World AIDS Day 2007
A Day of Reflection
Should we rethink HIV prevention in 2008?

Inside:
The “Evidence” Issue in HIV Prevention:
Scientific and Political Challenges

HIV Prevention in the United States:
Is 2008 a cause for hope, or a cause for alarm?

Action for social change through public policy research, advocacy and education
This issue of ActionLink focuses on HIV prevention. Judy Auerbach’s lead article reminds us of the need for a renewed understanding of the importance of “evidence” in prevention research and practice. David Holtgrave joins the many voices calling for a coordinated national HIV prevention effort. At a time when we are hearing about new, and unfortunately higher, numbers of HIV infection in the United States, the whole topic of prevention has taken on new meaning. For too long prevention has been undervalued, clearly demonstrated by the inability of both the Administration and Congress to adequately fund the federal prevention portfolio. The time to turn this state of affairs around is long overdue.

This year the World Health Organization has designated the theme for World AIDS Day to be, “Stop AIDS: Keep the Promise”. Can there be a clearer call to arms for the rededication to HIV prevention? Prevention is a key factor in our capacity to achieve the promise of a world without AIDS. However, this promise can only be achieved if resources are directed to coordinated national prevention efforts that are science-based and outcome-oriented, models based in evidence, not ideology. Cornerstones of such models include access to HIV testing and counseling, comprehensive sexual health education, risk reduction programs, such as syringe exchange, substance abuse treatment, and an understanding of how the lack of such basics as housing and food can destabilize the best of prevention efforts.

How will we keep the promise to stop AIDS? Worldwide, there are over 2.4 million new HIV infections each year and over 2 million people a year die of HIV/AIDS. Even with all the recent accomplishments of PEPFAR, Global Fund, and private foundations, these are staggering numbers. We should be very concerned that the nations of the world are not doing more – including the United States. It is time for our federal government to provide the resources necessary to reduce HIV infection in the United States. Likewise, all national governments need to participate in the worldwide eradication of HIV/AIDS.

As we enter the Holiday Season and a New Year, there are two hopes to express on behalf of The AIDS Institute. One is best wishes to all of our ActionLink readers, agency friends, supporters, and partners. The other is that as 2008 approaches, we may all commit to working together to advocate for HIV prevention. In that way, we each will do our part to “Stop AIDS: Keep the Promise”.

A. Gene Copello
**Supervised Injection Facility Trying to Make Its Way to San Francisco**

InSite, a facility in Vancouver, Canada, allows clients to inject their own drugs under the supervision of clinical staff. This clean, safe environment opened its doors in 2003 with the support of the City of Vancouver, the Vancouver Police Department, the Downtown East Side community, as well as the PHS Community Services Society. Upon entering, clients have access to clean injection equipment. Once finished, they are escorted to a post-injection room where they are then, if appropriate, connected with other on-site services. Two registered nurses are available to assist with wounds, abscesses and other infections. Peer support, addiction counseling, and referral to treatment services are all offered should a client decide to seek help. Since its opening, studies have shown that crime has dropped in downtown Vancouver, and addicts seek rehabilitation sooner and access to clean needles have helped with the spread of HIV, Hepatitis, and other diseases. IDUs are no longer gathering and using dirty needles from the streets or using puddle water to inject drugs.

With over 600 visits everyday and no overdoses, other cities are catching wind of InSite’s effectiveness. San Francisco, for example, is estimated to have 11,000-15,000 IDU’s, most of which are homeless men, and is therefore working to establish a similar facility. Sixty-five similar facilities exist in twenty-seven cities in eight countries, but San Francisco is the only US city considering one.

Between July 2006 and July 2007, one out every seven emergency calls in San Francisco was drug overdose related. The public health department recently co-sponsored a symposium on InSite and discussed if a safe injection site would be beneficial to reduce harm and improve health for their community. Several non-profits and social-service groups are on board and are advocating for community support, especially from Mayor Gavin Newsom and the Board of Supervisors. Operation location is a heated topic, but possible locations include AIDS clinics, drug treatment centers, or homeless shelters.

One tremendous barrier is political opposition. The U. S. Senate recently adopted an amendment offered by Sen. Jim DeMint (R-SC) to the Labor-HHS-Ed bill. His amendment would prohibit any Labor-HHS-Ed funding from going to “cities that provide safe haven to illegal drug users through the use of illegal drug injection facilities.”

In response to Sen. DeMint’s amendment, the Drug Policy Alliance circulated a sign-on letter encouraging conferees to remove this unnecessary amendment from the final Labor-HHS-Ed bill, stating that local public health measures should be guided by science, not politics. The AIDS Institute signed onto this letter. Fortunately, the conferees rejected DeMint’s amendment, but that does not mean the issue has gone away. The AIDS Institute and its partners will be on the look out for similar amendments in the future. (Angela Knudsen)
Introduction

At this point in the HIV/AIDS pandemic, there is general consensus among researchers, practitioners, program administrators, policy makers, and advocates that a comprehensive, multi-level approach to HIV prevention and the science that guides it is essential. This consensus comes from an understanding—after 26 years of research and lived experience—that HIV is a pathogen that is transmitted in the course of human relationships that take place in social and cultural contexts. This means that equal attention to biological, behavioral, and social factors—individually and in relation to each other—is required in order to have a real impact on the spread of HIV. As discussed below, this revelation is both promising and challenging in the questions it raises about how we will best identify what works in HIV prevention—that is, what constitutes appropriate evidence of efficacy and effectiveness for making decisions about what to implement and scale up.

Scientific Challenges

Over the life of the pandemic, there has been significant investment in biological and behavioral interventions research, focused primarily on individuals, which has produced limited effects. Behavioral interventions research—the most robust portfolio historically—has demonstrated that risk for sexual or drug-related HIV transmission can be reduced by as little as 0% and as much as 40% in different population groups, depending on the intervention. Where significant behavioral changes have resulted from these interventions, they chiefly have been assessed in short time periods—usually 3 to 18 months. The ability of people to sustain behavior change for risk reduction over the longer term—and at different stages of their lifecourse—remains unknown. Moreover, the relatively stable rates of infection observed over the past decade in the U.S. as a whole and in certain epicenters (such as San Francisco), as well as increased rates among specific population groups, suggest that much needs to be done beyond attempting to change behavior, one individual or small group at a time.

In recent years, increased attention has been paid to the area of biomedical technologies for HIV prevention, such as microbicides, latex diaphragms, male circumcision, vaccines, treatment for other sexually transmitted infections (STI), and use of antiretroviral therapy (ART) for HIV prevention (e.g., pre- and post-exposure prophylaxis and preventing mother-to-child transmission [PMTCT]), which are thought to have greater potential for population-level effects. These biological approaches have been made possible by significant advances in the basic sciences of virology and immunology. Many people believe that these technologies have the potential for much greater impact on HIV transmission because they specifically target features of the virus, rather than human behaviors per se, and because, as manufactured products, they can be widely and systematically distributed. And, it is presumed, individuals who are unable to negotiate other safer sex practices with their partners could use such technologies covertly, making these products more attractive than the male condom, which remains the most effective HIV prevention technology available.

But, while hundreds of millions of dollars and tens of thousands of volunteers have been engaged in research studies of biomedical technologies in the past ten years or more, so far only ART for PMTCT and male circumcision have shown efficacy in preventing HIV transmission or acquisition. We are still quite far from having an effective vaccine or microbicide, which continue to be the "holy grails" of HIV prevention because of their presumed broad application to a range of populations (i.e., not just pregnant women or adult, heterosexual men).

The limited success of biomedical technologies—combined with continued high rates of HIV infection in historically affected populations and emerging epidemics in new populations and settings in the U.S. and globally—suggests that a paradigm shift is needed. Countless scientific and policy analyses point to the need to pay closer attention to the social and structural forces—such as gender dynamics, stigma and discrimination, poverty, housing, and food security—that influence people's ability to engage in risk reduction, affect the success of clinical trials in most settings, and offer points of intervention themselves. This attention shift requires significant intellectual and financial commitment to the social science of HIV prevention, which so far has been under-developed.

The move toward a more inclusive and multi-dimensional HIV prevention research agenda that recognizes the interaction of biology, behavior, and social structure has raised some interesting questions about evidence—that is, how we know what works. Recent years have witnessed the growing popularity of the "evidence-based public health" approach, an outgrowth of "evidence-based medicine."
This approach emphasizes the application of rigorous research methodologies in public health science that parallel those used in clinical research—chiefly, the adoption of experimental study design, and specifically, the randomized controlled trial (RCT)—for assessing intervention efficacy.

The RCT is considered the most rigorous experimental method because of its high level of control, and thus its ability to minimize bias and to avoid false conclusions. Generally, in experimental studies, the investigator exercises control over some factor that, when varied, can produce different outcomes, as well as control over the recruitment of and inclusion criteria for study participants, the assessment of baseline measures, the content and delivery of the intervention, and the measurement of intervention outcomes. Random assignment of "like" individuals to experimental or control groups balances any potential effects of background or contextual factors that might influence the outcome of an intervention, thereby enhancing the internal validity of experimental interventions. A significant number of experimental studies of HIV prevention interventions have now been conducted, evaluated, and published, either individually or in meta-analyses and systematic reviews; these include behavioral and biomedical interventions using individual, small groups, and communities as the unit of analysis.

The RCT remains the "gold standard" method of obtaining evidence in clinical and public health intervention research; however, it does have some limitations that are particularly relevant for an interdisciplinary approach to HIV prevention. As many people have noted, the RCT—and experimental studies more generally—may be inappropriate and unethical in many situations. But even where appropriate, experimental studies may be limited in their replicability and generalizability. Some have argued that the very characteristics that make an intervention successful in an efficacy trial (i.e., under ideal research conditions), such as standardization in population group and intervention protocol, are fundamentally different from—and perhaps at odds with—interventions that succeed at a population level (i.e., under "real world" conditions), such as having broad appeal and being adaptable.

Sometimes, HIV prevention interventions have population-specific effects, which may be due to several factors: (1) the intervention itself may have to vary to fit differing contexts; (2) the quality of implementation may vary because of differing contexts; and (3) underlying HIV/STI epidemiology may vary, leading to different intervention effects (as in the case of the STI management trials conducted in Tanzania and Uganda that showed very different outcomes for HIV prevention). So, although interventions tested under the rigorous conditions of an RCT may demonstrate efficacy in one population, we cannot assume that simply scaling them up as-is will result in real-world effectiveness, especially if implemented in different settings.

Medical interventions (e.g., drugs or procedures) are generally more transferable to different populations than are behavioral and social interventions that inherently interact with participants’ characteristics and social contexts, and in which the causal chain between agent and outcome is more complex. The problem is that complex social phenomena—such as gender relations, poverty and economic inequality, and violence—cannot be reduced to a handful of variables that can easily be modified or controlled for testing in experimental designs. One can argue that it is precisely the confounding of people’s individual, community, and social characteristics that explains the problem of HIV in the first place. Moreover, social interventions address what are often perceived as intermediate (behavioral change) or distal outcomes (e.g., poverty alleviation, gender equity, educational attainment), rather than the proximate outcomes of ultimate interest (HIV incidence/prevalence). And, should social interventions be implemented, the time lag inherent in evaluating their impact on either intermediate, distal, or HIV outcomes at the population level can be significant. Because of these complicating factors, additional methods are necessary to evaluate the effects of prevention interventions.

Furthermore, recent experiences from studies of biomedical technologies for HIV prevention have cast doubt on the capacity of RCTs to answer important questions, even when they are the right methodology for the object under study. In the past six months, we have heard news about a vaccine trial and a microbicide trial that each showed no beneficial effect on HIV transmission; indeed, interim data from both trials suggested a higher rate of infections occurred among people in the intervention arms than in the control arms. It is unclear what caused these alarming outcomes: they may prove to be statistical anomalies, but it is possible that something about the specific vaccine and microbicide candidates increased biological susceptibility, or that participants in the experimental arms of the trials increased their risk behavior, thinking they were protected by the study product.

A recently completed trial testing the efficacy of the latex diaphragm for HIV prevention raised some additional issues about the capacity of RCTs to really answer the key questions at hand. Contemporary research ethics require that a certain "standard of prevention" be provided to all participants in any HIV prevention trial: individuals in both the experimental and control groups are provided with information about and access to proven prevention strategies—particularly male condoms—and are actively encouraged to use them. If participants follow this advice, it becomes very difficult to separate out an independent effect of the product under study, since any effect observed might be a result of either product use or condom use. This is precisely what occurred in the diaphragm study: all participants increased their condom use, so it became statistically impossible to detect an independent effect of the diaphragm and to make statements about its efficacy for HIV prevention over and above male condoms. This issue will be faced by all current and future HIV prevention trials, and will continue to make it difficult to answer the ultimate question of interest: Does this new technology reduce HIV infection rates by itself, and at what level of efficacy? (continued on page 6)
The “Evidence” Issue in HIV Prevention: Scientific and Political Challenges - Continued

All of these challenges are occurring as community-based organizations (CBOs) and AIDS service organizations (ASOs) that engage in HIV prevention programs are under increasing pressure from governmental and non-governmental funders to adopt evidence-based interventions. The U.S. Centers for Disease Control and Prevention (CDC), the primary funder of HIV prevention programs in communities across the country, is promoting a “tier of evidence” paradigm that places RCTs at the highest—and most fundable—level. CDC also encourages, if not requires, eligible CBOs and ASOs to adopt (and adapt, if necessary) behavioral interventions from a list of those that have been deemed by the agency to have proven efficacy. Other funders are requiring CBOs and ASOs to provide more rigorous evaluation data than in the past to demonstrate the efficacy of the “home-grown” programs they develop and implement. But most CBO and ASO staff do not have scientific training and are unaware of what constitutes appropriate “evidence” of program effectiveness, and most such organizations lack the financial resources to hire professional researchers.

I ideological and Political Challenges

Another challenge in the “evidence” arena comes from assaults to mainstream scientific evidence from voices outside the public health, science, and AIDS services communities—chiefly social conservatives with ideological agendas. In HIV prevention, these assaults have included casting aspersion on the well-demonstrated efficacy of male condoms for HIV prevention by focusing on their so-called “failure rates”; impeding efforts to publicly fund syringe exchange programs that have proven effective in stemming HIV transmission among injection drug users, their sex partners, and their children; and promoting abstinence-only-until-marriage sex-education and HIV prevention programs despite numerous scientific reviews that have found these programs ineffective at best and harmful at worst. These assaults continue to challenge notions of “evidence,” either by ignoring evidence altogether, constantly attacking the existing evidence base (almost always on faulty grounds), or attempting to equate opinions and belief systems (usually of a “moral” or religious nature) with scientific evidence.

The recent inclusion of over $200 million for abstinence-only programs in the House FY 2008 Labor, Health, and Human Services and Education appropriations bill is a good example of this tendency. As the bill was being debated, two new reports systematically reviewing abstinence-only programs were published (including one in the British Medical Journal). Both reported that such programs had no demonstrated efficacy in reducing HIV acquisition risk by delaying the onset of sexual activity, reducing the number of sex partners, or increasing condom use. On the contrary, the studies showed that only comprehensive sex education programs—which included messages about abstinence but also provided risk-reduction information—had evidence of efficacy for these outcomes. Nevertheless, ignoring the evidence and succumbing to ideological and political pressure from social conservatives who threatened to withhold support from other important funding bills if the abstinence-only money wasn’t included, the House appropriators voted to not only sustain but also to increase the funding of these programs.

These challenges to the adoption of evidence-based approaches do not mean that evidence doesn’t matter. On the contrary, as the example of needle exchange programs demonstrates, rigorously-gathered evidence of their efficacy has been essential for changing the minds of policy-makers at the local and state level in places as diverse as California, Illinois, Michigan, Washington, North Carolina, and New York, where programs have been implemented.

Conclusion

In the end, a comprehensive, multi-level HIV prevention research, practice, and policy strategy is best informed by a framework that includes different methodologies and different types of outcome data for establishing efficacy and effectiveness. Decisions about whether to scale-up specific interventions will depend on the strength of available evidence, which in turn is determined by a number of criteria, including the level of evidence, the quality of the intervention, the quality of outcome measures, the process evaluation of the intervention, and the context in which the intervention is delivered. Determinations about these criteria must be based on scientific and public health consensus, not ideology or politics.

Given current scientific and political challenges, it is timely to convene HIV prevention researchers, program implementers, service providers, advocates, and funders to have a focused discussion on some of the debates and dilemmas in defining and advancing evidence-based HIV prevention, and to articulate a productive way forward. The San Francisco AIDS Foundation, in partnership with the Caucus for Evidenced-Based Prevention, is spearheading a series of such discussions over the next year, with the goal of reaching a consensus on an inclusive yet still rigorous notion of evidence that encompasses “ways of knowing” from biological, behavioral, and social science, as well as the lived experience of individuals and communities affected by HIV/AIDS. It is our hope that this consensus will not only contribute to a productive way forward in HIV prevention research and practice, but also will serve as another counterweight to ideological and political assaults on evidence that may continue to confront us as we address more directly the social issues that surround the HIV/AIDS pandemic.

(Guest Writer: Judith D. Auerbach, Ph.D., Deputy Executive Director for Science and Public Policy San Francisco AIDS Foundation)

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with your comments and your thoughts
will be sent directly to our editors.
Thank you!
At the 34th meeting of the President’s Advisory Council on HIV/AIDS (PACHA), the Council heard from many HIV/AIDS leaders, including Global AIDS Ambassador Mark Dybul and passed several resolutions, including one that asks the President and the Secretary of HHS to work closely with Puerto Rico “to assist them in effectively utilizing HHS grant funds…and to promote the financial integrity of the Ryan White CARE Act.”

Over the course of two days, PACHA also heard from White House Domestic Policy Council Associate Director Anna Mitchell and Homeland Security Immigration Policy Director Igor Timofeyev. He has been working on implementing the President’s 2006 World AIDS Day directive to promulgate a regulation that would make it easier for people with HIV/AIDS to enter the United States for short term visits. Timofeyev reported the draft regulation would be out in a matter of days and their hope is to finalize it by this World AIDS Day, or at least by the end of this year.

Federal Update

HIV/AIDS Council Asks President To Focus On Puerto Rico & Supports PEPFAR Reauthorization

At the 34th meeting of the President’s Advisory Council on HIV/AIDS (PACHA), the Council heard from many HIV/AIDS leaders, including Global AIDS Ambassador Mark Dybul and passed several resolutions, including one that asks the President and the Secretary of HHS to work closely with Puerto Rico “to assist them in effectively utilizing HHS grant funds…and to promote the financial integrity of the Ryan White CARE Act.”

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Dr. Bernie Branson from the CDC provided an update on CDC’s HIV Testing in Medical Settings recommendations, and there was a panel discussion on HIV testing reimbursement. While representatives of Aetna and CareFirst Blue Cross and Blue Shield said they cover routine HIV testing, the response from the Centers for Medicare and Medicaid Services was not as positive. Joe Razes of CMS basically said they leave it up to the States to determine whether Medicaid would cover routine HIV testing. With so many people with HIV/AIDS who rely on Medicaid services, the Council was not pleased to hear his response.

The Council also heard from Dr. Nora Volkow, Director of the NIH’s National Institute of Drug Abuse, who spoke about crystal meth, received an update on HIV/AIDS in the Caribbean, and heard from Debra Fraser-Howze of the National Black Leadership Commission on AIDS. Fraser-Howze’s group recently brought together leaders of the black clergy to discuss HIV/AIDS in the African-American community. The ministers and others agreed to work on a “National HIV/AIDS Elimination Act.”

PACHA also agreed to a set of recommendations on the reauthorization of PEPFAR and called for a five year program totaling at least $30 billion for global AIDS care, treatment and prevention. PACHA called for evidence-based prevention programs such as the ABC approach, and for concentrated epidemics, an emphasis on condoms and harm reduction interventions, including needle exchange programs. Other recommendations the group endorsed were increased focus on healthcare workers, encourage the development of new drugs, eliminate import fees on HIV drugs, and expand into such as areas like the Caribbean.

In addition to the resolution pertaining to the situation regarding the expenditure of federal HIV/AIDS funds in Puerto Rico, the Domestic Subcommittee, Chaired by The AIDS Institute’s Carl Schmid, passed two other resolutions. One pertained to ensuring the availability of abstinence materials if a person chooses abstinence as a goal in prevention counseling and the other on the need to have information on risk avoidance and risk reduction when someone takes an HIV test.

The next PACHA meeting is scheduled for March 25-26, 2008 in Washington DC. For additional information on PACHA and its resolutions, recommendations and presentations go to: www.pacha.gov (Carl Schmid)

Rep. Mike Honda (D-CA) Introduces National Hepatitis B Act

On October 23rd, Representative Mike Honda (D-CA), along with Reps. Charlie Dent (R-PA), Adam Schiff (D-CA), Michael McNulty (D-NY), Ed Towns (D-NY), and Jim Gerlach (R-PA), introduced the National Hepatitis B Act (H.R. 3944). Identical to the bill introduced in the 109th Congress, this legislation would establish a comprehensive prevention, education, research, and medical management program to reduce liver cirrhosis and reduce cases of liver cancer caused by chronic hepatitis B infection.

Approximately 1.4 million Americans are chronically infected with hepatitis B. In addition, Hepatitis B is 100 times more infectious than HIV. Nearly 5,000 deaths per year in the United States can be attributed to chronic hepatitis B infection. Strong racial disparities exist when it comes to hepatitis B. Although Asian Americans and Pacific Islanders constitute only 4% of the U.S. population, they account for over half of the 1.4 million chronic Hepatitis B cases in the U.S.

This legislation would require the Secretary of HHS to consult with multiple agencies and organizations in development of a Hepatitis B prevention, education, research and medical management program. These include: CDC, NIH, National Cancer Institute, HRSA, SAMHSA, medical advisory bodies such as the Hepatitis B Foundation and National Viral Hepatitis Roundtable, and individuals infected with hepatitis B. Specific components of the Hepatitis B program would include: voluntary testing, counseling, immunization, creating Hepatitis B coordinators to state, local, and tribal health departments, education and awareness campaigns, and the creation of a Hepatitis B epidemiological surveillance program. The AIDS Institute is very supportive of this legislation and urges its passage.

(Suzanne Miller)
President Bush Vetoes Labor-HHS Bill

On November 13th, President Bush vetoed the FY 08 Labor-HHS appropriations bill (H.R. 3043), which would provide $150.7 billion in discretionary spending. A week earlier, both the House and Senate approved conference reports for the bill, which exceeded President Bush’s funding request by $9.8 billion.

In a disappointment to the HIV/AIDS community, in the bill the House and Senate conferees agreed upon, the higher funding levels proposed earlier in the year were reduced through the negotiation process, in most instances. For example, the increase for Ryan White programs is only $84.3 million, rather than $103 million proposed by the House. This includes an increase of $32.3 for Part A, $4 million for Part B Base, $33 million for ADAP, $11.5 million for Part C and $3.5 million for Part D.

The Early Diagnosis Grant Program survived the conference process; however a few modifications were made. While the program is still a $30 million carve out of CDC prevention funds, individual states may only be eligible for up to $1 million in funds, rather than $10 million, as called for under the reauthorized Ryan White law. If the money is not used by the end of March 2008, the remaining funds will be distributed for general CDC’s HIV/AIDS prevention programs.

In another disappointment, the conferees surprisingly agreed to the House proposed increase of $28 million for Abstinence only until marriage programs. The Senate had proposed a decrease of $28 million. Just a couple of weeks prior to the conference agreement, the US Senate passed their version of the Labor HHS Appropriations bill by a strong veto proof vote of 75 to 19. There were some amendments that impact HIV/AIDS programs.

Sen. Michael Enzi (R-WY) offered an amendment that would prohibit any funds in the bill to change Ryan White funding formulas. His amendment, which passed by a vote of 65 to 28, was directed at a provision in the House version of the bill that changes Part A funding formulas. This amendment was stripped by the House and Senate conferees.

An amendment offered by Sen. Jim DeMint (R-SC) that would prohibit any funding in the bill to any city that provides safe injection sites passed without debate or objection. This amendment was directed at the City of San Francisco which is considering creating a supervised center for injection drug users. This amendment was also stripped by the conference committee.

An amendment offered by Sen. Frank Lautenberg (D-NJ) that required abstinence only until marriage programs to be medically accurate was withdrawn.

The AIDS Institute, along with its partner organizations have been working over the last couple of months by conducting over 25 visits to the Hill to make sure the higher funding levels between the House and Senate bills will prevail.

The AIDS Institute sent a letter [insert link to letter??] detailing our funding requests to members of the House and Senate Appropriations Committees. In addition to higher funding levels for HIV/AIDS and Hepatitis care, treatment, prevention and research, The AIDS Institute asked Congress to decrease funding for abstinence only programs and not to fund the Early Diagnosis Grant Program, which takes funding away from the CDC.

Now that President Bush has vetoed the bill, Congress will attempt to over ride it, and if unsuccessful, will have to fashion another bill. The AIDS Institute will continue to push for the highest possible level of funding during this time when the Congress will be under pressure to cut funding. In the end, in order to get the President to sign the bill, it will most likely be bundled with other appropriation bills, but probably not until December. (Carl Schmid & Suzanne Miller)

Medicare Part D Open Enrollment Period Ends December 31st

It is that time of year again. Beginning November 15th, Medicare Part D eligible beneficiaries until December 31, 2007 can enroll in a drug plan, review their health care and drug coverage, and make changes. There’s also extra help available for people with limited income and resources. The extra help is worth up to $3,600 for some people to help pay for their drug coverage.

It’s important for all people with Medicare to complete their yearly Medicare Enrollment Review. They can follow these three important steps:

1. Prepare - Take time to gather information they’ll need to make a decision about their health and prescription drug coverage (medication list, provider list, any notice they received from Medicare, Social Security or their plan about changes to their plan)
2. Compare - Compare plans in their area on cost, coverage, and customer service.
3. Decide - Decide which plan is best for them.

You’ll find helpful Medicare tools and information at: www.cms.hhs.gov/center/openenrollment.asp. Use these resources to compare the cost or benefits of Medicare health or prescription drug plans in your area. Get answers to your Medicare questions. Learn how to lower health care costs and stay healthy. Find out about Medicare events in your community.

This year, CMS has an enhanced plan finder with options that offer more information and greater clarity on available drug plans, including out of pocket costs, pharmacy networks, and important Medicare news and updates. Navigation improvements also make the plan finder tools more user-friendly, so beneficiaries will find it easier to locate information about available drug plans before open enrollment begins on November 15, 2007.

“We want to encourage everyone to use our enhanced tools now and throughout the upcoming open enrollment period to review their current drug plan coverage and compare their options for 2008,” CMS Administrator Kerry Weems said. “More than 90 percent of beneficiaries in a stand-alone Part D prescription drug plan will have access to at least one plan in 2008 with premiums lower than they are paying this year.” (continued on page 9)
People without Web access can get the same information provided by the online, personalized plan comparison tools by calling 1-800 MEDICARE (1-800-633-4227), by visiting their local State Health Insurance Assistance Program (SHIP) office for free personalized counseling, or by attending one of the thousands of local enrollment events taking place across the country now through December 2007.

Beneficiaries should also have received their 2008 “Medicare & You” handbook. The handbook includes tips on selecting a plan and an overview of plan options. Beneficiaries already enrolled in a Part D plan will also receive an Annual Notice of Change that describes any changes in the benefits of their current drug plan.

While the medium monthly premium will stay about the same in 2008, there may be significant increases in some plans. There are significant increases in cost sharing for the different tiers of drugs that beneficiaries should also be looking out for when they choose a plan, along with the plan’s drug formulary. An added concern is about 1.8 million low income subsidiary beneficiaries could be assigned to a different plan in 2008 since their plan sponsor is no longer offering qualified plans for them. People should be careful when they move to a new plan that it best fits their individual needs. Finally, people with HIV/AIDS should be concerned that in 2008 there will be no plans that cover brand name drugs in the doughnut hole. Since most antiretrovirals are not generic, this benefit reduction will prove costly for beneficiaries and state ADAPs. (Carl Schmid)

Edwards and Obama Call For National AIDS Strategy

Two Democratic Presidential candidates, John Edwards and Barack Obama have released comprehensive global and domestic HIV/AIDS plans. Both of responded to the AIDS community’s request and call for a national HIV/AIDS strategy.

To read more about their plans, go to: 
http://johnedwards.com/issues/health-care/hiv-aids/
http://nationalaidsstrategy.org/OBAMAFactSheetAIDS.pdf

EDUCATION UPDATE

HIV/HCV Community Forum

On November 14, 2007, The AIDS Institute (TAI) in collaboration with Title II Community AIDS National Network (TII CANN) conducted a Community Forum for Treatment of HIV/HCV Coinfected Patients Under the Ryan White Program in Miami, Florida at the Hep C Alert Office. The target audience was healthcare providers, specifically physicians and nurses treating HIV coinfection. The purpose of the training was to engage the community in discussion regarding HIV/HCV coinfection and identify ways to integrate HCV into HIV care and treatment with existing resources. The agenda was comprised of Carl Schmid, Director of Federal Affairs for The AIDS Institute who provided the Ryan White CARE Act Amendment Overview & Policy Implications while Phil Reichert, Hepatitis Program Administrator for the Florida Department of Health, Bureau of HIV/AIDS presented on Coinfection Epidemiology & Hepatitis State Overview. Next, Andi Thomas, Executive Director for HEP C Alert explained Coinfection Diagnosis and Counseling and Recommended services and Dr. Jeffrey Beal, Clinical Director for the Florida/Caribbean AETC presented on the Clinical justification for treating HCV in HIV/HCV coinfected patients. Finally, Dr. Ernesto Lamadrid, Medical Director for the Florida Department of Health, Bureau of HIV/AIDS covered the Coinfection Standard of Care & Managing the side-effects of HCV/HIV Therapy while Gary Rose, Chair of TII CANN offered ways in which to Utilize Ryan White funds to provide coinfected services. (Michelle Scavnicky)

HIV/AIDS Prevention Education for Parents

Prevention education geared towards parents plays a critical role in fighting not only the HIV/AIDS epidemic, but also other sexual health issues. Research shows that “positive communication between parents and their children can help young people establish individual values and make healthy decisions. www.advocatesforyouth.org/parents/index.htm.”

Parent education about prevention increases parent’s knowledge about certain issues that children, teenagers, and young adults experience. According to Barbara Huberman, Director of Education and Outreach for Advocates for Youth, “parents who act on the belief that young people have the right to accurate sexuality information are parents whose teens will delay the initiation of intimacy and use contraceptives when they choose to become sexually active http://advocatesforyouth.org/parents/index.htm.”

Advocates for Youth, based in Washington, DC, currently supports the need for parent education about prevention. “Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their reproductive and sexual health. (http://www.advocatesforyouth.org/about/vision.htm)” Through their website they provide parents with training and supportive materials on talking with young people about prevention and sexual health. Parents often times feel disjoined from the youth and may not understand how to connect with young people about the issues that are surrounding them. With the materials provided by Advocates for Youth parents are able to initiate conversations about prevention and sexual health.

There is a vital need for parent education about prevention because when parents talk to and establish an open relationship with children they are more likely to have a healthy attitude about themselves. Prevention education for parents in certain venues such as, Parent Teacher Organizations or Associations would educate parents on the need for effective communication with young people about HIV/AIDS, STIs (Sexually Transmitted Infections) and sexuality. If parents gained more knowledge about the current issues that affect young people more young people would be able to talk to their parents about their own sexual health and they would not have to turn to media and/or an unreliable source. The AIDS Institute, through a donation from the DeBartolo Family Foundation, has instituted the development of a parent education curriculum that will provide education to parents in the Tampa Bay Florida area. (Sierra Johnson)

For more information about the Parent Education Program, please view: Advocates for Youth, “Parent’s Sex Ed Center”. www.advocatesforyouth.org/parents/index.htm

For more information about the Parent Education Program, please contact Michelle Scavnicky at MScavnicky@theaidsinstitute.org
The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) recently revised the global estimate of HIV prevalence downward from 40 million to 33.2 million. This revised estimate is due mainly to improved methods of determining the scope of the disease. Of the total difference in the 2006 and 2007 estimates, 70% are due to changes in the estimates in Angola, India, Kenya, Mozambique, Nigeria, and Zimbabwe.

James Sykes, Global Program Coordinator for The AIDS Institute said: “Although, the revised global estimate is about 16% less than previously thought, The AIDS Institute is still mindful of the fact that every day, over 6,800 people become infected with HIV and over 5,700 die from AIDS worldwide. This is mostly because of inadequate access to HIV prevention and treatment services. That is still over 2.4 million new infections and over 2 million deaths worldwide a year.”

The United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act, better known as the President’s Emergency Plan for AIDS Relief (PEPFAR), has provided treatment to over 1.1 million people since its inception in 2003. The AIDS Institute, on this World AIDS Day, calls on Congress to fully fund PEPFAR and keep the promise to stop AIDS. We call on the leaders of the United States and around the world to remain committed to the fight against the HIV/AIDS pandemic. STOP AIDS: Keep the Promise! (Carl Schmid and James Sykes)
For twenty years, U.S. policy has banned HIV+ noncitizens from traveling to or transiting through the U.S.; barred HIV+ people from coming to the U.S. to immigrate; and barred HIV+ immigrants are already in the U.S. from attaining any recognizable legal status except in extremely limited circumstances. While the travel and immigration restrictions are often talked about as distinct, they are in fact in severable, residing in a single sentence of the United States Immigration and Nationality Act that states that, “any alien -- (i) who is determined…to have a communicable disease of public health significance, which shall include infection with the etiologic agent of acquired immune deficiency syndrome . . . .” is ineligible to receive a visa or to be admitted to the U.S.

An effective challenge to the policy demands that advocates see it for what it is: not a travel ban, but an entry ban involving barriers at two points of entry. The first is obvious and literal: people with HIV are not allowed to enter the country. But finding themselves on this side of the U.S. border, unable to adjust their immigration status, their entry into the workforce, the healthcare system is also barred, as is their full participation in civic life and their access to housing and welfare benefits.

How We Got Here

When the U.S. Department of Health and Human Services (HHS) decreed HIV to be grounds for inadmissibility in 1987 -- six years into the AIDS epidemic -- homosexuality was still grounds for inadmissibility and derogative comments about the so-called 4Hs (Homosexuals, Haitians, Heroine users, and Hemophiliacs) were commonplace. Every early U.S. policy response to the epidemic was informed by animosity toward these first three groups. This included immigration policy. Attempts by two administrations, one Republican, one Democratic, to overturn the policy were squashed by Congress, which made the ban statutory in 1993. Unfortunately, this legislation was consistent with the history of U.S. immigration policy -- by and large a history of exclusion which has often evoked and distorted “public health” concerns to justify an ever-widening circle of inadmissibility. The policy itself owes its significance, which shall include infection with the etiologic agent of acquired immune deficiency syndrome . . . .” is ineligible to receive a visa or to be admitted to the U.S.

We know the exact opposite to be true: the bar dissuades travelers to the U.S. from bringing their antiretrovirals (ARVs). It forces HIV+ immigrants to go underground, encourages immigrants who don’t know their status not to get tested, not to seek preventive care, not to seek any care until they end up in the emergency room with full blown AIDS. If they are low-income or poor and cannot adjust their immigration status because they are HIV+, they don’t have recourse to the full slate of public programs and services they need to stay alive, let alone healthy. If they ask for asylum there is a good chance they will be placed in detention immediately and indefinitely and that is a dangerous particularly for someone with HIV as Victoria Arellano’s July 20th death in Immigration and Customs Enforcement (ICE) custody demonstrated so starkly.

Detention and Human Rights

Detention is increasingly becoming a life and death issue for HIV+ people inside the U.S. who are not legal permanent residents. More and more detention centers are being built and on any given day, ICE has in its custody 30,000 immigrants -- 300,000 people a year. Though they are criminalized, they are civil, not criminal, detainees (though of course there must be a single standard of medical care regardless). They are asylum seekers, people whose visas have expired, people who entered the U.S. without documents, etc. Some are held in ICE detention centers, but the majority are held in local jails with the general inmate population. Since 2004, at least 65 people have died in ICE detention. These are merely the deaths we know about. The Department of Homeland Security (DHS) to which ICE belongs is not required to make these deaths known to the public. Furthermore, we do not know how many people died after their release -- in the U.S. or back in their countries of origin -- as a direct result of their treatment by ICE. Even for those who manage to escape detention and deportation, the HIV entry bar can be deadly, as no recognizable legal status translates to no access to housing assistance, medical benefits, or food assistance.

A Rights-Based Approach

It is often very difficult to advance a human rights argument in the U.S. As advocates and activists, however, part of our work must be about legitimizing human rights discourse, even as we counter erroneous economic and public health rationales. The HIV entry bar is a clear violation of the International Covenant on Civil and Political Rights, the UN Declaration of Human Rights, and the UN human rights guidelines on HIV/AIDS, specifically:

Freedom of movement -- detaining individuals because of their HIV status, thereby restricting their movement by detention

The right to privacy -- disclosing applicants' HIV status to various officials, sponsors, and family members at immigration interviews, often placing them in great peril

Freedom from discrimination -- excluding individuals without legitimate justification to the U.S. Declaration of Human Rights, and the UN human rights guidelines on HIV/AIDS, specifically:

Where We Are Now

The DHS Proposed Rule

On World AIDS Day 2006, the White House announced that the President would “direct the Secretary of State to request and the Secretary of Homeland Security to initiate a rulemaking that would propose a categorical waiver for HIV-positive people seeking to enter the United States on short-term visas.” The use of the word “categorical” has led to some confusion. “Categorical” here does not mean “absolute” nor is the waiver under discussion even available to all HIV+ prospective travelers to the U.S. The application process would remain an individual one, with applicants required to provide assorted evidence related to their HIV status; their assets, and their knowledge of transmission. All that is “categorical” here is the authorization DHS is giving to consular officers in HIV+ applicants’ countries of residence to determine whether or not they may be admissible to the U.S. without having to send the paperwork to DHS for approval. (continued on page 12)