Community Loan Fund, Trenton, New Jersey; Martha W. Miller, President, Choice Federal Credit Union, Greensboro, North Carolina; Daniel W. Morton, Vice President and Senior Counsel, The Huntington National Bank, Columbus, Ohio; David L. Ramp, Assistant Attorney General, State of Minnesota, St. Paul, Minnesota; Marta Ramos, Vice President & CRA Officer, Banco Popular De Puerto Rico, Hato Rey, Puerto Rico; Robert G. Schwemm, Professor Law, University of Kentucky, Lexington, Kentucky; David J. Shirk, Senior Vice President, Frontier Investment Company, Eugene, Oregon; Gary Washington, Senior Vice President, ABN AMRO, Chicago, Illinois; and Robert Wynn, II, Financial Education Officer, Department of Financial Institutions, Madison, Wisconsin.

Board of Governors of the Federal Reserve System, June 14, 1999.

Jennifer J. Johnson

Secretary of the Board.

[FR Doc. 99–15693 Filed 6–18–99; 8:45a.m.]

Billing Code 6210–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Request for Nominations of Members to the Advisory Committee on Blood Safety and Availability

AGENCY: Office of the Secretary.

ACTION: Announcement of request for membership nominations.

SUMMARY: The Office of the Secretary requests nominations of individuals to serve on the Advisory Committee on Blood Safety and Availability (ACBSA) in accordance with its charter. Appointments will be made for a term of four years. It is not necessary to re-nominate individuals previously nominated; all nominations previously received have been retained and remain active.

DATES: All nominations must be received at the address below by no later than 4 p.m. EDT July 23, 1999.

ADDRESSES: All nominations shall be submitted to Stephen D. Nightingale, M.D., Executive Secretary, Advisory Committee on Blood Safety and Availability, Office of Public Health and Science, Department of Health and Human Services, 200 Independence Avenue SW., Washington, DC 20201. Phone (202) 690–5560.

FOR FURTHER INFORMATION CONTACT: Stephen D. Nightingale, M.D., Executive Secretary, Advisory Committee on Blood Safety and Availability, Office of Public Health and Science, Department of Health and Human Services, 200 Independence Avenue SW., Washington, DC 20201. Phone (202) 690–5560.

Nominations

Persons nominated for membership should be from among authorities knowledgeable in blood banking, transfusion medicine, bioethics and/or related disciplines. Members shall be selected from State and local organizations, blood and blood products industry including manufacturers and distributors, advocacy groups, consumer advocates, provider organizations, academic researchers, ethicists, private physicians, scientists, consumer advocates, legal organizations and from among communities of persons who are frequent recipients of blood and blood products.

Information Required

Each nomination shall consist of a package that, at a minimum, includes:

A. The name, return address, daytime telephone number and affiliation of the individual being nominated, the basis for the individual's nomination, the category for which the individual is nominated and a statement that the nominated individual is willing to serve as a member of the committee;

B. The name, return address, daytime telephone number at which the nominator may be contacted. Organizational nominators must identify a principal contact person in addition to the contact information;

C. A copy of the nominee's curriculum vitae.

All nomination information for a nominee must be provided in a complete single package. Incomplete nominations will not be considered. Nomination materials must bear original signatures, and facsimile transmissions or copies are not acceptable.

Dated: June 14, 1999.

Stephen D. Nightingale,

Executive Secretary, Advisory Committee on Blood Safety and Availability.

[FR Doc. 99–15627 Filed 6–18–99; 8:45 am]

BILLING CODE 4160–17–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Minority Health

Availability of Funds for Grants for the Minority Community Health Coalition Demonstration Program, HIV/AIDS

AGENCY: Office of the Secretary, Office of Minority Health.

ACTION: Notice of availability of funds and request for applications for the Minority Community Health Coalition Demonstration Grant Program, HIV/AIDS.

Purpose

The purpose of this Fiscal Year 1999 Minority Community Health Coalition Demonstration Grant Program, HIV/AIDS is to improve the health status, relative to HIV/AIDS, of targeted minority populations through health promotion and education activities. This program is intended to demonstrate the effectiveness of community-based coalitions involving non-traditional partners in:

(1) Developing an integrated community-based response to the HIV/AIDS crisis through community dialogue and interaction;

(2) Addressing sociocultural, linguistic and other barriers to HIV/AIDS treatment to increase the number of individuals seeking and accepting services; and

(3) Developing and conducting HIV/AIDS education and outreach efforts for hardly reached populations.

The overall goal is to increase the health status of minority populations by increasing the educational understanding of HIV/AIDS, increased testing, and improving the access to HIV/AIDS prevention and treatment services.

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of *Healthy People 2000*, a PHS-led national activity of setting priority areas. This announcement, the Minority Community Health Coalition Demonstration Grant Program, HIV/AIDS, is related to four of the 22 priority areas (1) Alcohol and other drugs; (2) educational and community-based programs; (3) HIV Infection; and (4) sexually transmitted diseases. Potential applicants may obtain a copy of Health People 2000 (Full Report: Stock No. 017–001–00474–0) or Healthy People 2000 (Summary Report: Stock No. 017–001–0473–1) through the Superintendent of Documents,

Government Printing Office, Washington, DC 20402–9325 or telephone (202) 783–3238.

Background

The Minority Community Health Coalition Demonstration Grant Program, HIV/AIDS is based on the hypothesis that the community coalition approach to health promotion and education activities can be effective in reaching minority target populations—especially those most at risk or hardly reached. Among the merits of using coalitions is the higher likelihood that: (1) The intervention will be culturally and linguistically competent, credible and more acceptable to the target population; (2) the project will address HIV/AIDS within the context of related socio-economic issues; and (3) the effort will contribute to overall community empowerment by strengthening indigenous leadership and organizations. The OMH is continuing, through this announcement, to promote the utilization of community coalitions to develop and implement health promotion/education activities to specifically focus on HIV/AIDS. The OMH is also interested in involving those organizations in the coalition that have not traditionally been involved in HIV/AIDS prevention activities or services and outreach (e.g., sororities/fraternities, rotary clubs, religious affiliates) so that hardly reached populations (e.g. inmates, homeless, women at risk, youth) are provided the services they need. By including organizations that have not traditionally been involved in HIV/AIDS activities, the community coalition will expand its network and ability to access and serve these hardly reached populations. Applicants are also encouraged to establish linkages with other federally funded programs supporting HIV prevention and care to maximize these efforts.

Disproportionate Effect of HIV/AIDS on Minorities

Current statistics from the Centers for Disease Control and Prevention (CDC) indicate that Blacks and Hispanics are disproportionately represented among the more than 640,000 people with AIDS that have been reported in the United States. While Blacks and Hispanics respectively represent approximately 13% and 10% of the U.S. population, 45% of people with AIDS reported in 1997 were Black and 21% were Hispanic. Asian/Pacific Islanders and Native Americans respectively represent 4% and 1% of the U.S. population and currently each account for 1% of people with AIDS. During 1997, the rate of new AIDS cases per 100,000 population in the U.S. was 83.7 among Blacks, 37.7 among Hispanics, 10.4 among whites, 10.4 among American Indians/Alaska Natives, and 4.5 among Asians/Pacific Islanders. Although Asian/Pacific Islanders and Native Americans do not appear to be disproportionately affected by HIV infection, it is believed that the low rate may be due in part to undercounting issues, especially in the Native American population.

The behaviors that increase the risk of infection with HIV include: unprotected sexual intercourse; the sharing of HIV infected needles or other drug paraphernalia; and having numerous unprotected sexual partners (homosexual or heterosexual). People who engage in more than one of these behaviors, for example, individuals who have unprotected sex with someone who injects drugs and shares needles or other ''works'', are at especially high-risk. HIV infections associated with use of injected drugs involve not only drug users themselves, but their sex partners and infants as well. Users of non-injected drugs, e.g. crack, who sell sexual favors to support their habit often expose themselves to multiple potentially infected partners.

Surveillance data shows that a large proportion of AIDS cases among minorities are diagnosed in the 20 to 29 year old age group, indicating HIV infection in adolescence or early 20's. Given the data regarding the incidence of the disease among teenagers, adolescents and adults, it is imperative to conduct targeted outreach activities to implement comprehensive HIV/AIDS prevention and education programs in racial/ethnic communities to reach these populations.

HIV/AIDS and Sexually Transmitted Diseases (STDs)

The behaviors which place individuals at risk for other STDs also increase a person's risk of becoming infected with HIV. Prevention through individual behavior change is the only method currently available to stop the spread of HIV infection. According to the CDC, biological studies suggest both increased susceptibility to HIV infection and increased likelihood of infecting other people when STDs are present. STD surveillance can provide important indications of where HIV infection may spread, and where efforts to promote safer sexual behaviors should be targeted. Therefore, it is important that HIV education and prevention programs integrate STDs as health care problems associated with the high-risk behaviors underlying HIV transmission.

Eligible Applicants: Public and private, nonprofit minority community-based organizations which represent a community coalition of at least three discrete organizations (see definitions of Minority Community-Based Organizations, Community Coalition and AIDS Service Organization found in this announcement.) The applicant and at least one of the three organizations must have significant experience in conducting HIV/AIDS education, prevention and outreach activities. As the applicant, the minority community-based organization must have at least five years or more experience in HIV/AIDS. One of the three organizations must be an AIDS Service Organization (ASO) with at least three years of experience. Additionally, at least one of the coalition members must be an organization rooted in the community, but with limited experience conducting HIV/AIDS programs.

In order to maximize the use of the limited resources available for this program and to address efforts where the HIV/AIDS problem is most prevalent, eligible applicants must be located in one of the following 15 metropolitan statistical areas. These are the areas indicated by the CDC in its HIV/AIDS Surveillance Reports for 1996 and 1997 as having the highest number of newly reported AIDS cases in 1995, 1996 and 1997.

- Atlanta, GA
- Baltimore, MD
- Boston, MA
- Chicago, IL
- Dallas, TX
- Ft. Lauderdale, FL
- Houston, TX
- Los Angeles, CA
- Miami, FL
- New York, NY
- Newark, NJ
- Philadelphia, PA
- San Francisco, CA
- San Juan, PR
- Washington, DC

The minority community-based organization will: serve as the lead agency for the grant; be responsible for management of the project; and serve as the fiscal agent for the Federal grant awarded. The coalition membership must be documented as specified under the project requirements described in this announcement.

National organizations, universities and schools of higher learning are not eligible to apply. However, local affiliates of national organizations which meet the definition of a minority community-based organization are eligible. Currently funded OMH grantees are not eligible to apply (e.g., Minority Community Health Coalition

Demonstration Program, Bilingual/Bicultural Service Demonstration Program). Organizations are not eligible to receive funding from more than one OMH grant program.

Deadline: To receive consideration, grant applications must be received by the Office of Minority Health (OMH) Grants Management Office by July 21, 1999. Applications will be considered as meeting the deadline if they are: (1) Received on or before the deadline date, or (2) postmarked on or before the deadline date and received in time for orderly processing. A legibly dated receipt from a commercial carrier or U.S. Postal Service will be accepted in lieu of a postmark. Private metered postmarks will not be accepted as proof of timely mailing. Applications submitted by facsimile transmission (FAX) or any other electronic format will not be accepted. Applications which do not meet the deadline will be considered late and will be returned to the applicant unread.

Addresses/Contacts: Applications must be prepared using Form PHS 5161–1 (Revised May 1996 and approved by OMB under control Number 0937–0189). Application kits and technical assistance on budget and business aspects of the application may be obtained from Ms. Carolyn A. Williams, Grants Management Officer, Division of Management Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, MD 20852, telephone (301) 594–0758. Completed applications are to be submitted to the same address.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of grant applications should be directed to Ms. Cynthia H. Amis, Director, Division of Program Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, MD 20852, telephone (301) 594–0769.

Technical assistance is also available through the OMH Regional Minority Health Consultants (RMHCs). A listing of the RMHCs and how they may be contacted will be provided in the grant application kit. Additionally, applicants can contact the OMH Resource Center (OMH-RC) at 1–800–444–6472 for health information.

Availability of Funds: Approximately $2.5 million is to be available for award in FY 1999. It is projected that awards of up to $150,000 total costs (direct and indirect) for a 12 month period will be made to approximately 13–15 competing applicants.

Period of Support: The start date for the Minority Community Health Coalition Demonstration Program, HIV/AIDS grants is September 30, 1999. Support may be requested for a total project period not to exceed 3 years. Noncompeting continuation awards of up to $150,000 will be made subject to satisfactory performance and availability of funds.

Project Requirements: Each applicant to this demonstration grant program must:

(1) Propose to conduct a replicable, model program using an integrated community-based response to the HIV/AIDS crisis through community dialogue and interaction designed to improve the health status of targeted minority populations.

(2) Have a coalition capable of ensuring that the target population is provided with HIV/AIDS health promotion and education outreach activities that are linguistically, culturally and age appropriate especially for hardly reached populations.

(3) Engage minority communities in activities that will impact attitudes and perceptions in these communities to increase the number of individuals seeking and accepting services.

(4) The coalition must consist of at least three discrete organizations which include: (1) a minority community-based organization; (2) an ASO; and, (3) one organization rooted in the community with limited experience in HIV/AIDS activities. As the lead, the minority community-based organization must have at least five years of documented experience in conducting HIV/AIDS education and health promotion activities. The coalition must include an ASO with at least three years of documented experience to ensure that information dissemination on HIV/AIDS and related issues is current and accurate from a medical point of view. The coalition must also include at least one organization rooted in the community that has not traditionally been involved in HIV/AIDS activities.

(5) Provide signed documentation between the applicant and each coalition member which specifies, in detail: (a) the roles and resources that each entity will bring to the project, and (b) states the duration and terms of the agreement. The document must be signed by representatives with authority from all the member organizations including the applicant (e.g., president, chief executive officer, executive director).

Use of Grant Funds: Budgets of up to $150,000 total cost (direct and indirect) per year may be requested to cover costs of: personnel, consultants, supplies, equipment, and grant related travel. Funds may not be used for medical treatment, construction, building alterations, or renovations. All budget requests must be fully justified in terms of the proposed goals and objectives and include a computational explanation of how costs were determined.

Criteria for Evaluating Applications

Review of Application

Applications will be screened upon receipt. Those that are judged to be incomplete, non-responsive to the announcement or nonconforming will be returned without comment. Each applicant may submit no more than one proposal under this announcement. If an organization submits more than one proposal, all will be deemed ineligible and returned without comment. Accepted applications will be reviewed for technical merit in accordance with PHS policies. Applications will be evaluated by an Objective Review Panel chosen for their expertise in minority health, experience relevant to this program, and their understanding and knowledge of the health problems and risk factors confronting racial and ethnic minorities in the United States.

Applicants are advised to pay close attention to the specific program guidelines and general instructions provided in the application kit.

Application Review Criteria

The technical review of applications will consider the following generic factors.

Factor 1: Background (15%)

Adequacy of demonstrated knowledge of the problem at the local level; demonstrated need within the proposed community and target population; demonstrated support of local agencies and/or organizations, and established linkages in order to conduct proposed model; and extent and documented outcome of past efforts/activities with the target population.

Factor 2: Goals and Objectives (15%)

Merit of the objectives, their relevance to the program purpose and stated problem, and their attainability in the stated time frames.

Factor 3: Methodology (35%)

Appropriateness of proposed approach and specific activities for each objective and target group. Logic and sequencing of the planned approaches in relation to the objectives and program evaluation. Extent to which the applicant demonstrates access to the target population. Soundness of the established linkages.

Factor 4: Evaluation (20%)

Thoroughness, feasibility and appropriateness of the evaluation design, and data collection and analysis procedures. Clarity of the intent and plans to document the activities and their outcomes to establish a model. The potential for replication of the project for similar target populations and communities.

Factor 5: Management Plan (15%)

Applicant organization's capability to manage and evaluate the project as determined by: the qualifications of proposed staff or requirements for ''to be hired'' staff; proposed staff level of effort; management experience of the lead agency; and experience of each coalition member as it relates to its defined roles and the project.

Award Criteria

Funding decisions will be determined by the Deputy Assistant Secretary for Minority Health, Office of Minority Health and will take under consideration: recommendations/ratings of the review panels and geographic and racial/ethnic distribution. Consideration will also be given to projects proposed to be implemented in Empowerment Zones and Enterprise Communities in the 15 eligible metropolitan statistical areas and those which reach out to neighboring rural communities impacted by the HIV/AIDS epidemic.

Definitions

For purposes of this grant announcement, the following definitions are provided:

AIDS Service Organization (ASO)—A health association, support agency, or other service actively involved in the prevention and treatment of AIDS. (HIV/AIDS Treatment Information Service's Glossary of HIV/AIDS–Related Terms, March 1997.)

Community-Based Organization—Public and private, non-profit organizations which are representative of communities or significant segments of communities, and which address health and human services.

Community Coalition—At least three (3) discrete organizations and institutions in a community which collaborate on specific community concerns, and seeks resolution of those concerns through a formalized relationship documented by written memoranda of understanding/agreement signed by individuals with the authority to represent the organizations (e.g., president, chief executive officer, executive director).

Cultural Competency—A set of behaviors, attitudes, and policies that enable a system, agency, and/or individual to function effectively with culturally diverse clients and communities. (Randall-David, E., 1989)

Intervention—An activity or series of activities (e.g., information dissemination, educational activities, coordinated network-related activities) designed to alter or modify a condition or outcome, or to change behavior to reduce the likelihood of a preventable health problem occurring or progressing further.

Minority Community-Based Organizations—Public and private nonprofit community-based minority organization or a local affiliate of a national minority organization that has: a governing board composed of 51 percent or more racial/ethnic minority members, a significant number of minorities employed in key program positions, and an established record of service to a racial/ethnic minority community.

Minority Populations—American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander. (Revision to the Standards for the Classification of Federal Data on Race and Ethnicity, **Federal Register**, Vol. 62, No. 210, pg. 58782, October 30, 1997.)

Risk Factor—The environmental and behavioral influences capable of causing ill health with or without predisposition.

Sociocultural Barriers—Policies, practices, behaviors and beliefs that create obstacles to health care access and service delivery (e.g., cultural differences between individuals and institutions, cultural differences of beliefs about health and illness, customs and lifestyles, cultural differences in languages or nonverbal communication styles).

Reporting and Other Requirements

General Reporting Requirements

A successful applicant under this notice will submit: (1) progress reports; (2) an annual Financial Status Report; and (3) a final progress report and Financial Status Report in the format established by the Office of Minority Health, in accordance with provisions of the general regulations which apply under CFR 74.50–74.52.

Provision of Smoke-Free Workplace and Non-Use of Tobacco Products by Recipients of PHS Grants

The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Public Health System Reporting Requirements

This program is subject to Public Health Systems Reporting Requirements. Under these requirements, a community-based nongovernmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based organizations within their jurisdictions.

Community-based nongovernmental applicants are required to submit, no later than the Federal due date for receipt of the application, the following information to the head of the appropriate State and local health agencies in the area(s) to be impacted: (a) a copy of the face page of the application (SF 424), and (b) a summary of the project (PHSIS), not to exceed one page, which provides: (1) a description of the population to be served, (2) a summary of the services to be provided, and (3) a description of the coordination planned with the appropriate State or local health agencies. Copies of the letters forwarding the PHSIS to these authorities must be contained in the application materials submitted to the Office of Minority Health.

State Reviews

This program is subject to the requirements of Executive Order 12372 which allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The application kit to be made available under this notice will contain a listing of States which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review. Applicants (other than federally recognized Indian tribes) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the

application deadline established by the Office of Minority Health's Grants Management Officer.

The Office of Minority Health does not guarantee that it will accommodate or explain its responses to State process recommendations received after that date. (See ''Intergovernmental Review of Federal Programs'' Executive Order 12372 and 45 CFR Part 100 for a description of the review process and requirements).

Authority: This program is authorized under section 1707(e)(1) of the Public Health Service Act, as amended by Public Law 105–392.

(OMB Catalog of Federal Domestic Assistance: The OMB Catalog of Federal Domestic Assistance number for the Minority Community Health Coalition Demonstration Program is 93–137.)

Dated: June 9, 1999.

Nathan Stinson, Jr.,

Acting Deputy Assistant Secretary for Minority Health.

[FR Doc. 99–15635 Filed 6–18–99; 8:45 am]

BILLING CODE 4160–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Minority Health

Availability of Funds for Grants for State and Territorial Minority HIV/AIDS Demonstration Grant Program

AGENCY: Office of the Secretary, Office of Minority Health.

ACTION: Notice of availability of funds and request for applications for State and Territorial Minority HIV/AIDS Demonstration Grant Program.

Purpose

The purposes of this Fiscal Year 1999 State and Territorial Minority HIV/AIDS Demonstration Program are to:

(1) Assist in the identification of needs within the state for HIV/AIDS prevention and services among minority populations by collection, analysis, and/or tracking of existing data on surveillance and existing providers of HIV services for minority communities;

(2) Facilitate the linkage of minority community-based organizations with other state and local recipients of federal funds for HIV/AIDS to develop greater resource capacity and interventions in the identified areas of need; and

(3) Assist in coordinating federal resources coming into high need, minority communities including identifying the different programs and facilitating access to federal technical assistance available to minority community-based organizations.

This program is intended to demonstrate that the involvement of State and Territorial Offices of Minority Health in coordinating a statewide response to the HIV/AIDS crisis in minority communities can have a greater impact on the communities' understanding of the disease, and the coordination of prevention and treatment services for minority populations, than agencies/organizations working independently.

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, a PHS-led national activity to reduce morbidity and mortality and to improve the quality of life. This announcement relates to 4 of the 22 priority areas established by Healthy People 2000: (1) Alcohol and other drugs; (2) educational and community-based programs; (3) HIV infection; and (4) sexually transmitted diseases. Potential applicants may obtain a copy of the Healthy People 2000 (Full Report: Stock No. 017–001–00474–0) or Healthy People 2000 Midcourse Review and 1995 Revisions (Stock No. 017–001–00526–6) through the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402–9325 or telephone (202) 783–8238.

Background

The Office of Minority Health's (OMH) mission is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help to address the health disparities and gaps. Consistent with its mission, the role of OMH is to serve as the focal point within the Department for service demonstrations, coalition and partnership building, and related efforts to address the health needs of racial and ethnic minorities. In keeping with this mission, OMH is establishing the State and Territorial Minority HIV/AIDS Demonstration Program to assist in addressing the HIV/AIDS issues facing minority communities across the United States. This program is based on the hypothesis that a broad, state-level approach to HIV/AIDS health care promotion and prevention can be effective in reaching minority populations by both defining existing needs of prevention and treatment, and supporting strategies to address these needs. It is anticipated that this approach will strengthen existing state activities in addressing this health issue by facilitating infrastructure development or expansion of State and Territorial Offices of Minority Health to: (1) Take a lead role in identifying major areas of need in minority communities; (2) link minority community-based organizations with other state and local partners in the identified areas of need; and (3) assist in coordinating federal resources coming into high need, minority communities including identifying the different programs and facilitating access to federal technical assistance available to minority community-based organizations.

Disproportionate Effect of HIV/AIDS on Minorities

Current statistics indicate that although advances have been made in the treatment of HIV/AIDS, this epidemic continues as a significant threat to the public health of the United States (U.S.). Despite showing a decline in the past two years, it remains a disproportionate threat to minorities. While African-Americans and Hispanics respectively represent approximately 13% and 10% of the U.S. population, approximately 36% of the more than 640,000 reported total AIDS cases are African-American and 18% are Hispanic. Asian/Pacific Islanders and Native Americans respectively represent 4% and 1% of the U.S. population and currently each account for less than 1% of the AIDS cases.

In 1997, more African-Americans were reported with AIDS than any other racial/ethnic group. Of the total AIDS cases reported that year, 45% (27,075) were reported among African-Americans, 33% (20,197) were reported among whites, and 21% (12,466) were reported among Hispanics. Among women and children with AIDS, African-Americans have been especially affected, representing 60% of all women reported with AIDS in 1997 and 62% of reported pediatric AIDS cases in 1997. During 1997, the rate of new AIDS cases per 100,000 population in the U.S. was 83.7 among African-Americans, 37.7 among Hispanics, 10.4 among whites, 10.4 among American Indians/Alaska Natives, and 4.5 among Asians/Pacific Islanders.

Data from a recent Centers for Disease Control and Prevention study (Trends in the HIV and AIDS Epidemic, 1998) comparing HIV and AIDS diagnoses in 25 states with integrated reporting systems provide a clearer picture of recent shifts in the epidemic. The study indicates that many of the new HIV diagnoses are occurring among African-Americans, women, and people infected heterosexually, with an increase also observed among Hispanics. During the period from January 1994 through June