Racial and ethnic minority populations have many important public health problems. Among these is the disproportionate rate of HIV and STDs. Factors such as poverty, underemployment, and poor access to the health care system contribute to HIV and STD's disproportionate impact on the public health of racial and ethnic minority communities. The following provides background information concerning needs in this critical public health program area.

As of December 1998, reported cases of AIDS in the United States totaled 688,200. Racial and ethnic minority populations have been disproportionately affected by HIV infections and AIDS since the beginning of the epidemic in the United States. Through December 1998, the CDC had received reports of 251,408 African-Americans, 124,841 Latinos/Hispanics, 4,974 Asian-Americans/Pacific Islanders and 1,940 American Indians/Alaska Natives with AIDS. Approximately 55% of all reported AIDS cases are among African-Americans and Latinos/Hispanics, while they represent only 23% of the U.S. population. Among the 376,199 adult and adolescent AIDS cases reported in racial and ethnic minority populations, gay-identified, bisexual, and other men who have sex with men accounted for 117,052 (31.1%), injecting drug users (IDUs) accounted for 137,724 (36.6%), gay-identified, bisexual, and other men who have sex with men who were also IDU accounted for 21,122 cases (5.6%), and heterosexual contact accounted for 52,067 (13.8%). Racial/ethnic minorities have accounted for a greater percentage of the newly reported cases of AIDS than their percentage of the national population and have consistently been over-represented among persons living with HIV.

These statistics do not indicate individuals are at risk just because they are members of a racial or ethnic minority group – these numbers simply reflect the fact that many minority populations are disproportionately represented in communities that have a high incidence of HIV and other sexually transmitted infections.

In response to predictions of these trends, the CDC initiated the National Minority Organizations (NMOs) HIV Prevention Program in 1988; its goal was to strengthen HIV/AIDS prevention efforts among minority communities throughout the United States. In 1993, the CDC continued this initiative through Announcement 305, The National/Regional Minority Organizations (NRMOs) HIV Prevention Program, funding 23 NRMOs for a five-year project period. The NRMOs' client organizations include both private minority organizations that need technical assistance and training to develop, implement, and improve HIV prevention programs and public and private "mainstream" organizations that are seeking to build capacity. Behavioral and social science, biomedical research, collaboration, community planning, evaluation, and organizational development were identified as the six priority areas critical to addressing HIV prevention for their programs.

This initiative was designed to facilitate accomplishment of the CDC's national goals for HIV prevention: establish and maintain HIV prevention programs implemented in collaboration with other organizations; affect the initiation and maintenance of behavior change among persons at risk for HIV; increase access to prevention and early intervention services for HIV-infected persons; and increase collaboration and support among the network of organizations providing HIV prevention services.

These goals are meant to produce better outcomes for the American people with regard to HIV. These goals are articulated in the Healthy People 2000 Objectives for the Nation, as specified in priority areas 18 and 19 (CDC Healthy People 2000 Review 1995).

The following is a diagram that illustrates the conceptual framework of 1) the relationship between the A-305 initiative, the CDC's national program goals for HIV prevention, and the Healthy People 2000 Goals for the Nation; and 2) the intent and rationale behind A-305.

Conceptual Framework of the NRMO Program