility

The Director, Health and Medical Services, will:

- provide advice and counsel on matters pertaining to HIV/AIDS prevention and treatment;
- recommend HIV/AIDS policy changes;
- represent the corporation on HIV/AIDS policy externally.

Individual business units will determine the required extent of policy implementation consistent with local need.

Employees who believe they have been subjected to harassment based on their HIV/AIDS status should immediately report the incident to their supervisor, a higher level of management, their local/designated Human Resources contact, their local



**Chevron will strive
to meet the challenge.**

Ombuds or the Company Hotline. For outside the U.S., the Hotline's number is +1-704-552-1236. In the U.S., the number is 1-800-284-3015. All complaints will be promptly and thoroughly investigated. The company will treat such complaints as confidentially as possible, releasing information only to those with a need or right to know.



Merck & Co., Inc.

Executive Summary - HIV/AIDS, Tuberculosis and Malaria Workplace Policy

Merck & Co., Inc. is a leading research driven pharmaceutical company with over 60,000 employees operating in more than 90 countries worldwide. Merck recognizes that infectious diseases, in particular HIV/AIDS, TB, and malaria, represent major health care burdens worldwide and pose a critical challenge to nations, communities and people across the globe, including Merck employees and their families.

Consistent with the company's longstanding commitment to its employees and to improving human health and expanding access to medicines and quality care, Merck has an HIV/AIDS, Tuberculosis and Malaria Workplace policy that ensures that our employees and their dependents have access to appropriate disease prevention programs and access to a minimum standard of medical care and treatment. The workplace policy formalizes and extends existing practices and applies to all Merck employees and dependents globally to lessen the social, economic and health burdens that accompany HIV/AIDS, TB, and malaria.

Policy Principles

The following principles guided the development of the HIV/AIDS, TB and Malaria Workplace Policy:

- Ensure that all employees and their dependents have access to prevention, care and treatment for HIV/AIDS, TB and malaria.
- Ensure that HIV/AIDS, TB and malaria care and treatment programs for all Merck employees and their dependents meet a minimum standard of care, and that prevention programs are locally appropriate.
- Promote confidentiality, equal opportunity, non-discrimination and reasonable accommodation of employees, including those with HIV/AIDS, TB or malaria.
- Supplement and support local governmental healthcare responsibilities.
- Provide company-sponsored benefits where local access to appropriate prevention, care and treatment is inadequate.

Policy elements include:

- 1. Non-Discrimination.** Equal opportunity for all people without regard to race, color, national origin, sex, sexual orientation, age, marital status, religion, veteran status, health status or disability with respect to employment. HIV screening for employment purposes is not conducted unless explicitly required by law.
- 2. Confidentiality.** Information about an employee's medical condition is private and is treated in a confidential manner.
- 3. Accommodation of Employees with HIV/AIDS, TB or Malaria.** As a matter of policy, Merck assigns employees to jobs that they are physically able to perform. Employees with HIV/AIDS, TB and/or malaria, as with any other disease, will be treated the same as other employees with regard to absenteeism, assessment, and consideration for reasonable accommodations. Moreover, HIV/AIDS, TB or malaria infection is not a cause for termination of employment.

Merck & Co., Inc.
HIV/AIDS, Tuberculosis and Malaria Workplace Policy

- 4. Prevention.** Prevention is a key component of a workplace policy. Geographically appropriate prevention initiatives will be a cornerstone of each subsidiary's program. Where the nature of work assignments may pose a known risk of infection to employees, appropriate safety education, training and prophylactic treatment will be provided, and based on locally appropriate norms.
- 5. Treatment and Care.** The policy provides access to a minimum standard of treatment and care for Merck employees and eligible dependents with HIV/AIDS, TB or malaria, respectively. Access includes voluntary counseling and testing, quality medical services and facilities (evaluation, education, monitoring, prevention and treatment advice), reliable laboratory services, ongoing access to appropriate quality disease related medications, and medical evacuation to a regional facility if local facilities and care are inadequate.
- 6. Continuation of Treatment Coverage.** The policy provides for continued treatment of eligible participants subsequent to the employee's end of employment with the company until they are covered by a new employer. The continued coverage provided shall be secondary to any government-provided coverage.

This workplace policy will be monitored and evaluated on an ongoing basis to ensure that programs are appropriate and effective.



Brink's is an organization that continues to evolve and grow as a global corporate citizen. As such, we're particularly concerned about the HIV/AIDS crises, which is destroying individuals, families and entire communities around the world. We at Brink's recognize that the workplace has a vital role to play in the wider struggle to limit the spread and effects of this devastating disease. Our concern is how this epidemic may adversely impact our employees, their families, and our communities

OUR GUIDING PRINCIPLES

In recognizing and respecting the rights of our employees around the world, and in promoting their engagement against the fight against HIV/AIDS, Brink's has adopted the following principles that support our Company's Global HIV/AIDS Policy Statement:

- Ensure that all employees and their dependents have access to prevention, care and treatment for HIV/AIDS, and provide company-sponsored benefits where local access to appropriate prevention, care and treatment is inadequate.
- Promote appropriate, preventative programs that assure all individuals and groups of employees are treated fairly and equally and that no groups or individuals are discriminated against within the context of HIV/AIDS.
- HIV/AIDS will not be a consideration for employment, retention or promotion of current or prospective employees.
- Ensure that individuals in the workplace affected by HIV/AIDS will be protected from stigmatization, harassment, retaliation, or discrimination.
- Ensure all employees the right to keep personal, non-business related information confidential, including information about their HIV/AIDS status. There are no obligations for any employee to inform Brink's regarding his/her HIV/AIDS status.
- Ensure that employees with HIV/AIDS are entitled to the same rights and opportunities as other employees, including those with serious or life-threatening illnesses.

- When an employee affected by HIV makes his/her condition known to the Company, Brink's will make reasonable attempts to provide an accommodation to enable that employee to perform the essential functions of the job, unless the accommodation would impose an undue hardship on the business.
- Educate employees by providing accurate information relative to HIV/AIDS.
- Develop sustainable partnerships with national and community based organizations in order to foster social responsibility and advance global citizenship.
- Identify resources for employees to seek voluntary counseling and testing.

OUR COMMITMENT

Brink's on-going involvement in the global fight against HIV/AIDS will continue to be characterized by our commitment to:

- Train our management
 - Provide accurate information and guidance to our employees
 - Leverage governmental and community programs and resources
 - Encourage and support employee volunteer activities, and
 - Provide support in on-going HIV/AIDS education and research.
-

Levi Strauss & Co. Worldwide HIV/AIDS Workplace Policy

P R E A M B L E

HIV/AIDS poses a complex challenge for the global workforce. It impacts the health of employees and their dependents, employee absenteeism, and productivity. At the same time, HIV/AIDS underscores the importance of employee rights, nondiscrimination, and confidentiality.

While LS&CO. believes that public health is primarily the responsibility of national and local governments, specific issues around HIV/AIDS require companies like ours to reinforce workplace practices that ensure confidential access to key HIV/AIDS prevention, treatment and care services.

Since the early 1980s, LS&CO. has been committed to addressing HIV/AIDS in the workplace. Our business response has been guided by our company values and advanced by our Citizenship Value Proposition (CVP). As such, our goals are to develop prevention education programs, and care and treatment initiatives, to ensure that our employees and their families are treated with dignity and respect, and can access HIV/AIDS services when needed. For additional information, please refer to the HIV/AIDS Prevention, Treatment and Care Program website on Threads: <http://lportal/sites/hiv/ep/default.aspx>.

The following global policy, supported by our Worldwide Code of Business Conduct, outlines key principles relevant to HIV/AIDS (e.g. confidentiality of personnel information, nondiscrimination). We encourage all LS&CO. employees to familiarize themselves with the content of this policy.

Recognizing that developments regarding HIV/AIDS are ongoing, we regard this policy as a living document that will be further enriched as more clarity emerges about HIV/AIDS, the management of the disease, and medical, occupational and employment developments surrounding it. Accordingly, we will monitor developments and amend this policy as appropriate. Any changes will be communicated on the HIV/AIDS Prevention, Treatment and Care Program website on Threads: <http://lportal/sites/hiv/ep/default.aspx> and through local HR representatives, where appropriate.

B A C K G R O U N D

Building on our values of Empathy, Originality, Integrity and Courage, the underlying philosophy of the Worldwide HIV/AIDS Workplace Policy is to ensure access to a healthy working environment, and comprehensive prevention, treatment and care for LS&CO. employees and their dependents worldwide. This policy supports our effort to advance best practices in HIV/AIDS workplace programs that position us as leaders in the apparel industry, while building on our strong legacy and commitment to addressing HIV/AIDS issues in the workplace.

P U R P O S E

The LS&CO. Worldwide HIV/AIDS Workplace Policy has been formulated in line with relevant national and international guidelines and codes of practice (see LS&CO. Worldwide Code of Business Conduct, Local Requirements). The Policy is intended to:

- support the Company's commitment to provide a safe and healthy workplace for all employees;
- heighten the awareness of employees (and their dependents) regarding HIV/AIDS issues, including prevention, treatment and care services, where possible;
- ensure a supportive work environment for all employees regardless of their HIV/AIDS status;
- eliminate stigma and discrimination in the workplace on the basis of actual or perceived HIV status, or vulnerability to HIV infection; and
- manage and mitigate the business impact of HIV/AIDS in the workplace.



BASIC PRINCIPLES

Environment:

- LS&CO. agrees and commits to the creation of a supportive environment where the human rights and dignity of employees and dependents, including those living with HIV/AIDS, are protected. All HIV-positive employees and those living with AIDS should be protected from HIV-related discrimination.
- LS&CO. endeavors to create a supportive (non-hostile) environment. We also endeavor to offer employees the opportunity to discuss their concerns and obtain information.
- LS&CO. will not discriminate on the basis of actual or perceived HIV status, or individuals perceived to be at increased risk of HIV infection, in the conditions of work, including recruitment, deployment, retirement, employee development, promotions, and access to and receipt of, benefits.
- LS&CO. will make every effort to ensure that employees with HIV are not stigmatized and will take appropriate action when such behavior is discovered.

Employment:

- LS&CO. will continue to follow appropriate hiring practices in accordance with legal practices in the locations where we operate.
- LS&CO. will not require mandatory testing for HIV, except as required by national or local laws or trade union agreements. When testing occurs, it must be with informed consent. Medical confidentiality and privacy regarding HIV/AIDS status will be protected.
- HIV status will not affect employment at-will, terms of employment, hiring practices, or any other aspect of employment as required under local law. The only medical criteria for all LS&CO. employees are fitness, capacity to work and ability to perform essential functions of the job.
- LS&CO. agrees that employees living with HIV/AIDS should, at a minimum, be managed in a manner comparable to employees suffering from any other chronic disease, in terms of employment policies and benefits, including but not limited to, absenteeism, assessment, work accommodation, disability benefits and leave of absence.

Confidentiality:

- LS&CO. is committed to ensuring absolute confidentiality of all employees' health information. Any breaches of confidentiality will be treated seriously and our Worldwide Code of Business Conduct will be applied in HIV/AIDS circumstances.

Local Differences:

- This HIV/AIDS policy shall be in compliance with international good practice guidelines, relevant national statutes and the LS&CO. Worldwide Code of Business Conduct.
- LS&CO. will do its utmost to allow local communities to benefit from the preventive activities that LS&CO. organizes for its employees.



ELIGIBILITY

Unless otherwise stated, this policy applies to the following populations:

- All LS&CO. employees (full-time, part-time, hourly, etc.) who are on LS&CO.'s payroll irrespective of participation in other employee-benefit programs.
- All legal dependents of LS&CO. employees, including spouses, domestic partners, and children, biological, adopted and orphaned.

Additional details on Program Eligibility criteria for the HIV/AIDS Prevention, Treatment and Care Program can be found on the Threads website: <http://lportal/sites/hiv/ep/default.aspx>.

DEFINITIONS

The following are terms defined to support this Policy. For more information and/or more detailed descriptions, please refer to the Worldwide Code of Business Conduct and the HIV/AIDS Prevention, Treatment and Care Program website on Threads.

AIDS (Acquired Immune Deficiency Syndrome)	The disease caused by HIV, which weakens the body's immune system until it can no longer fight off the simple infections that most healthy people's immune system can resist or control (such infections are called "opportunistic infections").
Dependent	All legal dependents of LS&CO. employees, including spouses, domestic partners, and children, biological, adopted and orphaned.
Spouse	One's legally married wife or husband.
Domestic Partner	An individual in an unmarried relationship with an LS&CO. employee sharing a committed relationship with the following characteristics: living together as an unmarried couple; financially interdependent; jointly responsible for each other's common welfare; and consider themselves to be life partners.
Discrimination	Prejudicial or harassing treatment of an employee based on that person's HIV status as applicable under local law.
Employee	Any person who is employed at-will or party to a contract of employment to which LS&CO. is the employer party.
HIV (Human Immunodeficiency Virus)	The virus that may cause AIDS.
HIV/AIDS	Another term for expressing the continuum of HIV-related conditions.
Stigma	Disapproval of personal characteristics or beliefs that are against cultural norms.

LS&CO. will review and update this policy on a regular basis to ensure that it is in line with legal regulations and other policies, and to ensure that the rights and interests of all groups are taken into account.

For additional information, please refer to the HIV/AIDS Prevention, Treatment and Care Program website on Threads: <http://lportal/sites/hiv/ep/default.aspx>.



APPENDIX C

Funders Concerned About AIDS: Alabama Spotlight

Spotlight: Alabama

HIV/AIDS, AIDS Organizations,
and Private Foundation
Support in Alabama,
2000-2005



Funders Concerned About AIDS

Spotlight: Alabama

HIV/AIDS, AIDS Organizations,
and Private Foundation
Support in Alabama,
2000-2005



Funders Concerned About AIDS

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Letter from FCAA's Executive Director

Dear Colleague,

Since 1987, Funders Concerned About AIDS (FCAA) has worked to mobilize philanthropic leadership, ideas, and resources in the fight against AIDS. As the epidemic has grown and changed, we have adapted our programming to fit the needs of those affected by HIV/AIDS and to reveal key opportunities for private philanthropy. One trend uncovered in recent research by FCAA is the growing internationalization of AIDS philanthropy, and we look forward to serving the field with internationally focused programming. However, we also remain firmly committed to focusing all funders on the domestic epidemic that continues to ravage the most disadvantaged in our own nation.

This year, FCAA is proud to introduce the **Spotlight** series, a new programming initiative dedicated to building awareness around specific regions, communities, and issues. Alabama is the first of these **Spotlight** regions.

Why Alabama? The U.S. South is home to over 40% of all people living with AIDS in the United States—a higher concentration than any other U.S. region. From 2001 to 2005, the estimated number of people living with AIDS in the South increased by 33%—a higher percentage increase than in any other U.S. region. The Deep South, comprised of Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina, faces broad public health challenges which exacerbate the spread of HIV and complicate the plight of those living with AIDS. And yet in 2006, only 19% of U.S. philanthropic commitments for HIV/AIDS went to the South. Alabama is one state that has experienced both the epidemiological challenges and funding shortfalls common to the region. Additionally, and encouragingly, Alabama is the site of a new National AIDS Fund (NAF) Community Partnership: the Alabama Community AIDS Fund. FCAA is focusing on Alabama as an entry-point into the Deep South. Working on the state level provides a microcosm for detailed research and allows us to highlight specific challenges, as well as opportunities for additional private philanthropic investment.

This report synthesizes three main sources of information: epidemiological research provided by the UCLA Program in Global Health; resource tracking data generated by FCAA; and qualitative, front-line perspectives from both foundation and AIDS service executives. It seeks to present a multi-layered portrait of HIV/AIDS in Alabama, the past philanthropic response, and key opportunities for funders. This approach underscores FCAA's commitment to data-driven research, as reflected in our yearly publication, *U.S. Philanthropic Commitments for HIV/AIDS*, and our dedication to movement-building across broad constituencies. **Spotlight: Alabama** is FCAA's first in-depth report of this kind, and we hope it serves as a starting place—for further research on philanthropy, for greater awareness of the crisis of AIDS in Alabama and the South, and for new philanthropic initiatives in the fight against AIDS.

The local focus of the **Spotlight** series also speaks to FCAA's mission of inclusion. Our mantra at FCAA in recent years has been "every grant counts." Whether your grantmaking focuses exclusively on HIV/AIDS or provides critical HIV/AIDS grants within far broader portfolios, we consider you an AIDS funder; FCAA is your affinity group. We hope the **Spotlight** series expands the range of AIDS funders, and look forward to continued service and collaboration in this essential effort.

Sincerely,



Sunita Mehta

Executive Summary

Like much of the Deep South, Alabama faces a growing HIV/AIDS epidemic in the context of broader health care challenges. Alabama is among the three poorest states in the nation and ranks 45th among all states in overall population health.¹ The AIDS case rate in Alabama was estimated at 11.4 per 100,000 people in 2005.² Moreover, by 2004, all of the states within the Deep South were among the 15 with the highest HIV death rates, with Alabama's at 4.3 per 100,000.³ The key epidemiological challenges of HIV/AIDS in Alabama include elevated risks for and impacts on vulnerable populations, including African-Americans, women, men who have sex with men (MSM), and youth; the rural geographical dispersion of at-risk and people living with HIV/AIDS (PLWHA) populations; late HIV and AIDS diagnoses; delayed access and poor adherence to care; and high rates of associated health problems, including poor general health, high rates of sexually transmitted infections (STIs), and potential for mental health difficulties.

U.S. Philanthropic Commitments for HIV/AIDS: 2005 & 2006, the most recent edition of FCAA's signature annual publication, found that "as in previous years, the Northeast of the U.S. received a considerable share of all domestic funding ... the regional distribution of domestic HIV/AIDS-related philanthropy contrasts with the epidemiology of the U.S. epidemic, as Southern states continue to account for the greatest number of new AIDS diagnoses and the largest number of people living with AIDS."⁴ The CDC reports that the South has a higher concentration of people living with AIDS than any other U.S. region, and yet in 2006, only 19% of U.S. philanthropic commitments for HIV/AIDS were directed to the South.⁵

Alabama's AIDS service organizations (ASOs) and related clinics represent an important point of service for PLWHA in Alabama. Though Ryan White Program funding to Alabama has increased, certain funding-gaps remain, and ASOs still face difficulties providing services sufficient to the problem of HIV/AIDS in the state. Private philanthropy has the potential to profoundly improve the ability of service organizations to deliver services effectively, to support programs tailored to local needs, and to strengthen the institutions necessary

for a sustained response to HIV/AIDS.

Private philanthropic support to Alabama's ASOs increased significantly between 2001 and 2005. While this growth is encouraging, it was fueled by trends that present unique development challenges to ASOs. Generally, large grants from a few non-Alabama foundations drove growth in dollar amounts, while an increasing number of small grants from Alabama foundations drove growth in numbers of funders and grants per year. To be used strategically, large grants must be maintained as dependable, long-term sources of revenue. Small grants indicate valuable potential, but may not represent an easily managed revenue stream or good value for time spent on development. In the past, private funders have not always sustained their support of Alabama ASOs consistently from year to year. This has created uncertainty in planning programs, and strain on the often-meager development resources of ASOs.

To help address these challenges, funders can:

- Support secondary services, including prevention education, outreach, and transportation.
- Provide increased support for operating and infrastructural costs.
- Work to foster sustained funding relationships with grantees.
- Support tailored, targeted prevention efforts.
- Fund programs to increase early detection of HIV infection and improve access to treatment.

Organizations Included in this Report

FCAA's mission is to mobilize the ideas, leadership, and resources of private philanthropy in the fight against HIV/AIDS. Additionally, one goal for this report was to provide a precise year-to-year comparison of grantmaking activity between specific organizations. Tax reporting conventions mean that these data are only readily available for private foundations registered as 501(c)3 organizations. For these reasons, this report focuses on grants made by private foundations *directly* to AIDS service organizations in Alabama, and does not examine individual or corporate givingⁱ or grants made by federated fundraising agencies.ⁱⁱ Government granting programs dedicated to HIV/AIDS are not the primary focus of this report, but constitute the backbone

of financing for the recipient organizations, and so are discussed briefly in relation to the challenges relevant to private philanthropy.

People living with HIV/AIDS (PLWHA) in Alabama rely on a wide range of community-based organizations (CBOs) and other non-AIDS-specific organizations. However, the design of this project and methodological constraints dictated a focus on a consistently determinable group of foundations and organizations. We chose to limit our research to the AIDS-specific service organizations in the state, and the foundations that directly supported them between 2000 and 2005.ⁱⁱⁱ A detailed discussion of methodology can be found in Appendix 1.

Private Foundations Supporting Alabama's AIDS Service Organizations^{iv}

FOUNDATION	LOCATION	TOTAL GRANTED TO ALABAMA ASOs, 2000-2005
Broadway Cares/Equity Fights AIDS	New York, NY	\$225,000
The Pfizer Foundation, Inc.	New York, NY	\$150,000
Wayne and Ida Bowman Foundation	Chattanooga, TN	\$139,000
Gill Foundation	Denver, CO	\$107,800
M•A•C AIDS Fund	New York, NY	\$78,387
Liz Claiborne Foundation	New York, NY	\$56,440
Caring Foundation	Birmingham, AL	\$54,200
Protective Life Foundation	Birmingham, AL	\$45,500
The Community Foundation of Greater Birmingham	Birmingham, AL	\$44,350
Alabama Power Foundation	Birmingham, AL	\$35,050
Robert R. Meyer Foundation	Tuscaloosa, AL	\$27,500
Children Affected by AIDS Foundation	Los Angeles, CA	\$23,176
Community Foundation of Greater Memphis	Memphis, TN	\$18,000
Daniel Foundation of Alabama	Birmingham, AL	\$17,500
Saks Inc. Foundation	Birmingham, AL	\$16,500
Hess Foundation, Inc.	Birmingham, AL	\$15,000
UPS Foundation, Inc.	Atlanta, GA	\$11,000
Amsouth Bancorporation Foundation	Birmingham, AL	\$10,021
National AIDS Fund	Washington, DC	\$10,000
The Joseph S. Bruno Charitable Foundation	Birmingham, AL	\$10,000
Until There's A Cure Foundation	Redwood City, CA	\$10,000
The Claude Bennett Family Foundation	Birmingham, AL	\$8,220

Private Foundations Supporting Alabama's AIDS Service Organizations^{iv} (cont'd)

FOUNDATION	LOCATION	TOTAL GRANTED TO ALABAMA ASOs, 2000-2005
The Campbell Foundation	Ft. Lauderdale, FL	\$6,000
Boehringer Ingelheim Cares Foundation, Inc.	Ridgefield, CT	\$5,000
DaimlerChrysler Corporation Fund	Auburn Hills, MI	\$5,000
Carol W. & Myron J. Rothschild Fund	Montgomery, AL	\$4,500
Abahac, Inc.	Birmingham, AL	\$4,000
Federated Department Stores Foundation	Cincinnati, OH	\$4,000
The Community Foundation of South Alabama	Mobile, AL	\$3,300
Berman Charitable Foundation	Anniston, AL	\$3,000
The Ronne & Donald Hess Foundation	Birmingham, AL	\$2,000
Joy M. & James Grodnick Charitable Foundation	Mobile, AL	\$1,100
Citation Charitable Foundation	Birmingham, AL	\$1,000
James I. Harrison Family Foundation	Tuscaloosa, AL	\$1,000
Reese Phifer, Jr. Memorial Foundation	Tuscaloosa, AL	\$400
Gordy-Mead-Britton Foundation	Montgomery, AL	\$350
The Aaron Aronov Family Foundation	Montgomery, AL	\$250
Mayer and Arlene Mitchell Charitable Foundation	Mobile, AL	\$200

AIDS SERVICE ORGANIZATIONS^v

AIDS Action Coalition of Huntsville	Huntsville, AL
AIDS Alabama (formerly, AIDS Taskforce of Alabama)	Birmingham, AL
AIDS Outreach of East Alabama Medical Center (EAMC)	Auburn, AL
Birmingham AIDS Outreach	Birmingham, AL
Health Services Center, Inc. (formerly, AIDS Services Center, Inc.)	Anniston, AL
Jefferson County AIDS in Minorities (AIM)	Birmingham, AL
Montgomery AIDS Outreach	Montgomery, AL
Selma AIR	Selma, AL
South Alabama CARES (formerly, Mobile AIDS Support Services)	Mobile, AL
West Alabama AIDS Outreach	Tuscaloosa, AL

ⁱ The report does include grants made by foundations affiliated with corporations but registered as separate, 501(c)3 organizations.

ⁱⁱ Additionally, to avoid double-counting grants, the report may exclude some support to national organizations that support HIV/AIDS services in Alabama. For instance, the National AIDS Fund (NAF) recently began a new initiative, Southern REACH, which was supported by substantial grants from Ford Foundation and the Elton John AIDS Foundation. However, Southern REACH is directed towards organizations across several Deep South states, and the precise allocations to the ASOs considered here could not be determined.

ⁱⁱⁱ At the time of this report's preparation, 2005 was the latest year for which at least 95% of relevant grantmaking data was available, based on estimates from FoundationSearch.com. Due to the small size of the data sets and the need to provide comparable figures year-to-year, years with partial data sets could not be included. However, there has undoubtedly been grantmaking activity in the interval, and if the trends in this report were extended, it could be assumed that significant numbers of new grantmakers had joined the fight against AIDS.

^{iv} Due to the unavailability of certain tax records, two foundations supporting Alabama ASOs were identified after portions of this report went to press. These grantmakers, Children Affected by AIDS

Foundation (CAAF) and Until There's A Cure Foundation (UTAC), are included in the table to recognize their commitments, but their grants were not integrated into database analyzed in the data sections of this report. These grants were made as follows: In 2001, UTAC made one \$10,000 grant to AIDS Alabama. In 2004, CAAF made one \$13,176 grant to AIDS Outreach of EAMC. In 2005, CAAF made one \$5,000 grant to Birmingham AIDS Outreach and one \$5,000 grant to Jefferson County AIDS in Minorities.

^v Though it is a vital source of HIV/AIDS-related care, the 1917 Clinic at the University of Alabama at Birmingham is not included as a grantee in this report, for several reasons. While the UAB Center for AIDS Research, which houses the 1917 Clinic, receives support from private philanthropy, these grants are often institutional in scale and support a much broader range of activities than the Clinic alone (including research, clinical trials, and broader programs affiliated with other parts of the university). Furthermore, the nature of tax reporting on these grants makes it nearly impossible to tell which part of the funds support work like that of the other ASOs in this report, making meaningful comparisons impossible. Finally, the location of the 1917 Clinic within a much larger organization may well mean that the relevant funding issues are quite different from those faced by smaller, independent organizations.

Part 1

The Context for Private Philanthropy

“Sadly, poverty is a great friend to AIDS/HIV, fuelling infection rates and decreasing the quality and length of lives of those living with the virus who are poor. At the M•A•C AIDS Fund, we have focused a great deal of our funding in the South on alleviating poverty-related issues such as food insecurity and lack of stable housing. One of the greatest challenges over the next few years will be to educate other private and public donors that, just as in Africa and the Caribbean, we cannot truly address AIDS/HIV in the U.S. without addressing poverty.”

Nancy Mahon, Esq.,
Executive Director, M•A•C AIDS Fund

General Health and HIV/AIDS in Alabama and the South

At the end of 2005, 40% of people living with AIDS resided in the South, a higher concentration than any other region in the country.⁶ From 2001 to 2005, the estimated number of people living with AIDS in the South increased by 33%, a higher percentage increase than any other region.⁷ In the same period, the South was the only U.S. region in which the number of deaths among PLWHA increased.⁸

The alarming public health profile of the 21st century South reflects, in part, the continuing legacy of historical and demographic factors, including slavery, mass migration, segregation, the loss of a highly agrarian economy, and a geographically dispersed population.

Health and Poverty in Alabama and the South

Alabama is the 30th largest state in the United States and is bordered by Tennessee, Georgia, Mississippi, and Florida and the Gulf of Mexico. In the 2007 report from the United Health Foundation, which ranks the overall health of each U.S. state, five of the six states of the Deep South fell within the ten worst health profiles in the nation. Alabama ranked 45th in overall health.⁹

On other indicators of general health, Alabama scores near the bottom, with the second highest preterm birth rate (16.1%), the fourth highest low birth weight rate (10.4%) and the sixth highest infant mortality rate (9.1 per 1,000 population) in the country. For Alabama’s African-American residents, these figures are dramatically worse.¹⁰

Alabama is among the three poorest states in the country, with 22% of its residents living beneath the Federal Poverty Level (\$15,577 for a family of three in 2005) and 44% designated “low income” (with an annual income less than 200% of FPL).¹¹

HIV/AIDS in Alabama and the Deep South

The Deep South as a region (defined as Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) experiences broad public health challenges that complicate the specific problems of HIV/AIDS. Additionally, this region has experienced the greatest proportional increases in HIV/AIDS rates each year since 1990.¹²

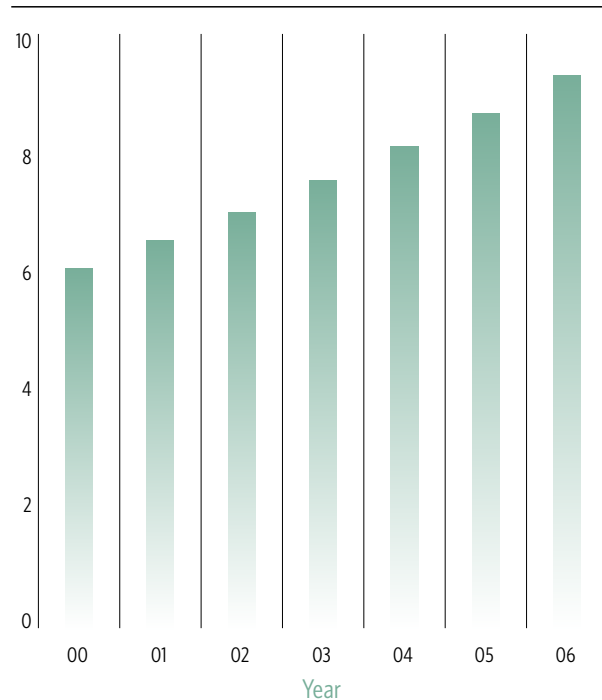
As one report found, “from 2000 to 2003, the number of newly reported AIDS cases increased 35.6% in the U.S. Deep South, while increasing 4.0%

in other Southern states and 5.2% nationally, excluding the Deep South states.” This report characterized the HIV/AIDS epidemic in the Deep South as “more similar to the epidemic in less wealthy nations than to other areas of the U.S.”¹³

By 2003, all of the states within the Deep South were among the 15 with the highest HIV death rates, with Alabama having a death rate of 4.3 per 100,000 population.

As of 2005, Alabama had an 11.4 per 100,000 incidence rate of reported AIDS cases,¹⁴ and the combined number of Alabama PLWHA in 2005 was 8,252.¹⁵

Figure 1: HIV/AIDS Prevalence in Alabama by Year, 2000-2006
in thousands



Source: HIV/AIDS Surveillance, HIV Incidence, and HIV Prevalence Studies: Annual Progress Report; January 1-December 31, 2006. Alabama Department of Public Health, Bureau of Communicable Disease, Division of HIV/AIDS Prevention Control.

“We’re seeing growth in younger ages—13, 14, 15. A lot of 18 year-olds, and a lot of those 18, 17 year-olds are also African-American gay men.

We’re seeing a really significant growth... among those very young and very old. It’s been real noticeable over the past four, five years.”

Mike Murphree, Executive Director,
Montgomery AIDS Outreach

HIV Transmission Risk in Alabama

Among all Alabama residents, the highest HIV transmission risk category continues to be sex between men who have sex with men (MSM), which accounted for 52% of all HIV/AIDS diagnoses in 2006. High-risk heterosexual sex (36%) and intravenous drug use (10%) rank second and third.¹⁶ These figures are comparable to national transmission risk statistics; for HIV/AIDS cases diagnosed in 2005, the CDC reports the following transmission figures: MSM (49%); high-risk heterosexual sex (32%); IDU (14%).¹⁷

By gender and across racial groups, the Alabama risk behavior profile differs significantly.

For all females, the highest risk behavior was heterosexual sex. Notably, African-American women had a significantly higher risk of HIV infection from heterosexual sex, accounting for 91% of all reported HIV/AIDS diagnoses in 2005 versus 66% for white women.¹⁸

Among males, MSM accounted for the majority of newly diagnosed infections in 2006 for both African-American (64%) and white (82%) men. Similar to the disparity between African-American and white

“About 68% of our population is from communities of color. We have five counties that we’ve been designated to serve ... that covers about 3,060 square miles. The majority of people we serve are indigent, low-income. Two counties in our service area are in the top ten for highest rate of infection in the state—that’s Macon and Russell county.”

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

females, there was a higher percentage of reported cases due to heterosexual sex for African-American men (23%) than white men (5%).¹⁹

Across all categories, the risk of HIV transmission is increased and complicated by Alabama’s high rate of sexually transmitted infections (STIs).^{20,21} Among all states, Alabama ranks fourth for gonorrhea, ninth for primary and secondary syphilis, and 28th for chlamydia.²²

Key Epidemiological Challenges

Alabama faces an array of epidemiological challenges related to HIV/AIDS, some which mirror those on a national scale, and others which reflect specific characteristics of the Deep South. Poor general health indicators and poverty exacerbate each of these and demand innovative approaches to address them.

Impact on Vulnerable Populations

Increasingly, Alabama’s HIV/AIDS epidemic is concentrated in its most vulnerable populations, including African-Americans (particularly women and youth), Latino migrant workers, and rural residents.

African-Americans shoulder the greatest burden of the HIV/AIDS epidemic. Among African-American females, this impact is particularly severe, as the number of new HIV/AIDS cases diagnosed has exceeded those among white males for eight consecutive years. There has also been an alarming 89% increase in diagnoses of HIV/AIDS among young African-American males (ages 13 to 24) between 2001 and 2005.²³ At the end of 2005, African-Americans made up 26% of Alabama’s total population, but 43% of those living under FPL, 64% of persons estimated to be living with AIDS, and 71% of new AIDS cases.²⁴

Latinos have the second highest case rate in Alabama, despite accounting for a small number of total HIV/AIDS diagnoses.²⁵ Alabama’s Latino population grew 208% between 1990 and 2000,²⁶ a trend linked to the increasing number of migrant workers in the state. Migrant and undocumented workers are presenting new challenges to surveillance that are proving elusive to a public health infrastructure developed for a domestic population. Many and complex factors are at play, including the cyclical movement of migrant men between Mexico and the U.S., limited data on the risk indicators associated with migrant workers in the South, and the relationship (not fully captured by research) between male Latino immigrants and sex workers.

Based on 2000 U.S. Census data, 45% of Alabama’s population is considered **rural**. PLWHA in rural areas must often travel considerable distances to medical centers for care. (The University of Alabama at Birmingham outpatient HIV/AIDS clinic reports that 33.7% of patients traveled 50 miles or more to receive HIV care.²⁷) Increasing distance from home to clinic is predictive of less frequent access to HIV outpatient services.²⁸

Care Issues

In Alabama and throughout the Deep South, delayed access to treatment and suboptimal frequency of

“The disproportionate impact of HIV/AIDS in the South—especially among women, African-Americans and Latinos—prompted the Pfizer Foundation to invest in prevention programs as the best defense against further spread of HIV in the region. The Foundation funded 23 HIV/AIDS services organizations in nine southern states to support targeted programs to prevent new infections in those populations most at risk.”

Caroline Roan, Executive Director,
Pfizer Foundation
Senior Director WW Philanthropy, Pfizer Inc.

care are pervasive. Poverty and low-income status are predictors of late diagnosis of HIV/AIDS and may also be one explanation for delayed access to care.²⁹ In 2005, less than half of newly diagnosed Alabama residents received care in compliance with current federal guidelines (a minimum of three care visits annually for measurement of CD4+ T-cell counts and viral load levels).^{30,31}

Mental health services for PLWHA in the South do not appear to be meeting the demonstrated needs of the population, especially for rural residents. Nationally, approximately 50% of HIV-infected patients are afflicted with mental illness.³² Studies have demonstrated that unmanaged mental illness in HIV-positive individuals is positively correlated with a wide range of risks, including not seeking care, poor adherence to antiretrovirals (ARVs), and a more rapid progression to AIDS.^{33,34,35} One study revealed a lower likelihood of mental health service utilization by HIV-positive individuals in the South versus other U.S. regions.³⁶ Other research indicated that rural participants were less likely to seek mental health services and those that did reported fewer visits.³⁷

PLWHA are aging. As the overall distribution of PLWHA in Alabama among age groups has remained

stable, the number of residents living with HIV or AIDS has steadily increased while the death rate has dropped by approximately 60% since its high in 1995. This is creating a growing population of older men and women with HIV/AIDS,³⁸ which could in turn have an impact on the state’s ability to provide care, especially when combined with the challenges identified above.

AIDS Service Organizations

Many of the most vulnerable PLWHA in Alabama rely on the state's network of AIDS service organizations (ASOs) for medical and support services. There are both clinical and non-clinical ASOs in Alabama, as well as a group of community-based organizations (CBOs) that often support PLWHA directly or indirectly, but do not identify solely as HIV/AIDS organizations.

Nationally and in Alabama, ASOs often face funding challenges that make it difficult to meet the need for services. Secondary services and prevention education are less often emphasized by government funding programs, making them important areas for philanthropic support.

A recent report from the AIDS Taskforce of Greater Cleveland (ATGC) that sampled 100 ASOs nationwide over a four-year period indicated that the number of ASOs with a budget surplus decreased from 66% in 2001 to 44% in 2005. Across the national sample, "ASOs rely heavily on government grants and contracts, followed by public support. However, between 2001 and 2005, the organizations in our sample increased their reliance on program revenue and special events."³⁹

Regionally, the South "had fewer organizations with a budget surplus and relied more heavily on program revenue and special events than other regions. The Northeast had the greatest number of organizations with a budget surplus."⁴⁰ FCAA research indicates that philanthropic commitments to HIV/AIDS organizations in the Northeast increased from 34% of total domestic commitments in 2005 to 48% in 2006. As discussed above, the South is the U.S. region with the highest proportional figures for HIV/AIDS, but received only 19% of all U.S. philanthropic commitments for HIV/AIDS.⁴¹

Private philanthropic support has played a proportionally small role in most organizations' overall budgets; in keeping with national trends, most ASOs in Alabama get the bulk of their revenue from government grants and contracts. For large Alabama ASOs that do extensive government contracting, private philanthropic support can represent less than one percent of total revenue, but generally the grants identified in our research combined to contribute between 1% and 10% of annual revenue per year, with the percentage often changing dramatically from year to year.^{vi} The consistency of

"We are heavily, heavily dependent on federal funds, particularly Ryan White Part C, and immediately after that, Ryan White Part B."

Mike Murphree, Executive Director
Montgomery AIDS Outreach

"80% of our money is government ... the other 20% is a combination of United Way, special event fundraising, donors, or other non-government grants."

Associate Director
AIDS Alabama

philanthropic support as a revenue stream is explored further in Part 2.

Despite their modest proportional contribution, however, philanthropic grants nevertheless represent an essential source of support, because of the general need for funds, and restrictions built in to government programs. In Alabama, many of the broader epidemiological challenges—including geographic dispersion, poor access to and adherence to care, and the need for prevention education tailored for vulnerable populations—call out for flexible, long-term solutions. In interviews with FCAA, ASO executives emphasized the need for sustained philanthropic support, especially for areas unfunded or underfunded by government

^{vi} FCAA obtained the 990 tax forms for the ten ASOs considered in this report and compared the grants made to each organization with their overall revenue figures.

Federal Funding Support

“We could make our clinics even better—the money is there in Ryan White Part B. But it’s a reimbursement-based program in Alabama, and we have to front these costs first in order to be reimbursed. As an agency with limited financial streams, incurring these costs to cover salaries and services is difficult. We could do so much more if we had a nest egg to cover these outlays.”

Mike Murphree
Executive Director, Montgomery AIDS Outreach

programs, such as the Ryan White Program.

The following table presents the total federal funding directed to Alabama in fiscal year 2006. State and local funding is not included.

Ryan White Program Funding	\$19,367,328
CDC	
HIV Prevention	\$2,268,498
HIV/AIDS Surveillance	\$900,852
CBO/CBA	\$438,499
DASH	\$246,311
Miscellaneous	\$324,442
Total	\$4,178,602
SAMHSA	
Center for Mental Health Services	\$0
Center for Substance Abuse Prevention	\$754,320
Center for Substance Abuse Treatment	\$2,655,157
Total	\$2,655,157
Housing Opportunities for People with AIDS (HOPWA)	
Total	\$1,656,000
Office of Minority Health Funding	\$0
Grand Total	\$27,857,087

Source: Henry J. Kaiser Family Foundation. Statehealthfacts.org. Accessed March 18, 2007.

It is important to note that Medicaid is the largest source of financing for HIV/AIDS care in the nation; over half of all adults and 90% of children with AIDS are enrolled in the program. However, as it is not an HIV-specific program, its role in financing the operations of the ASOs discussed here is outside the purview of this report. The following section explores the Ryan White Program in more detail, as the largest federal grant program specifically for HIV/AIDS, and the majority of HIV-specific federal funding for Alabama’s ASOs.

The Ryan White Program

The Ryan White Program (formerly known as the Ryan White CARE Act) is the largest federal grant program designed specifically for people with HIV/AIDS and it provides the majority of financing for many HIV/AIDS organizations. Funding is organized under Parts (previously, Titles), which distribute grants to different types of recipients and programs. Appendix 2 describes the structure of the Ryan White Program in greater detail.

The 2006 reauthorization of the Program changed several aspects of its funding mechanism, including a promise of larger grants to states without “eligible metropolitan areas,” (the urban centers that had historically borne the brunt of HIV/AIDS and had received proportionally greater shares of federal funds).⁴² The reauthorization also introduced the requirement that

“Ryan White grants are reimbursement in nature, and therefore providers and community-based organizations (CBOs) must normally incur expenses in order to request reimbursement. Reimbursement is usually requested in one of two ways: through a line item or unit cost reimbursement. Because these are both reimbursement mechanisms after expenditures are incurred, many providers and CBOs struggle with cash flow and sometimes ensuring that most expenses are covered by these grants. Some expenses are not allowable under Ryan White grants, including construction and capital purchases. This makes it doubly difficult for small organizations in particular to keep services flowing so that client needs are met adequately.”

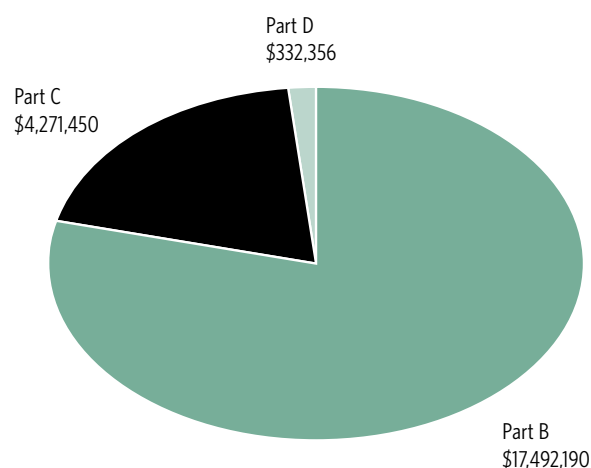
Murray Penner, Deputy Executive Director
of Domestic Programs,
National Alliance of State and Territorial AIDS Directors
(NASTAD)

75% of funding from Parts B and C be spent on “core medical services” (see Appendix 2).

Ryan White in Alabama

The state received more money overall as a result of the 2006 reauthorization, with Part B funding increasing from approximately \$12.4 million, a typical annual sum since 2004, to about \$17.5 million in fiscal year 2006.^{43,44} Parts B and C together constitute 98.5% of Ryan White funding to Alabama. The remainder is Part D (formerly Title IV), which covers family and community-based services to children, youth and women living with HIV. Figure 2 shows the proportional distribution of Ryan White Program funding for fiscal year 2007.⁴⁵

Figure 2: FY 2007 Ryan White Program Support to Alabama by Part



Source: Henry J. Kaiser Family Foundation. Statehealthfacts.org. Accessed March 18, 2007.

In Alabama, as discussed in more detail above, delayed initiation of and/or inconsistent adherence to HIV/AIDS treatment is pervasive in both urban and rural areas. The Ryan White Program’s emphasis on core medical services would seem to take for

granted that services are established and reaching those that need them. Several of the ASO executives surveyed expressed a need for funding for non-medical support services. Additionally, Program funds are reimbursement-based, meaning that ASOs must incur the costs of providing services before receiving funding. This can make it difficult for organizations to maintain or expand programs in the context of growing client load.

As noted above, Ryan White Program funding constitutes the vast majority of HIV-specific program funding for many of the ASOs discussed in this report. Government grants in general represent the main funding stream for most ASOs nationally. So, where the structure of these grants does not align fully with the needs faced by the PLWHA and service communities, it is imperative that private philanthropy recognizes the opportunity to provide uniquely targeted assistance.

“We are not a clinic, and the trend has been for supportive services to take cuts statewide.”

Anonymous survey respondent

“The scarcity of HIV prevention education funding in Alabama is shameful. People wonder why HIV rates are exploding in the South, yet neither the federal nor state government provides enough dollars to do the work. We have five or six projects funded at about \$60,000 each from the Centers for Disease Control and another \$300,000 that the Alabama Legislature provides. And that’s pretty much all of the prevention funding for the whole state.”

Kathie M. Hiers, CEO
AIDS Alabama

Part 2

Private Philanthropic Support

“We fund in the Deep South because it is home to disproportionately impacted populations, but it is where efforts are least developed. In more rural areas, that lack of programming capacity is often coupled with a lack of development capacity and an inability to pursue and report on private grants. However, turning our back is not an option.”

Patrick Flaherty, Deputy National Director
Gill Foundation

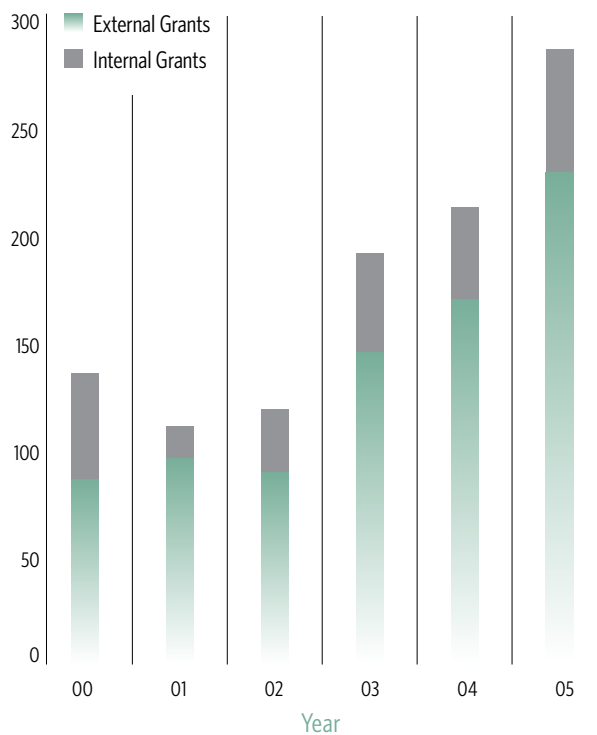
Given the epidemiological profile and public funding challenges discussed above, it is evident that private philanthropy can play a key role the response to HIV/AIDS in Alabama. This section presents data on the recent activity of private funders supporting ASOs in Alabama and explores the degree to which philanthropy has met the needs of these organizations.

Overall, private philanthropic support to Alabama ASOs more than doubled from 2000 to 2005, mainly due to increases in large grants from foundations based outside the state. Support from Alabama-based foundations stayed relatively consistent over that period. The number of unique funders making grants to Alabama ASOs also increased nearly every year both within and outside Alabama. However, most of the grants made are proportionally small: an average of 73% of grants made per year are under \$4,000. A pattern of small, numerous grants may raise unique challenges for AIDS service organizations. The following section explores these trends and their ramifications in greater detail.

Trends in Support from Private Philanthropy to Alabama ASOs, 2000-2005

The total philanthropic support to Alabama’s ASOs more than doubled between 2000 and 2005. Much of this growth was due to an increase in the number of large grants (generally, \$20,000 to \$50,000) from foundations based outside Alabama. Support from

Figure 3: Total Grant Amounts from Private Foundations to Alabama ASOs by Year, 2000-2005
in thousands (\$)



Note: Figure 2 omits grants below \$4,000.
Source: FCAA calculations of data from FoundationSearch.com

grantmakers within Alabama has remained relatively consistent, with a developing pattern of more numerous, but smaller, grants, as evidenced by the drop in the size of average and median grants since 2003. While overall support has grown, the largest grants come from outside Alabama. Inside Alabama, and among smaller grantmakers, growth is less significant.

- From 2000 through 2005, total yearly grantmaking (above \$4,000) increased by 112%.
- External grantmaking increased by 166%.
- Internal grantmaking increased by 16%.
- From 2000 through 2005, the average grant from an external funder increased by 77%, from \$8,624 to \$15,267.
- The average grant from an internal funder increased in 2003, but over all five years decreased from \$9,800 to \$8,150, a decrease of 17%.
- The recent decrease of the external median, in the context of a rising average, indicates an increase in the proportional contribution of larger grants to the total granted by non-Alabama foundations.

Small Grants

Between 2000 and 2005, individual grants under \$4,000 accounted for 23% on average of the yearly total dollar amount given to Alabama ASOs by Alabama grantmakers.^{vii,viii} However, these grants represented an average of 73% of the total *number of grants* made. Thus, while consistently providing only a modest share of dollar amounts, small grants represent the majority of activity by Alabama grantmakers.

Grants below \$1,000 make up 34% of the total number of grants made from 2000 through 2005, but only 2% of total grant dollars (59 grants out of 175, and \$27,441 out of \$1,120,568).

Regarding external (outside Alabama) grantmakers, a similar dynamic exists, when small and larger grants are reviewed together. In 2005, there were 15 grants from external funders for a total of \$229,000. Ten of these

grants (68%) were \$5,000 or less, and represented only 21% of the total dollars sent to Alabama. For each year from 2000 through 2005, the bottom half of each year's grants from non-Alabama funders represented an average of 26% of the total amount granted to Alabama's ASOs.

Figure 5 displays grant counts by year for external grants and internal grants above and below \$4,000.

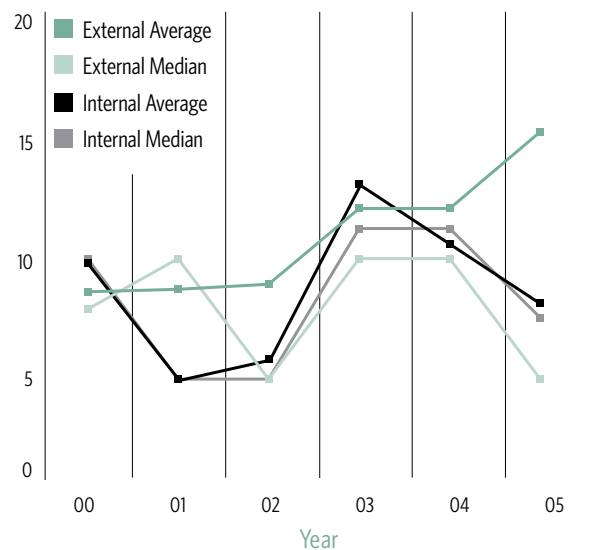
In other words, the majority of grant activity represents a minority of resources. From the perspective of a grantseeker, a greater volume of smaller grants may not represent a dependable or coordinated financial stream, and may involve proportionally greater transaction costs and development effort.

Asked what his organization would do with a grant between \$500 and \$1,000, one survey respondent answered, "That would not really make a difference in our issues right now. In fact, if I were going after grants, I would not waste a whole lot of energy, because I

Figure 4: Averages and Medians for Grants

Over \$4,000 by Year

in thousands (\$)

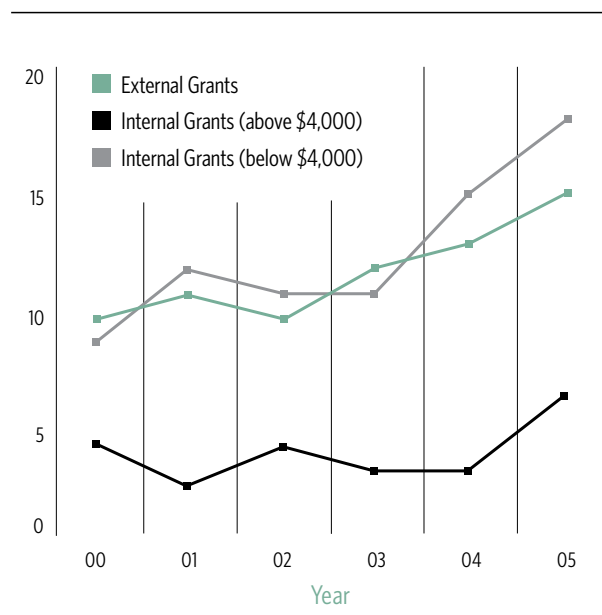


Source: FCAA calculations of data from FoundationSearch.com

“My problem is I don’t have anybody to work with me on [pursuing private philanthropy]. If I had a grantwriter, it would be so easy, because I could handle the overseeing of the agency... but unfortunately a lot of programs in our state, a lot of the agencies like ours, and certainly smaller ones, we do not have grantwriters on staff, and that makes it harder.”

Mike Murphree, Executive Director,
Montgomery AIDS Outreach

Figure 5: Number of Grants from Private Philanthropy to Alabama ASOs by Year, 2000-2005



Source: FCAA calculations of data from FoundationSearch.com

don’t have the time and I don’t have a grantwriter, going after a series of thousand dollar grants.” For a grant between \$1,000 and \$5,000: “That’s a little better ... but... unless it’s a one-pager... it would not be worth that time.” (Mike Murphree, Executive Director,

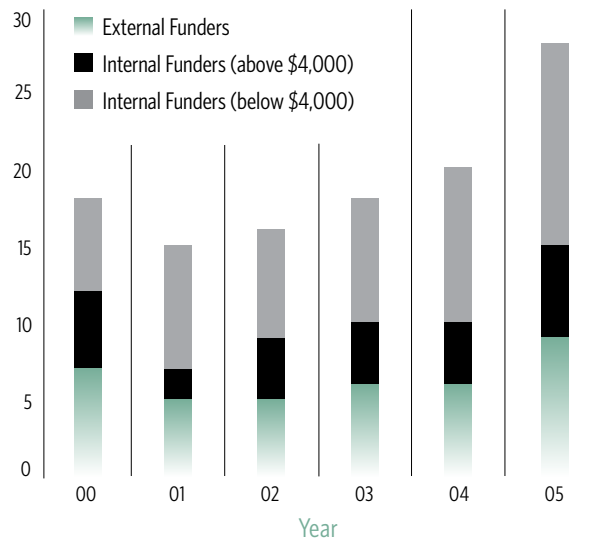
Montgomery AIDS Outreach)

This pattern is even more pronounced on a national scale. FCAA’s recent publication, *U.S. Philanthropic Commitments for HIV/AIDS: 2005 & 2006*, revealed that in 2005, only ten funders contributed 71% of all HIV/AIDS funding by U.S.-based funders. In 2006, the top ten were responsible for 90%, with the Bill & Melinda Gates Foundation alone accounting for 75% of all HIV/AIDS funding by U.S.-based funders.

“And since Katrina, we really got slammed. There’s only a certain amount of money you can raise, and it basically went towards that. We would catch whatever was left over.”

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

Figure 6: Number of Unique Funders Supporting Alabama ASOs by Year, 2000–2005



Source: FCAA calculations of data from FoundationSearch.com

The Funder Population

From 2001 to 2005, more funders made grants to Alabama’s ASOs each year. Figure 6 shows the growth in unique funders per year between 2000 and 2005. While figures are unavailable for external grantmakers funding below \$4,000, small Alabama grantmakers represent the largest and fastest growing segment of the funder population.

The general growth in unique funders is an encouraging development. However, a key challenge for grantees, especially those with limited development capacity, remains the cultivation of funders to the point where their grants enable the growth of sustained programs.

^{vi} FoundationSearch.com, the database drawn upon to create this report, does not include grants below \$4,000. A more detailed discussion of FoundationSearch.com and the \$4,000 cut-off is found in Appendix 1. FoundationSearch.com does create a list of giving interests for each foundation, however, based off all the keywords found in the process of digitizing the 990 tax information that makes up the database.

^{vii} FCAA manually searched the tax-forms of Alabama foundations that had listed “HIV/AIDS” as a giving interest to uncover grants below \$4,000. A similar search of national funders was deemed unfeasible due to the great number of “HIV/AIDS”-interested foundations nationwide. However, the findings for Alabama grants below \$4,000 are quite relevant to the claims of this study.

“HIV/AIDS in the Deep South involves public health challenges that require innovative, long-term responses. Recognizing this, Broadway Cares/Equity Fights AIDS makes it a priority to fund our grantees sustainably. Regular grants allow organizations to maintain programs year-to-year and maximize their effectiveness. Additionally, we work to streamline the grant application process, freeing grantees to spend more energy on the essential work of fighting HIV/AIDS.”

Tom Viola, Executive Director,
Broadway Cares/Equity Fights AIDS

- There is potential for “growing” funder support levels, but many ASOs cannot afford dedicated development staff, indicating a potential vicious cycle in funding shortfalls.
- From 2001 through 2005, more unique funders made grants each year.
- However, most of these new funders made grants below \$4,000.

Continuity of Private Philanthropic Support within Recipient Organizations

Figures 7a through 7f show the private philanthropic support received by individual ASOs^{ix} both as an annual total and by individual grant. Each broad green column shows the total amount received in a given year. Within the broad bars, each grant making up that total is depicted with its own column, to scale. Any foundation

that made at least one grant from 2000—2005 to the recipient in question is consistently coded with a letter identifying its grants (or lack thereof) from year to year. These letter codes are consistent between figures. Please note that the scale of the vertical axis changes between figures.

Figures 7a-f: Private Philanthropic Support to Individual ASOs by Grant, 2000—2005

Figure 7a: AIDS Alabama

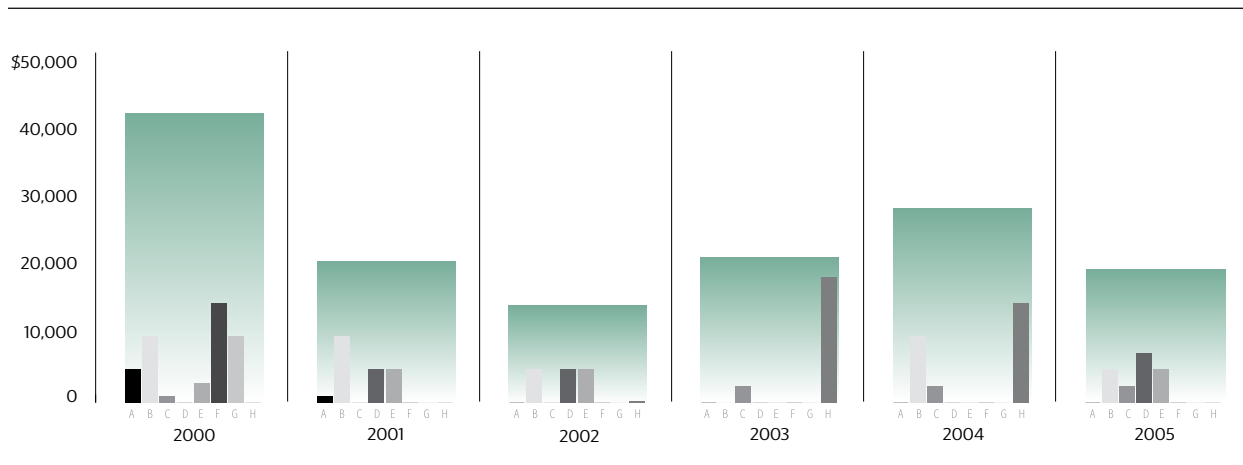


Figure 7b: Birmingham AIDS Outreach

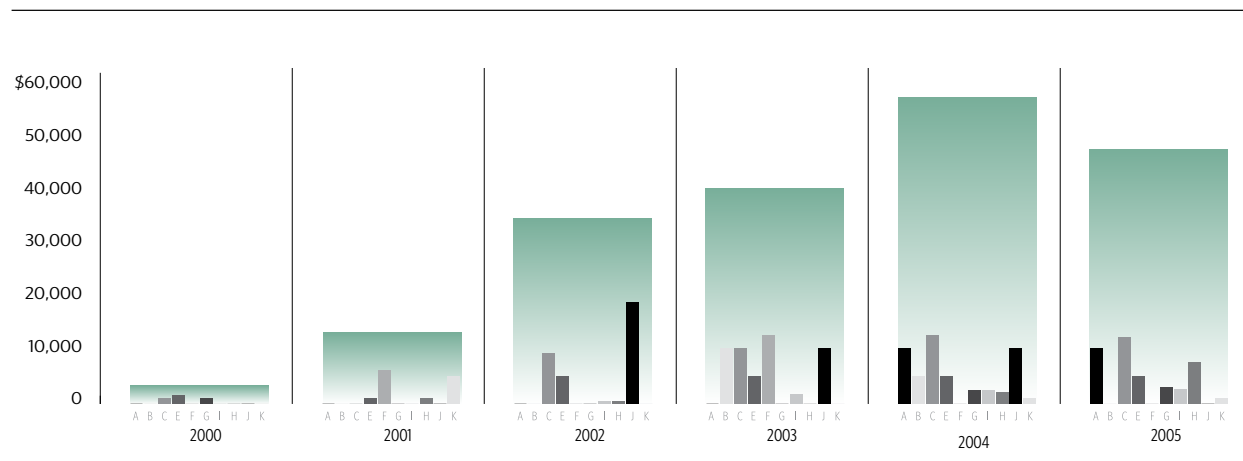


Figure 7c: Health Services Center, Inc.

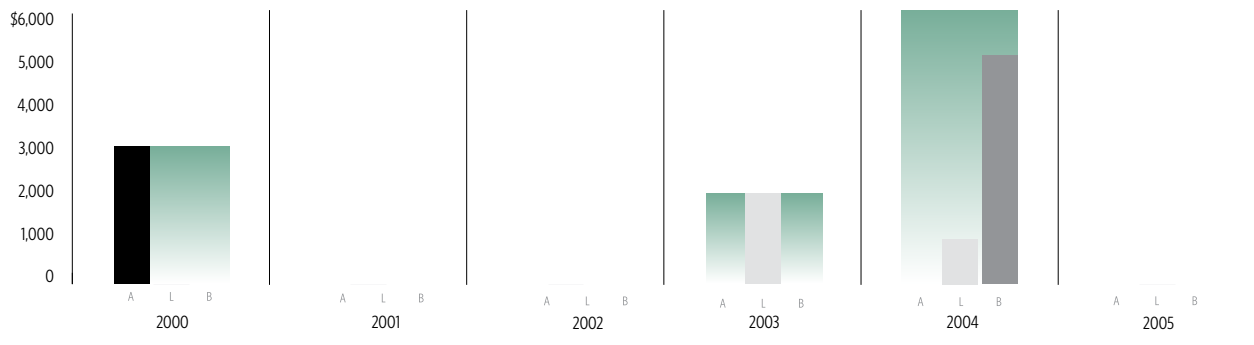


Figure 7d: Mobile AIDS Support Services

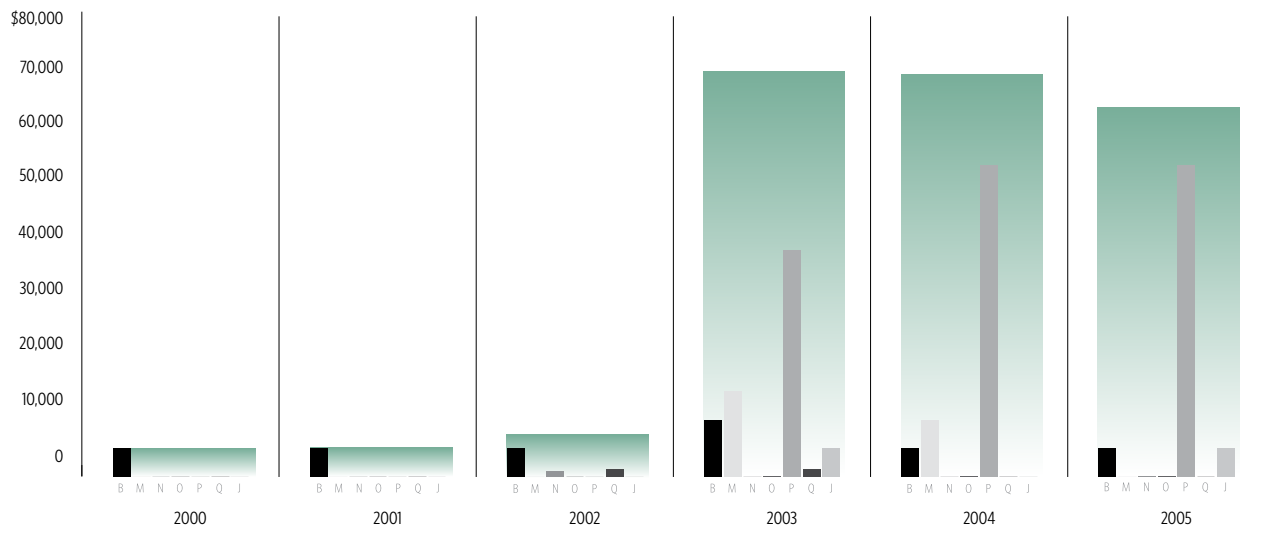


Figure 7e: Montgomery AIDS Outreach

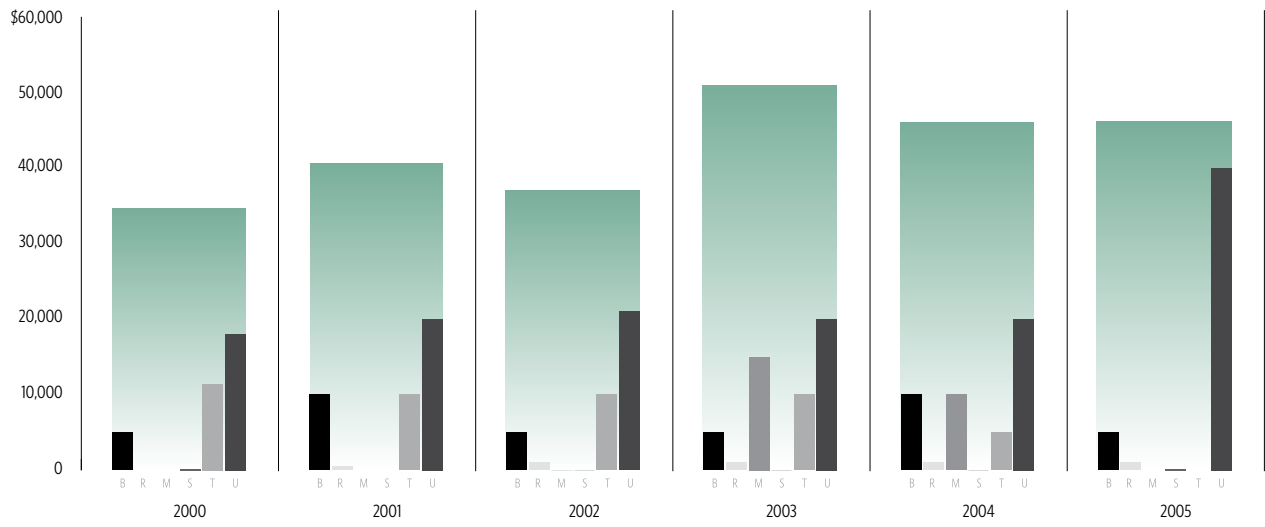
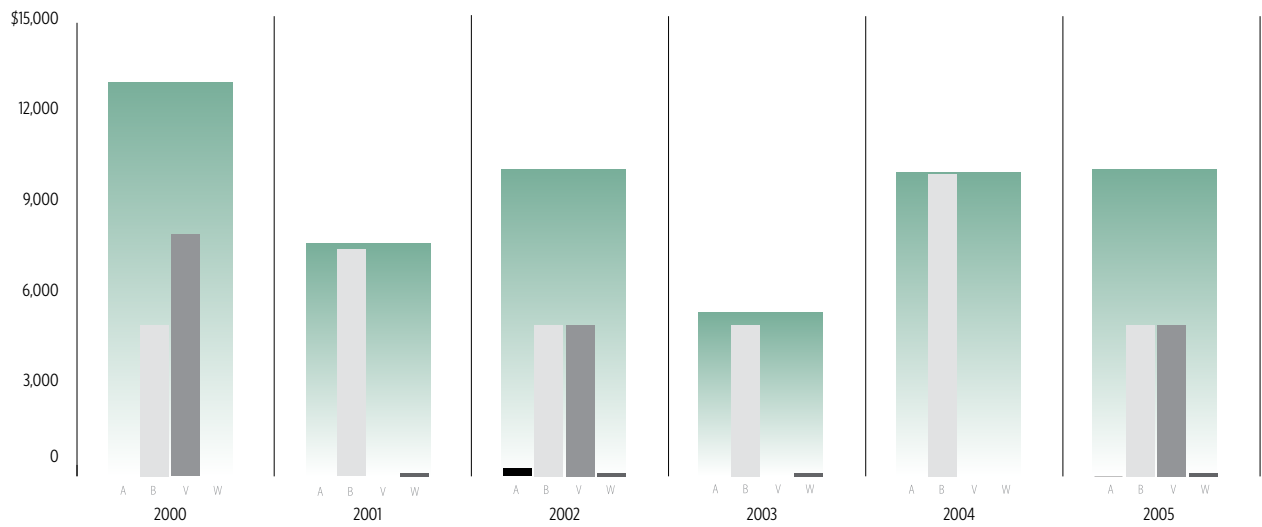


Figure 7f: West Alabama AIDS Outreach



* Of the ten ASOs considered in this report, only the six depicted received philanthropic support from more than one foundation in the six-year period studied.

Part 3

Conclusions

“One of the concerns many people have about foundations is how foundations often will not give to operating expenses or to the kind of day-to-day work of delivering services that have to be carried out. And I think that’s another thing I would like the foundation community to rethink.”⁵⁴

Sen. Hillary Rodham Clinton
1999 White House Conference on Philanthropy

The key epidemiological challenges of HIV/AIDS in Alabama include specific risks for and impacts on vulnerable populations, the geographical dispersion of at-risk and PLWHA populations, late HIV and AIDS diagnoses, delayed access and poor adherence to care, and high rates of associated health problems, including poor general health, high rates of STIs, and potential for mental health difficulties. These problems are related to broad geographic and demographic factors, and require long-term, structurally appropriate responses. Though both public and private financial support has increased, growth has not been sufficient to tackle increases in HIV prevalence, or to fully meet financial needs.

What Funders Can Do:

Support secondary services, including prevention education, outreach, and transportation.

As discussed in detail in Part 1, a successful long-term response to the epidemic will almost certainly require greater support to secondary services, including work to connect PLWHA to steady medical attention, and prevention education for those most at-risk for HIV. The present need in Alabama may not be drugs and medical services, but outreach, transportation, prevention education, and infrastructure improvements tailored to the state’s rural geography. Additionally, funders can help facilitate access to confidential mental health services and integrate them with HIV care, particularly in rural communities, and support efforts to link existing rural and urban services and facilitate

housing, employment, and health care for migrating residents. Funders should consider increased support to non-medical services, a key funding-gap under major government programs.

Provide increased support for operating and infrastructure costs.

Several executives surveyed by FCAA stressed the difficulty of covering basic infrastructure costs for their organizations, including rent, utilities, and technology. Private philanthropic support is rarely approved for these costs, and while some government funding is available, reimbursement-based funding and restrictions on construction and capital expenditures make consistent coverage difficult. These costs are not “extra;” failure to cover them strains service provision, human resources, and long-term organizational viability. Funders should consider increased operating support to ASOs to enable the effective implementation of necessary programs.

Work to foster sustained funding relationships with grantees.

In an environment of generally poor health and structural barriers to prevention and care, programs need to be sustained year-to-year to make an impact. Regardless of grant size, philanthropic funding that is regular and predictable can be used more effectively by grantees to support long-term programs and to form an authentic revenue stream within a larger budget. This is even more critical when government funding programs do not prioritize the programs most needed in Alabama.

Funders should consider ways to make their support to individual grantees sustainable over the long-term, and to reduce costs and bureaucracy around applications for small grants. The grant application process costs grantseekers time, money, and energy. Especially for grants below \$5,000, funders should consider streamlining the application process so that recipients get the maximum net value from the grant.

Support tailored, targeted prevention efforts.

Greater resources are needed for prevention, due to the heightened vulnerability of specific populations and risk groups, including African-Americans, women, youth, and migrant workers, and a relative shortfall of public prevention funding. Additionally, from 1999 to 2003, just seven of Alabama's 67 counties (Baldwin, Houston, Jefferson, Madison, Mobile, Montgomery, and Tuscaloosa) accounted for 65% of HIV/AIDS diagnoses.⁴⁶ Funders should consider supporting prevention efforts targeted at these groups and areas.

Fund programs to increase early detection of HIV infection and improve access to treatment.

For people already infected with HIV, early detection and steady access to medication can help delay progression to AIDS. Alabama's rural geography is only one factor that distances PLWHA from care centers, and public funding is less readily available for transportation and outreach programs. Funders should consider supporting these programs to improve the prospects of those living with HIV and AIDS.

"We're still running a deficit, and that deficit comes from overhead costs. As you know, in writing grants, the majority of your grants are program-specific and it's restricted funds ... Only one grant gives us the ability to pay towards our phones, our computers, things like that, our copiers, the basic stuff you use every day that people don't realize. As a result of that, we struggle."

Marilyn Swyers, Executive Director
AIDS Outreach of East Alabama Medical Center

“We had to let go of a paid provider who was here a half day a week. We had to discontinue our nutrition program and have our nurses do it—we had a dedicated registered dietitian that we paid ... to come work with new clients and clients that were at risk. We had to lay her off. We had to do away with all our emergency financial assistance.”

Mary Elizabeth Marr, Executive Director
AIDS Action Coalition of Huntsville

In Closing

This report focused solely on private philanthropic support to AIDS service organizations in Alabama. Other recent research reveals a broader national context for the grantmaking trends identified in this report.

A 2006 report from the Center for Effective Philanthropy (CEP), *In Search of Impact*, which surveyed both foundation CEOs and grantees, found that “the typical grant made by the large foundations in our study is program restricted, small, and short-term.”⁴⁷ Half of the foundation CEOs surveyed preferred program grants to operating grants, while only 16% of CEOs indicated a preference for operating grants. 60% of these cited “responsiveness to grantee needs” as the motivation.⁴⁸ However, the report also found that “there is agreement among [foundation] CEOs on at least one thing: Operating support is viewed as being most effective—and more effective than program support—in creating impact on and encouraging sustainability of grantee organizations.”^{49,50}

The CEP report also found that grantees, however, “are as likely to suggest larger grants or multi-year grants—or bundle these attributes—as they are to suggest more operating support grants.”⁵¹ The report concluded that “there is a tension...between these leaders’ views of what is best for their foundations—and even what they believe creates the most positive social impact—and what might best serve the organizational interests of their grant recipients.” And among grantees,

there exist distinct preferences for operating support, and sustained support of any kind. The report found that “grantees are as likely to suggest larger grants or multi-year grants—or bundle these attributes—as they are to suggest more operating support grants.”⁵² *Daring to Lead*, a 2006 report by CompassPoint Nonprofit Services, surveyed a national sample of nonprofit executive directors and asked them to “rank six potential actions by funders in terms of what would be most helpful to them in their work. The largest number of executives ranked the provision of more general operating support as the most helpful. The provision of multi-year support was the second most highly ranked action.”⁵³

Spotlight: Alabama represents one starting place for further exploration of philanthropy’s essential role in fighting HIV/AIDS. However, it is clearly evident that the question of *how* funders make grants is just as important as that of what they support. In the fight against AIDS, in Alabama and the world over, grantmakers have the unique opportunity to express philanthropy’s independence, both by innovating in areas of dire need, and by responding to the voices of those closest to the fight—their recipients.

Appendices

Appendix I: Methodology

FCAA designed this project with an emphasis on interdisciplinary research. Scientific literature was identified using electronic databases. Data on foundation grantmaking was generated in FoundationSearch.com, an online grant database. FoundationSearch.com receives forms 990 from the Internal Revenue Service, scans, and digitizes them. Grants above \$4,000 are entered in a searchable database tagged with various identifiers, including Granting Foundation, Year, Grant Amount, Recipient, and Grant Description, as well as address fields for both grantmaking and recipient organizations. FCAA identified the population of grant recipients via initial internet and FoundationSearch.com searches, and through conversations with key staff of identified organizations in Alabama.

To identify grants to Alabama ASOs below \$4,000, FCAA manually searched the tax forms for 2000 through 2005 of all foundations based in Alabama that listed HIV/AIDS as a giving interest in their FoundationSearch.com profiles. FCAA elected not to perform similar searches on a national scale due to the vastly greater numbers of foundations giving to HIV/AIDS and of recipient organizations. However, our findings for small grants in Alabama revealed significant trends for understanding HIV/AIDS philanthropy, and this is a population of grantmakers that should not be ignored.

To ensure that we did not miss grants, FCAA also relied on prior research (our annual resource tracking document) to identify a population of foundations that had made grants to AIDS organizations based in the South. We examined the giving history of these foundations as revealed by FoundationSearch.com and the foundations' annual reports to identify grants to our selected population of ASOs. Only in one case was a foundation identified via this process that had not been found via database searches.

Following scientific literature review and initial research on foundation giving, FCAA distributed a survey on challenges in financing AIDS work in Alabama to the executive directors of Alabama's ASOs and collected responses via written submissions and

phone interviews. Interviewees could elect the level of anonymity they preferred. All quotes attributed to ASO directors and key staff are verbatim extractions from these surveys and interviews. Three ASO executives did not complete the survey following repeated requests for contact.

Appendix 2: Funding under the Ryan White Program Structure of the Ryan White Program^{55,56}

Part A: Funds "eligible metropolitan areas" (EMAs), defined by a cumulative total of more than 2,000 reported AIDS cases over the most recent 5-year period, and "transitional grant areas" (TGAs), those with 1,000-1,999 reported AIDS cases over the most recent 5-year period. At least 75% of Part A funds must be spent on core medical services. Part A represented 29% of Ryan White Program funding in fiscal year (FY) 2007. Alabama has no EMAs or TGAs and did not receive Part A funds.

Part B: Funds all U.S. states and territories. Also includes ADAP and Emerging Communities (ECs) grants. At least 75% of funds must be spent on core medical services. Part B grants are made directly to states or to "consortia" of service organizations. Part B represented 57% of total Ryan White Program funding in FY 2007 and approximately 79% of funding to Alabama.

Part C: Funds public and private organizations for Early Intervention Services (EIS) and Capacity Development & Planning. 75% of funds must be spent on core medical services. Part C represented 9% of Ryan White Program funding in FY 2007 and approximately 19% of funding to Alabama.

Part D: Funds public and private organizations directly to provide family-centered and community-based services to children, youth, and women living with HIV and their families. Part D grants do not carry a core medical earmark. Part D represented 3% of total Ryan White Program funding in FY 2007 and approximately 2% of funding to Alabama.

Part F: Funds dental, educational, minority-related, and other special projects. Part F represented 3% of

total Ryan White Program funding in FY 2007. Alabama did not receive any direct Part F funding.

Core medical services are defined below. The remainder of Part B grants can be used for support services, defined as “services, subject to the approval of the secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).”⁵⁷

“Core medical services” include:⁵⁸

- Outpatient and ambulatory health services
- AIDS Drug Assistance Program treatments
- AIDS pharmaceutical assistance
- Oral health care
- Health insurance premium and cost sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services (defined under section 2614(c))
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence services

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