
# A RENEWED COMMITMENT IS NEEDED TO STRENGTHEN AND EXPAND THE MINORITY AIDS INITIATIVE (MAI)

**THE MINORITY AIDS INITIATIVE (MAI) WAS CREATED BY CONGRESS IN 1998** in response to the highly disproportionate impact of HIV in Black and Latinx communities and the inadequate investments and support for community-based responses in these communities.[1] Since that time, despite broad national progress in reducing new HIV infections, increasing access to health care, and improving HIV viral suppression and other outcomes among people with HIV, the share of new diagnoses among people of color overall has grown.[2] Thus, these communities often are not equally benefitting from national investments made to respond to HIV.

The MAI was intended to buttress the HIV community's proud legacy of grounding prevention and care responses in community leadership and community-based services. Its primary goal was to expand access to HIV services in the most heavily impacted communities by building the capacity of communities themselves to deliver effective HIV services to reduce the large and persistent racial and ethnic disparities observed across HIV metrics.[3] While the program has been maintained for the past 25 years, funding has remained relatively stagnant since its enactment, and policymakers have rarely highlighted the MAI's essential role, evaluated its progress, or proposed changes to improve and strengthen the program. Today, incomplete knowledge about what the program does and how it fits into the overall HIV response is holding it back from achieving its goals. Addressing the following four issues may provide a pathway for reinvigorating the MAI:

## INCREASING TRANSPARENCY AND ACCOUNTABILITY

MAI is administered in two ways. Most funds are allocated via the MAI formula program to the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services

## ELEVATING MAI IN THE HIV RESPONSE

**CRITICAL POLICY ACTIONS CAN STRENGTHEN THE MAI:**

**Increasing Transparency and Accountability**
Release MAI program and financial data and conduct program evaluations.

**Defining the MAI's Unique Role in the HIV Response**
Direct agency recipients of MAI funds to identify proactive administrative steps to ensure that MAI funds are not only providing services, but also supporting the capacity of minority communities themselves to respond to HIV.

**Highlighting New Strategies for Building Services Capacity in Communities of Color**
Examine and leverage past capacity building successes, and explore new approaches for a multi-year, staged capacity building initiative.

**Tailoring the MAI Program to Have Maximum Impact**
Identify viable strategies for ensuring that program funds reach minority-led CBOs and lead to measurable improvements in community-led capacity.

Administration (SAMHSA), and the Ryan White HIV/AIDS Program, which is administered by the Health Resource and Services Administration (HRSA). (Note: some parts of Ryan White are also set by statute.) Separately, a small portion of these agency funds is directed to the Health and Human Services (HHS) Office of the Secretary to administer the Minority HIV/AIDS Fund (MHAF). In 2023, $60 million is allocated to the MHAF. Information about the formula funding program, by far the largest component of the MAI, is only minimally available: some insight can be gathered from a funding breakdown in a 2013 report from the Government Accountability Office (GAO) for FY 2011. This report showed that $364.1 million was allocated through the formula portion of the program.[4] When agencies transmit the President's budget request to Congress, they publicly release a Congressional Justification (CJ) that provides some of the most detailed information about funding and program priorities of federal programs. Detailed budget information about the MAI (including information pertaining to funding levels and grantees), however, is missing from many agency CJs.

### POLICY ACTION: Release MAI program and financial data and conduct program evaluations.

Part of the lack of attention and focus on the MAI stems from the limited amount of available information about the size of the program, what the program is funding, and the program's impact. A current understanding of how the program is functioning to meet its goals is needed. The White House, through the Office of Management and Budget (OMB), should publicly release a summary of agencies' MAI funding and work with individual agencies to include these details about program activities and expected and measured outcomes in the agency CJs and other publicly available materials. Further, the HHS Office of Infectious Disease and HIV/AIDS Policy (OIDP), which administers the MHAF and plays a coordinating role across HHS agencies, should conduct an assessment that highlights MAI successes, identifies ways to strengthen coordination across agencies, and recommends potential administrative or legislative changes to the program.

## DEFINING THE MAI'S UNIQUE ROLE IN THE HIV RESPONSE

A critique of the MAI formula program is that it lacks a clearly defined purpose distinct from other HIV programs. While the federal government funds a number of programs and initiatives that assist in responding to HIV, including health care and income support programs, such as Medicaid, Medicare, and Social Security, and several HIV-specific programs, the MAI formula program should provide strategic assistance to ensure that racial and ethnic minority communities have equal access to these programs. Additionally, these communities should be provided with the resources needed to overcome structural barriers to services that maintain HIV disparities and perpetuate inequitable access and outcomes.

### POLICY ACTION: Direct agency recipients of MAI funds to identify proactive administrative steps to ensure that MAI funds are not only providing services, but also supporting the capacity of minority communities themselves to respond to HIV.

The initial goal of the MAI was to reduce the disproportionate impact of HIV in communities of color. It did this by both investing more in services and seeking to bolster the capacity of minority-led CBOs to provide such services. In 1995, the Supreme Court ruled in *Adarand Constructors v. Peña* (discussed further on page 3), that strict scrutiny is required for programs using race and ethnicity in awarding funding. Further, throughout the 1999 Supplemental Appropriations Act that first funded the MAI,[2] Congress directed multiple agencies, including CDC and HRSA, to fund indigenous CBOs (i.e., those originating from the minority communities themselves) to support activities such as capacity building to increase their ability to deliver effective prevention and treatment services. Starting in the Bush Administration, however, HRSA began dedicating a larger share of its Ryan White MAI formula funding to services delivery rather than strengthening the capacity of minority-led CBOs. CDC also has directed more of its MAI formula funds into its larger flagship program for CBOs; none of these funds are required to be distributed to indigenous, minority-led CBOs.[5] While these critical programs should continue, policy decisions attributed to *Adarand* have moved the MAI away from one of its priority original purposes: supporting minority-led CBOs.

Therefore, even as overall HIV funding may now be more explicitly directed to serving highly impacted minority communities, the MAI formula program has moved away from dedicating funding to CBOs originating from the minority communities themselves. What is needed now are concerted efforts to re-focus the limited resources of the MAI on building the capacity of minority-led CBOs: they are often the ones most able to provide culturally and linguistically appropriate care and services to racial and ethnic minorities.

Agency leaders should, while still adhering to Supreme Court precedents, work with Congressional appropriators to identify a pathway for gradually enhancing the capacity building focus of MAI formula funds while still protecting the aforementioned initiatives from harmful funding reductions. Minority-

led CBOs that provide tailored services to those who need them most are crucial to delivering efficient and effective HIV services and achieving our national HIV policy goals.

## HIGHLIGHTING NEW STRATEGIES FOR BUILDING SERVICES CAPACITY IN COMMUNITIES OF COLOR

Since the beginning of the HIV epidemic, individuals in affected communities have seen the need for services and have advocated, volunteered, and created new organizations. Many grew and matured, and some have even transitioned into federally qualified health centers (FQHCs). Relatively few of these organizations, however, are minority-led. Some reasons for this include systemic racism, structural barriers, and reduced community resources and community infrastructure to support minority-led organizations. Despite these organizations' very close ties to the affected communities and ability to engender great levels of trust and support, many struggle to remain financially viable. For these organizations to sustainably thrive over time, new approaches are needed.

**POLICY ACTION: Examine and leverage past capacity building successes, and explore new approaches for a multi-year, staged capacity building initiative.**

Expertise is needed for CBOs to operate sustainably, comply with all laws, retain broad community and financial support, evaluate and strengthen programs, train and develop staff, and ensure proper governance through a Board of Directors. Most younger organizations do not have such expertise, and it is unreasonable to expect them to start from scratch and achieve complete and immediate competency in these and other areas. Further, many smaller, minority-led CBOs struggle more, due to less money, time, and expertise, to respond to community needs in ways that other (often white-led) organizations with greater access to private resources can. New efforts are needed to consult community stakeholders and re-envision capacity building. One approach is to develop a multi-year technical assistance curriculum for fledgling CBOs that initially focuses on pressing organizational needs, such as financial management and governance, and may lead into a tailored five-to-ten-year plan for individual CBOs. This would help progressively improve administrative infrastructure and capacity and assist organizations in responding to changing needs as they grow and transform over time.

## TAILORING THE MAI PROGRAM TO HAVE MAXIMUM IMPACT

Federal programs funded with taxpayer support must maximally benefit the American people. Since racism and other deeply entrenched structural barriers impede our ability to achieve our national ideals, and HIV is heavily and disproportionately concentrated within specific communities, federal investments will only have the greatest impact if they are focused on the communities with the largest needs. Minority-led CBOs are well-suited to address these needs because they often have developed deep levels of understanding and trust with the communities they serve.[6] There is no consensus, however, regarding the most appropriate tools to be used to remedy unequal racial treatment.

## SUPREME COURT PRECEDENTS AND STRICT SCRUTINY

**Questions have been raised over the ability of the federal government to use race and ethnicity in awarding funds. This has affected the MAI.**

**Adarand Constructors, Inc. v. Peña, 515 U.S. 200 (1995):** In 1995, a federal program provided a financial incentive to any prime contractors who hired subcontractors controlled by "socially and economically disadvantaged individuals"; it was presumed this included racial minorities. A different company was awarded the subcontract over Adarand Constructors, Inc. because it did not meet this standard. When the Supreme Court heard the case, it held that all racial classifications, like the one surrounding this financial incentive program, must pass strict scrutiny review.

**Strict Scrutiny:** This means that the classification must (1) serve a compelling government interest, and (2) be narrowly tailored to further that interest.

**Federal Agency Responses:** Federal agency leaders have consciously moved away from explicitly funding minority-led CBOs though the MAI. Additionally, due to limited federal funding levels and the often rigidity of funding opportunities, many CBOs have found it challenging to diversify their funds and optimize their services capacity and delivery.

**Looking Ahead:** In 2022, the Supreme Court heard cases related to affirmative action at Harvard and UNC-Chapel Hill—decisions are expected later this year. Race-based debates over government contracting and voting rights are having wide-reaching effects. The MAI has been constrained by these broader disagreements over what is appropriate and fair to consider when redressing racial inequities.

## POTENTIAL CRITERIA FOR FOCUSING MAI IN COMMUNITIES OF COLOR

**For some, the preferred approach is to apply strict scrutiny and use race/ethnicity as one criterion in awarding funding under the MAI.**

Other approaches could result in a similar outcome:

### HIV-RELATED DATA

In 2019, Black people made up 13% of the U.S. population, yet accounted for 42% of new HIV diagnoses. Not only were viral suppression rates lower for Black people than all people diagnosed with HIV—61% compared to 66%—but only 8% of Black people who could benefit from PrEP were prescribed it. This was 15% lower than people who could benefit from PrEP overall. Distributing funds to CBOs and giving priority to organizations whose leadership and client population aligns with the population groups with the greatest need for PrEP, for example, would not need to rely on racial classification.

### THE SOCIAL VULNERABILITY INDEX (SVI)

CDC's Social Vulnerability Index uses 16 U.S. Census variables, including poverty, access to public transportation, and crowded housing, to determine how much support and resources specific locales should receive to respond to external stresses.

Historically, socially vulnerable communities were created via racial segregation, gentrification, and redlining; they now tend to house many minority individuals. Thus, if MAI funds were distributed via SVI data to specific census tracts (with requirements that the staff and leadership of funded agencies reflect the community), it would be possible to avoid strict scrutiny review.

**Sources:** Tia Sherèe Gaynor & Meghan E. Wilson, *Social Vulnerability and Equity: The Disproportionate Impact of COVID-19*, 80 Pub. Admin. Review 832 (Oct. 2020); *HIV Surveillance Supplemental Report: Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas*, 2019, 26(2) Ctrs. for Disease Control & Prevention (May 2021).

### POLICY ACTION: Identify viable strategies for ensuring that program funds reach minority-led CBOs and lead to measurable improvements in community-led capacity.

Many HIV community members advocate for race/ethnicity to be a factor used to award funds to CBOs. Most importantly, however, is ensuring that federal resources build the capacity of the communities with the greatest needs. Various other approaches that use objective data, such as the social vulnerability index or HIV-specific data, also can be used to ensure that MAI funds reach CBOs that can most effectively address HIV disparities and achieve the MAI's original aims.

## THE TIME IS NOW

Congress created the MAI to support the provision of community-led HIV services and expand access to these services. Increasing policy attention, recommitting to capacity building, and bolstering MAI formula funding and the MHAF are all critical to achieving the MAI's strategic purpose, meeting the goals of the National HIV/AIDS Strategy, and meaningfully progressing toward ending the HIV epidemic in the United States.

## ENDNOTES

1 Regina Aragón & Jennifer Kates, *The Minority AIDS Initiative*, Kaiser Family Found. (June 2004), bit.ly/3hIFF3Y.

2 Landon Myers & Jeffrey S. Crowley, *Quick Take: The Minority AIDS Initiative (MAI) is an Essential Tool for Fighting HIV*, O'Neill Inst. for Nat'l & Glob. Health Law fig.1 (Jan. 2023), bit.ly/3Ky1EXN.

3 *See* H.R. Rep. No. 105-825, at 1265-66, 71-72 (1999); H.R. Rep. No. 107-229, at 36 (2001).

4 *Report to Cong. Comms.: Minority AIDS Initiative*, U.S. Gov't Accountability Office (Nov. 2013), bit.ly/3O8clug.

5 *Notice of Funding Opportunity PS21-2102: Comprehensive High-Impact HIV Prevention Programs for Community Based Organizations*, Ctrs. For Disease Control & Prevention (July 2021).

6 *See, e.g.,* Paul A. Burns et al., *Leveraging Community Engagement: The Role of Community-Based Organizations in Reducing New HIV Infections Among Black Men Who Have Sex with Men,* 7 Journal of Racial and Ethnic Health Disparities 193 (2020).

O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

MARCH 2023

This brief is a product of the HIV Policy Project of the **O'Neill Institute for National and Global Health Law** and was developed with support from, and in partnership with ***Gilead Sciences, Inc.*** It is informed by stakeholder consultations held in September and December 2022 and was authored by **Jeffrey S. Crowley** and **Landon Myers**. The views expressed are solely those of the authors.

**http://bit.ly/USHIVpolicyproject**