African Americans and HIV/AIDS
What are we doing to protect future generations?

Action for social change through public policy research, advocacy and education
Another new year is upon us. This year we will see the election of a new President and many new Members of Congress – as well as local and state officials. We also see ourselves in the AIDS movement still at a crossroads, a place we have been for several years now. Questions continue to linger about AIDS specific services versus mainstreaming as we talk about health care reform. There is still the ongoing debate about how do we develop new and better prevention methods to curb the increasing domestic epidemic. Concerns about the lack of new drugs, and, more important, a new class of drugs, to combat HIV/AIDS as viral resistance continues to hang over us. The backdrop to many of these questions is the lack of unified national goals, problems with “working together”, and the erosion of domestic funding over the past several years.

Election years and campaigns – especially presidential election years – always give us pause to think more about where the country is headed. It’s a great time for those of us in the AIDS movement to ask where our movement is headed as well. We are in the season where we need to come together, “work together”, in really articulating a new and a better vision for HIV/AIDS research, prevention, social services, care, housing, and medical treatment. As the nation searches its soul about where America is headed during this presidential campaign season our task is to search the soul of the AIDS movement and articulate a vision for the future. It is critically important that every candidate for political office at the federal, state, and local level hear our message. We have an incredible story to tell them. The history of our movement over the past twenty plus years demonstrates that when people care and have hope, we do indeed make a difference. But we need more government support to make a big difference. The way we move from the crossroads we find ourselves in is through advocacy.

Yes, health care reform will have an impact. Yes, the new CDC incidence numbers may raise questions about prevention programs. Yes, the concern about the future of drug development is real. But we move through these issues by advocating common goals – the need for more funding and sound, evidence-based public policies that promote prevention, ensure care and treatment for people living with HIV/AIDS, and provide innovative research strategies that lead to better medical care and drug development, ultimately a cure. These are the messages that all candidates for political office need to hear, and hear from all of us. Every one of our voices counts.

We are in the season. It’s one of the best times to express your views to the candidates. Write them, call their campaign offices, and attend one of their town hall meetings. We can shape the future of the AIDS movement by doing so. The future depends on us.
The media spotlight shined on Republican presidential candidate Mike Huckabee when it was revealed that in 1992 he said people with AIDS should be isolated and the federal government should not spend money on AIDS research. In reaction to his comments, The AIDS Institute and the Human Rights Campaign worked together with TAI Board member Jeanne White-Ginder to request a meeting with the candidate and explain to him how harmful and damaging his words were. The incident generated hundreds of news stories across the country.

"It's so alarming to me," she said in a telephone interview with the AP. "It's very important to me that we don't live in the darkness" when people thought AIDS was transmitted through casual contact, such as by "kissing, tears, sweat and saliva," White-Ginder said. "We have to treat this disease like a disease, and like Ryan always said, not like a dirty word."

Huckabee originally stood by his comments on national TV, but eventually backed off saying, he would meet with White-Ginder. The winner of the Iowa Republican Caucus eventually called White-Ginder on the telephone and they had a 30 minute conversation. He told her he did want to meet with her and he supported AIDS programs and funding increases. He also said he had been misinformed in the past about AIDS.

To date, while Huckabee has said he would meet with White-Ginder, that meeting has not occurred. The AIDS Institute applauds White-Ginder for standing up yet again to educate Americans about HIV/AIDS. (Carl Schmid)

The U.S. Food and Drug Administration (FDA) issued a final rule on December 18, 2007 requiring manufacturers of over-the-counter stand-alone vaginal contraceptive and spermicidal products containing the chemical ingredient nonoxynol 9 (N9) include a warning stating that the chemical N9 does not provide protection against infection from HIV (the virus that causes AIDS) or other sexually transmitted diseases (STDs). Stand-alone spermicides include gels, foams, films, or inserts containing N9 that are used by themselves for contraception.

FDA issued the rule in an effort to correct misconceptions that N9 protects against sexually transmitted diseases, including HIV infection. FDA is requiring that the labels warn consumers that the chemical N9 in stand-alone vaginal contraceptives and spermicides can irritate the vagina and rectum, which may increase the risk of contracting HIV/AIDS from an infected partner. A new warning was first proposed in January, 2003. (Carl Schmid)
A Defining Moment: HIV in the African American Community

It has often been said that the campaign to end the HIV epidemic will be a marathon and not a sprint. As we pass the 26 year milestone, that adage has become increasingly true to those of us who have spent the later parts of our youth and now our early middle age fighting the virus that has robbed the lives of millions worldwide. Of course, we have seen and felt the devastation in our communities, amongst our families and friends — and in our own lives. For those of us who have buried lovers and spouses, and yet survived, the will to defeat the HIV epidemic and to see it vanquished is perhaps more urgent now than ever.

As we observe Black History Month, it is fitting to note that the HIV epidemic today follows a long history of tragedy and triumph for Blacks in America. From 1600 to the mid-1800s, the Atlantic slave trade brought 10 million Africans to the U.S., in 1860 alone, 3.9 million people were enslaved in the South and border states. Almost 1/3 of all southern families owned slaves. In Mississippi and South Carolina it approached one-half.

Yet, our ancestors survived slavery and began the great march toward freedom. In fact, Black immigration from Africa and Caribbean accelerated from the mid-1900s through the 20th century joining millions of other immigrants who have crossed oceans to find a new life in this great land. Despite hardship, in the post civil war era of the 20th century, according to the Census Bureau, Blacks have shown amazing resilience: fighting Jim Crow laws and other forms of racial segregation; achieving education, civil and voting rights; today holding over 9,000 of the 500,000 in the United State; and establishing 1.2 million Black-owned businesses in 2002, generating $88.8 billion in revenue. Most significantly, Blacks in America have contributed mightily to the culture of our country, especially in music, human rights advocacy and sports. This progress has not come without challenge. Blacks comprise 13% of population (39.7 million), but 30% of people arrested, 41% of people in jail, and 49% of people in prison. (U.S. Census, Human Rights Watch). Indeed, 13% of the Black adult male population has lost been disenfranchised and the right to vote that our forebears fought to achieve because of felony laws. In 2004, 73% of Black male high school dropouts in their 20s were jobless. And ½ of high school graduates were jobless.

On economic equality, Asian income is $55,000, non-Hispanic white income is $48,000, and Black income is $30,000. This and other factors have resulted in a considerable health disparity whereas the Centers for Disease Control reports Black male lifespan is 68 while 75 for whites, Black women is 73 while 81 for white women. Data from the United Nations shows that Black male life is shorter in the United States than Iran (69), Colombia (69.3) and Sri Lanka (71.5).

So despite the progress towards freedom and equality that our people have made over the past four centuries, we are now confronted with a social, economic and health disparity that threatens our future prosperity. Nowhere are these circumstances made more apparent than in the HIV epidemic —and the syndemics of sexually transmitted diseases, sexual violence and addiction -- which have reached a critical phase, especially among Black women and gay men.

The HIV Epidemic in Black
Of the estimated 184,991 adult and adolescent HIV infections diagnosed during 2001–2005, more (51%) occurred among Blacks than among all other racial/ethnic populations combined. Most (62%) of new HIV/AIDS diagnoses were among persons aged 25–44 years; in this age group, Blacks accounted for 48% of new HIV/AIDS diagnoses. The rate of AIDS diagnoses for Black adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics.

In 2007, the CDC reported that among African-American men, close to half (49%) of new HIV/AIDS cases in 2004 were attributed to sex with men, making this the primary mode of HIV acquisition in our population. Estimated numbers of persons living with AIDS at the end of 2005, by race/ethnicity, sex, and transmission category—50 states and the District of Columbia represents that 125,134 Black men are living with AIDS and of that number 65,269 are men who have sex with men (MSM). Moreover, the Young Men’s Study (YMS) Phase 2 study conducted in 1999 found an overall HIV prevalence of 13% among 23-29 year old MSM with a significant disparity between African Americans and white men: HIV prevalence was 32% among African-American vs. 7% for white MSM (MMWR, 2001).
Data from NHBS conducted in 2004-05 confirms that HIV prevalence among MSM at least 18 years old was higher in African-American than white MSM (46% vs. 21%, respectively). Recent analysis of data from the EXPLORE Study, a large-scale behavioral intervention trial for MSM conducted between 1999 and 2003, found that HIV incidence was higher in African-American than white MSM, even with controlling for sex and drug risk behaviors, sexually transmitted infections and other covariates (Koblin, 2006).

From the beginning of the epidemic, Black women also have been disproportionately affected as well. In January 1983, the Centers for Disease Control and Prevention (CDC) documented the first two cases of AIDS in women. One of these women was Black; the other was Latina. By 1988, African Americans accounted for half of all AIDS cases identified in females in the United States (Mann, 1989). In 2003, women constituted 28% of HIV/AIDS cases in the United States; approximately 69% of those cases were among non-Hispanic Black women (MMWR, 2004). Heterosexual transmission is now the most commonly reported mode of HIV transmission among women. Between 2001 and 2004, women were diagnosed with heterosexually transmitted HIV at a rate of 58.3 per 100,000 Black females, compared to 2.2 for whites, 15 for Hispanics and 2.8 for Asian and Pacific Islanders (MMWR, 2006). Of the 127,150 women living with HIV/AIDS—based on data from 33 states with long-term confidential name-based HIV reporting—-64% were Black. Of the Black women living with AIDS at the end of 2005, 66% acquired their infection through heterosexual contact (CDC, 2006). In absolute numbers, more Black men have AIDS than Black women; however the absolute numbers for Black women are rising at a staggering rate. Black women are the fastest growing population of new AIDS cases, accounting for two-thirds (67%) of reported cases among women.

For Black Gay Men and Black Women, AIDS is Among the Leading Causes of Death Among Young Adults

Despite continuously accumulating data that demonstrates the impact of the HIV epidemic and other health disparities among Blacks there has been little commitment from policy makers and elected officials at the Federal, State or local level.

Black Gay Men – Making Our Voice Known
For the past two years, the National Black Gay Men’s Advocacy Coalition (NBGMAC) has been committed to improving the health and well-being of Black gay men through federal advocacy and community organizing. NBGMAC is the nation’s first health policy coalition to address the rising incidence infections occurring among Black gay men. The catalyst for the formation of the Coalition was the data released in June 2005, by the CDC reporting that 46% of Black gay men were found to be HIV positive in a study conducted in 5 U.S. cities represented in the chart below:

NBGMAC believes that turning the course of the epidemic requires immediate action and a new approach in our leaders view of Black gay men. A reversal of the epidemic can be achieved only if our nation adheres to a core set of principles:

- The lives of Black gay men must be valued and respected.
- Our nation must establish and adhere to a national plan to combat the HIV epidemic.
- The leadership of Black gay men and their organizations must be supported and promoted.
- Black gay men must be involved in all consultation, program planning and research to develop effective services to address HIV among our population.
- Federal and State governments must commit to partnership with Black gay men and must be held accountable for the allocation of resources that will enable a sustainable response.

While NBGMAC is clearly committed to the lives of Black gay men, the coalition also recognizes its responsibility to join with the larger Black community in responding to the epidemic. As the numbers of African-American gay men and women living with HIV has increased and resources for prevention, care and treatment have been cut or remained stagnant, tensions between our communities over prioritizations of resources have surfaced and threatened our ability to work constructively together. Additionally, at times in the past few years our identities and our lives have been pitted against each in ways that have laid blame and not solutions to how we respond to the HIV epidemic.

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Black Gay Men and Black Women Working Together

The Black Women’s HIV/AIDS Network and the National Black Gay Men’s Advocacy Coalition, in partnership with the National Minority AIDS Council, created and participated in a historic, facilitated forum of 24 Black gay and Black women leaders in HIV June 1-3, 2007, in Charlotte, NC to foster a new understanding between these two critical components of the Black community. The Forum convened in the heart of the southeastern United States to acknowledge it as the epicenter of HIV disease in the African-American community.

The Charlotte Meeting was designed to promote frank discussions between Black gay men and Black women about the current state of the HIV movement as it affects their communities, the response to HIV from within the African-American community and strategies to promote greater unity between our communities and foster collaboration on future policy and programmatic initiatives. The Charlotte Meeting was designed as a model that can hopefully be replicated in communities across the country that need to encourage honest and respectful dialogue between Black gay men and Black women on how to work together to address the issues of HIV/AIDS.

The two-day forum was an unqualified success in transforming the spirit and content of the interactions between the participants. By confronting many long-standing issues, participants were able to break through and commit to moving forward with a sense of unity while respecting the unique aspects of each community’s agenda. A core purpose was developed and it states:

We are committed to moving in alliance with integrity to value, strengthen, and affirm the lives of Black women and Black gay men—thus benefiting the Black community and American society.

As a result of the successful dialogue in Charlotte those gathered reached several agreements, including:

• Agreed to a set of core principles that both groups and leaders present will use in interacting with one another.
• Agreed to reject the zero sum paradigm established for federal HIV resources. Black women and Black gay men require and deserve federal resources to meet the needs of their communities and the two communities will no longer allow themselves to be pitted against one another in competition for scarce resources.
• Agreed to an ongoing series of meetings between the leadership of the National Black Gay Men’s Advocacy Coalition and the Black Women’s HIV/AIDS Network to establish trust, share information, and identify strategic opportunities for collaboration as each entity promotes its policy agenda.
• Agreed to collectively engage US Department of Health and Human Services (HHS) agencies with shared policy interests and empower each other’s agendas to ensure appropriate representation in HHS policy, funding, planning and outreach activities. Meetings will be prioritized based on timeliness and impact.

The outcomes of the Charlotte meeting were possible because of the intentional commitments made by all participants to engage authentically with a sense of purpose on behalf of our larger communities. Since that time, the Network and the Coalition leadership has continued to meet in Atlanta with the CDC, and in Washington and Palm Springs to strategize together.

A federal agenda to save lives

In partnership with the Network, NBGMAC and our member organizations such as the AIDS Institute will continue to advance our shared legislative and policy priorities in 2008 to turn back the devastation of the HIV epidemic in Black communities. Among the most urgent:

• The CDC and NIH must develop a coordinated plan and sufficiently fund high quality research initiatives to determine effective culturally competent prevention interventions and to better understand the dynamics of the epidemic among African-Americans. The HIV Prevention Trials Unit and other NIH-funded mechanisms must foster more focused research with Black women and Black gay men.
• The CDC, Health Resources and Services Administration, Center for Medicaid and Medicare Services, Federal Bureau of Prisons, Veterans Administration must develop a coordinated plan and provide resources to community groups to support a multilevel approach to African-Americans learning their HIV status and getting into appropriate care and prevention services.
• 25 years into the HIV epidemic our nation is still under-resourced in its prevention system. This is in part due to a lack of sustained partnership and a viably funded network of HIV prevention providers. The current capacity building and technical assistance programs at CDC are broken – resulting in an absence of robust prevention service systems in the communities most in need. NBGMAC supports a comprehensive plan at CDC and among all HHS agencies to develop the capacity of a high-quality prevention and services network, targeted to service our community, that is sustainable for multiple grant cycles and provides the continuity of community based service required for effectiveness.

• To reverse the trends in HIV infection rates and early death, it is absolutely urgent that a concentrated effort be placed on providing HIV prevention services and access to health and social services to Black youth under the age of 25.

• NBGMAC calls on the Center on Mental Health, SAMSHA and the National Institute of Mental Health, NIH to conduct research and fund community based initiatives expanding mental health services with an emphasis on addressing childhood sexual abuse, depression and other related conditions.

• NBGMAC calls on Congress to support and pass legislation that will provide for condom distribution, HIV testing and health care services in correctional settings.

• NBGMAC calls on the Department of Housing and Urban Development in partnership with the Health Resources and Services Administration, HHS to develop, implement new program guidelines and increase funding to local communities that will enhance housing opportunities for high-risk populations of young people and people living with HIV.

• The NBGMAC calls on the CDC to provide accurate data on and the scope of the epidemic in the United States in order to better addresss the HIV prevention needs of disproportionately impacted communities.

This is a critical and transformational moment for our nation. As new leadership emerges in the Congress, a presidential campaign emerges and the nation’s leaders confront the many challenges currently facing the United States, it is an opportunity to bring forward new solutions to our most pressing problems. It is critical, however, that collectively as a community, as advocates and as a nation that we commit to maintaining a focus on the HIV epidemic as a priority of our leaders. That focus should demonstrate a clear commitment to serving Black communities by bringing an end to the HIV epidemic through prevention, care, treatment and research to enhance these strategies, including a vaccine.

The resilience of Black people has been demonstrated in innumerable ways since our earliest days in the United States as descendants of forbears who endured the Middle Passage, slavery and legally enforced discrimination. Black people have fought consistently for the equal distribution of basic rights and freedoms inherent to all humanity. Our collective struggle for civil rights, economic prosperity and autonomy of action, word, and deed exemplify the work of a people intent on breaking the chains of prejudice on our minds and hearts. It is with this history at our back that we must go forward to address the many challenges associated with and exacerbated by the HIV epidemic.

Guest Writer: A. Cornelius Baker is the National Policy Advisor to the National Black Gay Men’s Advocacy Coalition

WEBSITE OF THE MONTH

[Image of a website with the domain name www.nblca.org]

NATIONAL BLACK LEADERSHIP COMMISSION ON AIDS, INC.

The National Black Leadership Commission on AIDS (NBLCA) was founded in November 1987. The NBLCA’s mission is to inform, coordinate and organize the volunteer efforts of the indigenous Black leadership, including clergy, elected officials, medical practitioners, business professionals, social policy experts, and the media to meet the challenge of fighting HIV/AIDS in their local communities. The NBLCA conducts policy, research and advocacy on HIV and AIDS to ensure effective participation of our leadership in all policy and resource allocation decisions at the national, state and local levels of communities of African descent nationwide.
Senators Introduce HIV Travel and Immigration Bill; The AIDS Institute Comments on Waiver Proposal

Sens. John Kerry (D-MA), Gordon Smith (R-OR) and Richard Durbin (D-IL) have introduced the “HIV Nondiscrimination in Travel and Immigration Act of 2007” (S.2486). This is a companion to Rep. Barbara Lee’s bill (HR 3337) which amends the Immigration and Nationality Act (INA) that bar HIV positive individuals from entering the United States.

“It’s incredible that the federal government still tolerates a ban that not only restricts AIDS experts with the disease but also refugees who are seeking asylum in our country,” said Sen. Kerry. “My legislation will end this draconian law. The attempts to fix this law through a complex waiver system, while admirable, still don’t do anything to rectify the discriminatory underlying problem. That is why I have introduced this legislation to permanently strike this unfair provision from the books.”

Since 1993, the INA has designated HIV as grounds for inadmissibility to the U.S. A cumbersome waiver option is available to those wishing to enter this country, but the process is incredibly restrictive. The bill would strike the HIV restrictions from the INA and ask for a full review of the public health aspects of travel and immigration restrictions against those with HIV.

The AIDS Institute strongly supports the bill and is working on securing its passage. The AIDS Institute also submitted comments to the Department of Homeland Security on its proposed rule that would provide a categorical waiver to people with HIV to enter the country on a short term basis.

While The AIDS Institute applauded the Bush Administration for undertaking the rulemaking, if we are to “end discrimination against people living with HIV/AIDS”, as the President announced, we asked the Administration to join us in requesting that the Congress amend the Immigration and Nationality Act to strike the language designating HIV as an inadmissible condition.

In general, we are concerned that the requirements proposed in the rule for obtaining visas for short-term visits for people with HIV appear to be extremely burdensome and do not offer the categorical waiver as was envisioned. The AIDS Institute commented that the manner in which it is executed could greatly reduce the many concerns that have been voiced over its burdensome requirements. The final rule is expected to be released very soon. (Carl Schmid)


During the final two weeks of 2007, Congress passed and President Bush signed S. 2499, the “Medicare, Medicaid, and SCHIP Extension Act of 2007.” Congressional leaders in both the House and Senate had been negotiating on a much larger Medicare package during the last few months of 2007. However, the final version of the bill was very limited in scope, and did not include key HIV/AIDS related provisions that The AIDS Institute and other community partners had advocated for.

Key components of the final legislation include: A six-month delay on a Medicare physician fee cut that was initially scheduled to take effect on January 1, 2008; extension of the State Children’s Health Insurance (SCHIP) Program through March 2009; and extension of the Title V abstinence-only-until-marriage program and Transitional Medical Assistance (TMA) through June 2008.

The AIDS Institute is deeply disappointed that the legislation failed to include several relatively low-cost, yet critically important provisions for the estimated 100,000 beneficiaries living with HIV/AIDS who rely on Medicare for their life-saving medications. One of these critical provisions is the allowance of expenditures by the AIDS Drug Assistance Program (ADAP) to count towards True Out of Pocket (TrOOP) expenses. Currently, ADAP’s may wrap around Medicare Part D by covering beneficiaries’ deductibles, coinsurance and co-payments, but these costs have been barred from counting towards TrOOP. If these expenditures were able to count, the “donut hole” in Part D coverage could be filled and the cost burden reduced on already financially strapped ADAPs.

Another top priority for The AIDS Institute is the codification of special protections for six protected drug classifications, including HIV antiretrovirals. This provision would require “all or substantially all” antiretrovirals, along with five other classes of drugs, to be included on every Medicare Part D drug plan formulary. Currently, the Centers for Medicare and Medicaid Services (CMS) requires drug plans through annual guidance to cover “all or substantially all” drugs in the six protected classes, but The AIDS Institute strongly feels that in order to ensure future, consistent coverage of these critical medications, this provision must be permanently codified in legislation.

As Congress looks towards a more comprehensive Medicare package in 2008, The AIDS Institute, along with our community partners, will continue to advocate for the inclusion of these critically important provisions for Medicare beneficiaries living with HIV/AIDS. (Suzanne Miller)

Disclaimer about contents: Guest articles, and any opinions expressed, do not necessarily reflect the views of The AIDS Institute. The information contained in guest authored works has been obtained from sources believed to be reliable, however, its accuracy and completeness are not guaranteed.
The AIDS Institute Comments on ADAP Quarterly Report Submissions

The AIDS Institute recently submitted comments to the Office of Management and Budget in response to a Federal Register notice regarding the HRSA ADAP Quarterly Reports that all State ADAPs must complete. While we voiced our strong support for continuing the reports, we suggested three changes.

First, with the advent of Medicare Part D, we believe each state ADAP should report on how it is interacting with the Medicare drug program. Information such as the number of ADAP patients using Medicare Part D and the contributions paid by ADAP for Medicare premiums, co-pays, deductibles and other expenses should be included.

Secondly, The AIDS Institute recommends the reports be made public, minus proprietary pricing information, on a timely basis. Having this important information may be helpful to HRSA, but in order for the public to know how the ADAPs in each state are meeting the medication needs of our Nation’s low income people with HIV, we feel the reports should be made public.

Lastly, The AIDS Institute recommends that the reports be submitted on a semi-annual basis rather than a quarterly basis in order to reduce the work load on both the states and HRSA.

(Carl Schmid)

CDC to Announce New HIV Incidence Numbers

It is no longer a secret; the CDC is slated to announce new HIV incidence numbers for the US, and from what has been reported, they are dramatically higher than the 40,000 annual new infections they have been reporting in the past. The new numbers will be published in the next month or so in a peer reviewed scientific journal. Given that the numbers are expected to be higher than what the CDC has been estimating in the past, it has become a high profile issue.

In our World AIDS Day press release, Executive Director Gene Copello said, as the CDC is about to release these new numbers, “We urge the U.S. government and all Americans to rededicate their efforts to Stop AIDS here in our own country. Our Nation and its people have become complacent, but we have a real emergency and we must do much, much more to prevent HIV in this country.”

“We need prevention policies and programs that speak to these communities and to an end to failed policies, such as abstinence-only until marriage programs and bans on needle exchange programs,” said Carl Schmid, Director of Federal Affairs. “The CDC, state health departments and community based organizations also need increased funding.” added Schmid. “It is a disgrace that adjusted for inflation, CDC’s HIV prevention budget has fallen by 19.3% from FY02-07.”

CDC has explained that the new numbers will be the result of new ways of estimating the number of new HIV infections in a given year and can distinguish recent from longstanding infections. (Carl Schmid)

FY 2008 Omnibus Spending Bill Includes Cuts to Domestic HIV/AIDS Programs & Inadequate Increases

On December 26th, President Bush signed into law a $555 billion omnibus spending bill for Fiscal Year 2008, which bundled 11 different appropriations bills into one package. The Labor, Health and Human Services, and Education (Labor HHS) portion of the bill, which includes funding for domestic HIV/AIDS programs, was funded at $144.8 billion, and included a 1.747% across the board rescission. This is a slight increase above FY 2007, in which funding totaled $144.6 billion.

Overall, domestic HIV/AIDS programs received minimal increases and even cuts, in some cases. While the year began with great optimism and the HIV/AIDS community expected substantive increases to its programs, in the end, the funding levels were very disappointing.

The total increase over FY 2007 levels for Ryan White programs was a mere $29 million, which includes a $23.2 million increase for Part A, a surprising $19.3 million decrease for Part B base, an increase of $19 million for ADAP, and increases of $5 million and $1.9 million for Parts C and D, respectively. In addition, funds for the AIDS Education and Training Centers and the Dental program were decreased by $600,000, and $200,000, respectively.

At the CDC, HIV Prevention programs received a disappointing $3.5 million decrease while the Viral Hepatitis program received a $200,000 increase. NIH research received an increase of only $330 million, most of which is a pass through for the US contribution to the Global Fund. The Housing Opportunity for People With AIDS (HOPWA) Program, which is included in the appropriation for the Department of Housing and Urban Development, received an increase of $14 million. After the House proposed an increase and the Senate a cut, abstinence-only education programs ended up being flat-funded.

Also included in the omnibus measure were several important policy changes, including the lifting of a ban barring the District of Columbia from using its own local funds for syringe exchange programs, the Early Diagnosis Grant Program, and changes to Part A funding formulas. The AIDS Institute strongly supported lifting the DC ban on syringe exchange funding, but has strongly advocated against funding the Early Diagnosis Grant Program. The omnibus makes $30 million from CDC’s HIV prevention budget available to states with certain testing laws in place. States must have been eligible by December 31, 2007 in order to receive funds, yet it is unclear if any states were eligible to receive funding for FY 2008. The law requires that awards to states be capped at $1 million, and CDC is required to redistribute unspent funds to other HIV prevention programs after March 31, 2008.

The Part A “stop loss” language, which would change Part A funding formulas, was included in the omnibus bill but with some modifications. Part A jurisdictions that lost 13.4 % or more in funding from FY 2006 to FY 2007 will be eligible for stop loss funding. The “stop-loss” provision is expected to cost $7.7 million. In the original version of the bill, jurisdictions that lost 8.4% or more in funding would have been eligible.

The process for FY 2009 will soon begin with the President proposing his last budget on February 4th. The AIDS Institute and its partners are already working to ensure better funding levels this year. (Suzanne Miller)
First Response Center of Metropolitan Interdenominational Church (MIC)

The faith-based advocacy and education program of The AIDS Institute welcomes two stalwarts of the faith community to the Board of Directors. The Right Reverend Edwin C. Sanders, pastor of Metropolitan Interdenominational Church, Nashville, TN, and Rick Warren, Pastor, Saddleback Church, Lake Forest, CA, were voted onto the Board at the fall '07 meeting in December. Reverend Sanders and Pastor Warren both lead dynamic congregations with inspirational ministries devoted to the care and treatment of people with HIV/AIDS. This issue of ActionLink focuses on the First Response Center of Metropolitan Interdenominational Church (MIC).

Metropolitan Interdenominational Church held its first Sunday service on February 1, 1981. From its inception, the congregation has been composed of a broad cross-section of people. It is a faith community known for being inclusive, reconciling and engaged. Metropolitan Interdenominational Church has been involved in HIV/AIDS ministry since its early years when one of the twelve founding members of the church died from AIDS-related complications. That event is said to have sparked the congregation’s awareness of and commitment to addressing the epidemic and lead to the establishment of the First Response Center in 1994.

The First Response Center (FRC) is comprised of nine ministries in critical areas of need where persons, especially African Americans, are either currently under-served or no services exist in Davidson County, Tennessee. The ministries of the FRC are: The Wellness Center (HIV/AIDS), the Dinah Project (a response to sexual violence), Parents Assisting Children to Achieve (child advocacy program), Davidson County Harm Reduction Program (outreach to IDUs), MetroCan (HIV outreach prevention), Imani Coalition (HIV linked network service), MICTAN (faith-based HIV capacity building assistance), Men of Faith, Men of Color (HIV outreach to gay, bisexual men), and the Alcohol and Drug ministry. The First Response Wellness Center is the oldest and largest ministry of the First Response Center. It evolved in response to the manner in which HIV/AIDS is devastating the African American community, knowing that a non-traditional method of identifying need and delivering service was necessary to combat the devastation.

• The Wellness Center operates on the premise that the African American Church as a cornerstone institution in the African American community provides "the first response" to persons in need or in crisis. The Center is committed to providing a caring and confidential environment where anyone can receive service and information. The First Response Wellness Center is Middle Tennessee’s leading church-based AIDS service organization.

• MetroCan exists to help individuals increase knowledge, attitudes, and behaviors aimed at reducing risk of STD/HIV infection and increase self-sufficiency through improved employment and housing stability, improved mental health status, and decreased involvement with the criminal justice system. Through collaboration with other community resources, MetroCan provides a coordinated system of case management services; referrals for substance abuse treatment, HIV harm reduction interventions, and need-based referrals to community-based organizations.

• The Imani Coalition is a faith community-based collaboration between nine organizations that provide HIV/AIDS prevention education and services to African Americans in Nashville-Davidson County. The goal of the Imani Coalition is to improve the health status of African Americans disproportionately affected by HIV, STDs, and TB. The Imani Coalition’s partner agencies have come together to form a linked network of case management services for the prevention and treatment of HIV/AIDS, STD, TB, and substance abuse.

• Metropolitan Interdenominational Church Technical Assistance Network (MICTAN) is a clergy-led initiative providing capacity building and technical assistance to faith-based organizations, community-based organizations (CBOs) and community coalition development projects (CCDs) locally and regionally. The goal of MICTAN is to empower churches to develop viable HIV/AIDS prevention and education programs for African Americans within their communities.

• Men of Faith, Men of Color (MFMC) is a program of Metropolitan Interdenominational Church whose primary goal is to reduce the transmission of HIV/AIDS among gay and bisexual men through education, fellowship, and community service. By creating a safe, compassionate, non-judgmental environment for services, the program reaches a significant number of gay and bisexual men.

• Dinah Project is a safe and confidential place surrounded by the love of Jesus Christ. They provide community worship services focused on community recognition, forgiveness and healing; clergy, adult and youth lay education workshops and in-services; a speakers’ bureau, and a forum to address spiritual and theological issues associated with sexual violence.

• Parents Assisting Children to Achieve – PACA is a ministry of the First Response Center and is designed to provide support services to parents who have children experiencing difficulty in the school system. PACA operates under the policies and procedures of the First Response Center. The PACA ministry is designed to utilize volunteers to support parents in advocating for their children in the school system.

• The Davidson County HARM Reduction Program (DCHRP) is a culturally diverse community organization whose mission is to reduce the spread of HIV/AIDS infection and reduce harm to injection drug users (IDUs) and their partners in Middle Tennessee. This done by providing IDUs with safe injection equipment and up-to-date information on HIV/AIDS, including risk-reduction strategies and safer sex practices to prevent HIV infection and STDs.

Metropolitan Interdenominational Church is located at 2128 Eleventh Avenue, North, Nashville, TN 37208 www.metropolitanfrc.com (James Sykes)
Global HIV/AIDS Funding Update

2008 is a presidential election year and there are several pieces of legislation pending that the global community is monitoring and advocating for passage before the campaigns become full tilt. The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, better known as "The President’s Emergency Plan for AIDS Relief (PEPFAR, P.L. 108-25)" is due to expire in September of this year. Last May, President Bush called for reauthorization of the law and pledged an additional $15 billion to the effort. The new funding level would be $30 billion and would reflect a doubling of the U.S. commitment to fight this global pandemic. Many advocates in the global health and the faith communities are seeking a reauthorization level of $50 billion dollars. PEPFAR has enjoyed unparallel bipartisan support and we fully expect that support to continue as various drafts of the legislation are being written by staff in each chamber of Congress. The AIDS Institute is working with our community partners and with the Office of the Global AIDS Coordinator to ensure the most effective and realistic modifications are made to the final draft of the legislation as it moves between the House and Senate.

The AIDS Institute commends Congress for passing the Omnibus Appropriations Package last month. The Global HIV/AIDS portfolio fared well as a whole, although some did not receive funding at the level the global advocacy community requested, and some received a decrease in funding. The allocations are as follows:

- USAID/Child Survival and Health Programs (HIV/AIDS Programs) received $350 million.
- Global HIV/AIDS Initiative (PEPFAR) received $4.7 billion, with $4.15 billion of 15 focus countries.
- Global Fund – US contribution for FY 2008 $545.5 million
- TB received $162.4 million.
- Malaria received $350 million which includes $270 for the President’s Malaria Initiative (PMI).

We will have more to report on the various programs as we move through reauthorization and as the year progresses.

(James Sykes)

The AIDS Institute would like to take this opportunity to thank and acknowledge the work of The Institute for Technology in Health Care (ITHC). Dr. Cesar A. Caceres is a founding member of ITHC and is the recently elected Board President of The AIDS Institute.

ITHC’s is interested in the use of technology to benefit health. The goal of the ITHC’s efforts is to demonstrate that technology from any field can be transferred to benefit a variety of healthcare needs. As a result of increased incidence of many chronic diseases such as HIV/AIDS, The AIDS Institute recognizes the need for education and the importance of technology to achieve those education goals.

Current technological innovations are continuously being developed that are both helpful to health care providers and are empowering patients for self-care and management of their health. Technology in healthcare, at its best, will provide seamless access for health care services, independent of time and place.

Some of the innovative technologies in healthcare include:
- Mobile and wireless devices for information storage, transmission, processing and feedback
- Wearable and home based health and wellness measurement devises and monitoring technologies
- Electronic Health Care Records
- Information and education portals accessed via the Internet for health care providers and patients.

Clearly, technology offers a myriad of ways to collect, store and disseminate information to individuals in the healthcare industry. This will allow providers to be more efficient, with greater accuracy and in turn, benefit both providers and patients. (Denise Ruppal)

GLOBAL ORGANIZATION OF THE MONTH

AERAS GLOBAL TB VACCINE FOUNDATION

Aeras Global TB Vaccine Foundation was founded in 1997 to help develop new concepts and tools to control the global TB epidemic. Today the organization focuses solely on developing new vaccines against TB and ensuring their availability to all who need them. In September 2007, Aeras received a five year, US$200 million grant from the Bill & Melinda Gates Foundation to accelerate TB vaccine development. Prior to this grant, in February 2004, Aeras received an US$82.9 million grant from the Bill & Melinda Gates Foundation for new TB vaccine development. Aeras also receives funding from the Dutch Ministry of Foreign Affairs, the U.S. Centers for Disease Control and Prevention, and the Danish International Development Agency. It is the goal of Aeras to develop, test, characterize, license, manufacture and distribute at least one new TB vaccine by 2015.

WWW.AERAS.ORG
Technology in Healthcare

Ph.D. Uses Cartoons to Teach About AIDS

According to World Health Organization data, the virus killed an estimated 2.1 million people this year. Yet, despite its lethality, educational programs about diagnosis, transmission, and prevention remain limited in many areas of the world. When it comes to HIV/AIDS, ignorance is deadly.

Piya Sorcar, a Ph.D. student in the school of education, seeks to remedy this ignorance with an AIDS/HIV curriculum designed to transcend cultural barriers. The curriculum features cartoon animations that discuss the issue of HIV/AIDS transmission, infection, and prevention with virtually no mention of topics with a sexual nature. Sorcar’s background has played a large role in motivating her research and development.

“I was born in Colorado but my family roots are in West Bengal,” said Sorcar. “I have visited India many times, from childhood, and my parents always emphasized the importance of education and using it as a tool to improve social welfare. As I am now studying technology and education at Stanford, I am passionate about establishing India as a model for educational innovation.”

According to Sorcar, the ignorance surrounding HIV/AIDS in her native country was cultural aversion toward explicitly discussing sexual topics.

“Diseases such as HIV/AIDS that are transmitted sexually present significant challenges because social stigma often precludes open discussion, especially in Asian countries,” said Sorcar. “In fact, although India has one of the largest populations of HIV/AIDS sufferers, several states have banned sex education, and with it HIV/AIDS education.” After receiving funding from Time Warner, Sorcar collaborated with a myriad of Stanford departments as well as the South Korean Medical Research Information Center.

“What we often forget is that HIV is a virus, and we study viruses in biology classes all the time,” she said. “Hence, by bringing the subject back to the basics — focusing on biological aspects of the virus — we can discuss it more openly and clearly.” Sorcar specifically decided to use non-threatening, non-sexual cartoon characters in her educational animations to reduce any viewer discomfort with openly sexual subjects. “When I originally ran the study in India, I gauged the comfort of students in learning HIV/AIDS material with various illustrations,” she said. “People were most comfortable with simple cartoon-like graphics and actually, the simple graphics seem to get the points across just fine. It was important that individuals learn about this subject while feeling comfortable.”

Whenever it seemed sexuality could not be avoided, Sorcar watered down openly sexual topics as much as possible yet still maintained the meaning behind her message. “For instance, when we discuss various bodily fluids, we show a simple outline of the human body and used animated boxes to show where particular fluids come from,” she said. “In order to connect particular fluids to human actions and behaviors, we built on some ideas from old Bollywood films.

For instance when we are talking about saliva and kissing, an animated couple comes very close together and then the camera pans up a tree and we see two birds kiss instead.”

Because sexual education in schools has been limited, much HIV/AIDS education in India has been relegated to billboard advertisements and 30-second TV spots. Sorcar said that these two methods of education limited HIV/AIDS education to only certain demographics.

“For example, television ads are only delivered to homes with television sets and electricity, which tend to be the higher socioeconomic classes,” said. “Billboard HIV/AIDS messages are usually expressed in written text, which limits impact to the 62.5% of the population that is literate.”

Sorcar has tried to extend the reach of her animated educational program through various platforms.

“We hope to build versions which will span across many platforms,” she said. “Currently, we have versions of the AIDS animation on-line and available on CD-ROMS, for areas with limited Internet connectivity. Our next step is to build versions for mobile phones, which can be disseminated using a push or pull strategy. We are exploring whether governments and mobile service providers would be interested in partnering with us in order to either make this content freely available to download or better yet, to have it be pre-installed on new cell phones or PDAs.” Sorcar also aims to introduce her curriculum through the Web 2.0.

“We definitely want to create a Facebook app, perhaps more than one, and also expand to other social networks and online distribution channels,” she said. “In our first large-scale pilot test on 423 young adults in India, we found students were rapidly seeking and educating others about HIV/AIDS prevention through their peer networks, with nearly 90% of them sharing information they learned from the tutorial with someone else.”

As for other uses for her AIDS/HIV education curriculum, Sorcar said that she would expand the educational program so that it could be used for other diseases as well.

“After developing HIV/AIDS education modules for multiple countries, we want to use our research findings to develop prevention education on other diseases like malaria, tuberculosis etc.,” she said. “We are focused on how to best communicate public health messages while maximizing comfort and learning. My dissertation work is about exploring innovative ways to teach about taboo subjects without talking about them. HIV/AIDS education in the developing world is just one example of this.” (By: Mike Ding, Stanford University)

You can visit the material at:
www.stanford.edu/~sorcar/ita/swfs/asian_version.html

We Want To Hear From You!
Let us know if you have an interesting article that you would like to see in our Technology in Healthcare section of ActionLink Journal.
Please email us at ActionLink@theaidsinstitute.org
Thank you!
Dr. Caceres is currently the president of the board of directors of The AIDS Institute and has his medical practice and lives in Washington, DC. He obtained his pre-medical and medical degrees from Georgetown University. He obtained specialty training in Internal Medicine at Tufts and Boston Universities in Boston, Massachusetts. He received Cardiology specialization and research training from George Washington University.

Dr. Caceres worked for the Public Health Service where he won two Superior Service Awards for developing the country's first functional computer-electrocardiographic interpretive system. Later he joined George Washington University where he was Professor of Clinical Engineering. Dr. Caceres also patented an electronic stethoscope.

He has been a Clinical Professor in the Department of Family Practice at Georgetown University, Washington, DC. Dr. Caceres has edited and co-authored nine textbooks dealing with various aspects of medicine and health care. He has published over one hundred medical journal articles.

Dr. Caceres saw the first patients with HIV in DC in 1982 and has been involved with the diagnosis and treatment of HIV ever since. In an OP-Ed article on HIV in October 1985 in the Wall Street Journal and a letter to the Editor in the Journal of the American Medical, Dr. Caceres pointed out that the methodology used by the Centers for Disease Control to report the causes of HIV transmission understated the national figures of those who had become infected as a result of recreational drug use. As a result of these publications, the Centers for Disease Control changed their methodology for HIV reporting. He is fluent in English and Spanish.

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Etravirine (Intelence) Approved for use by FDA

Tibotec’s new non-nucleoside reverse transcriptase inhibitor (NNRTI) Etravirine (Intelence) has been approved by the Food and Drug Administration (FDA) for use in HIV positive individuals with a history of drug resistance.

Etravirine is the first new NNRTI to be approved in roughly a decade. It works against HIV strains already resistant to other NNRTI’s (Sustiva, nevirapine and delavirdine).

Appropriate dosing for Etravirine is 4 pills a day at a cost of $5.45 per pill ($7957 for a years supply). According to Tibotec, Etravirine is stronger than the already available NNRTI’s and development of resistance to the drug is expected to take longer than the other FDA approved NNRTI’s. Etravirine is the first NNRTI that works against resistance in this class.

The main side effect of Etravirine is rash. The FDA has cautioned patients to contact their physician immediately if a rash appears. Other side effects include diarrhea, nausea, vomiting, abdominal pain, fatigue, tingling or pain in hands or feet, numbness, headache and high blood pressure. Special care must be taken when utilizing Etravirine. Etravirine interacts with many medications and adjustments must be made with a host of drugs including certain HIV antivirals, TB medications, heart disease therapies and several drugs used to treat opportunistic infections.

Etravirine should not be combined with Norvir (ritonavir)-boosted Aptivus (tipranavir), Norvir-boosted Lexiva (fosamprenavir) or Norvir-boosted Reyataz (atazanavir); any protease inhibitors given without a boosting dose of Norvir; or any of the other approved NNRTI’s.

Etravirine can interact with several drugs used to treat TB, MAC and other bacterial infections including Biaxin (clarithromycin), Rifadin (rifampin), Priftin (rifapentine) and Mycobutin (rifabutin) as well as several medications used to treat thrush (candidiasis) and other fungal infections, including Diflucan (fluconazole), Sporanox (itraconazole), Nizoral (ketoconazole), Noxafil (posaconazole) and Vfend (voriconazole). Dose adjustments of antifungal medications may need to be altered if used in combination with Etravirine.

Etravirine can also interact with certain heart medications, including Vascor (bepridil), Tambocor (flecainide) and Rythmol (propafenone). These medications can greatly reduce Etravirine in the bloodstream. Monitoring blood levels of these heart medications is recommended if using them in combination with Etravirine.

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The anticonvulsants Tegretol (carbamazepine), Luminal (phenobarbital) and Dilantin (phenytoin) should not be used in combination with Etravirine.

Cholesterol-lowering drugs, also known as "statins," can interact with Etravirine. Etravirine may decrease blood levels of Zocor (simvastatin) and Mevacor (lovastatin). Lescol (fluvastatin) may increase levels of Etravirine in the bloodstream. (continued on page 14)
Etravirine can be given with Lipton (atorvastatin), although it may be necessary to adjust the dose of Lipton if cholesterol levels do not improve. Etravirine may interact with Pravachol (pravastatin) or Crestor (rosuvastatin).

Viagra (sildenafil), Levitra (vardenafil) and Cialis (tadalafil) levels in the bloodstream may decrease when combined with Etravirine. Doses of these medications may need to be adjusted. Herbal products can also interact with Etravirine. St. John’s Wort should not be used with Etravirine, since it can reduce the amount of Etravirine in the bloodstream.

Other drug interactions are possible. Both physicians and patients should investigate possible interactions carefully. (Guest Writer: Jeannie Gibbs)

The State of HIV/AIDS in African Americans

Although comprising only 13% of the total population in the United States, African Americans account for half of all U.S. HIV infections.* Statistical differences exist across the board for African American men, women and adolescents in comparison to other races.

The AIDS case rate per 100,000 black adults and adolescents (95.1) was 10 times that of white Americans and the highest among any group. African Americans account for 55% of all AIDS deaths in the U.S. and have on average the shortest survival period after diagnosis.

African American men equal 41% of HIV cases in the U.S. Of HIV positive women in the U.S. black women account for 63% of all cases. African American children suffer similar disparities as adults comprising 63% of all HIV cases in children under 13 years of age. Although Black teens (aged 13–19) represent only 16% of U.S. teenagers, they accounted for 69% of new AIDS cases reported among teens.

The statistical differences between African Americans in the U.S. and all other races is startling and warrants a great deal of research so that innovative targeted prevention efforts can be facilitated as well as barriers to treatment and care removed.

In order to fully address the dramatic differences of high rates of HIV infection amongst African Americans as well as factors which cause a quicker progression to AIDS and ultimately death, it is necessary to honestly and openly evaluate risk factors, common practices and perceptions that contribute to these factors. Environmental, behavioral, biological, and economic aspects are among the causes believed to contribute to these disparities. According to the Center for Disease Control (CDC) additional factors that put black people at a higher risk for infection include being unaware of a partners risk factors, other STD’s (of which African Americans are at a higher risk for) and poverty.

Statistics show that 25% of African Americans live in poverty. Poverty affects individuals in many different facets. HIV testing, treatment, education and transmission are most often not priorities in the face of everyday pressing issues such as the securement of food, shelter, money and other necessities.

Poor living conditions and the day to day struggle for survival which can preoccupy the majority of ones time can lead to depression and disparity which has been shown to negatively affect the immune system. Investing time, effort and money for transportation to get tested for HIV is too often not a priority. Being unaware of one’s HIV status and consequently not receiving treatment can lead to disease progression and/or unknowingly passing on the virus through unprotected sex.

The HIV Cost and Services Utilization Study (HCSUS), a nationally representative study of people with HIV/AIDS receiving regular or ongoing medical care for HIV infection, found that African Americans fared more poorly on several important measures of access and quality than whites. HCSUS also found that African Americans were more likely to report postponing medical care because they lacked transportation, were too sick to go to the doctor, or had other competing needs.

Poverty and a disadvantaged upbringing can prevent young people from finishing school thus greatly limiting future options for stable, well paying employment.

Faced with few if any viable options for their future due to a lack of educational, social and financial support, many black youths may develop a lack of self preservation and self worth contributing to risky practices. A 2006 study by the Minority AIDS Project of black LA gang members found that 26% of respondents felt it didn’t matter if they got HIV, because they believed they would probably die young anyway.

"Many kids, particularly males aged 16-19, don’t feel they’ll be alive at 21 so they live recklessly not seeing the need or having the desire to protect themselves or others" states Bobby Gregory of Got Tested, a New York based youth testing and education project.

Poverty is a complex issue with intricate consequences. The effects of poverty on the Black community are deep rooted and multifaceted. Prevention efforts must take into account the far reaching results of which poverty has on many African Americans.

Sexual practices

Certain sexual practices can contribute to HIV transmission. Unprotected receptive anal intercourse, a practice being adapted by many young people, is believed to be at least 10 times more risky than unprotected receptive vaginal sex. ‘Many of our youth’ according to Tiffany Simmone also of Got Tested ‘are of the belief that oral and anal sex do not carry the same risk of HIV infection as vaginal intercourse’.

Education geared towards this sensitive issue must be delicately addressed when working with today’s youth, particularly African American youth who have the highest rates of infection in this age group and these faulty beliefs dispelled.

A sexual practice known as being on the down low, which is rooted within the black community but also seen among other groups, may contribute to the spread of HIV infection. This is when men who do not identify as being gay or bisexual have sexual relations with other men. Although there is not specific data presently available regarding HIV risk factors for these men, it is a known practice for many of them to have unprotected sex with their male partners as well as their female partners without informing their female partners of their activities.
Sexually transmitted diseases often go undiagnosed in this population. The majority of these men are not forth coming with their physicians regarding their sexual practices which may leave them vulnerable to anal infections. Without this information or visible signs of infection most physicians do not think to test for STD's. Left untreated some STD's leave them more vulnerable to HIV due to open sores or lesions.

**Biological factors**
African Americans have the highest rates of sexually transmitted diseases in the United States. They are 18 times more likely then whites to have gonorrhea and 5 times more likely to have syphilis. Some STD's cause lesions, inflammation or sores anally and to the genitals generating points of entry for HIV. Certain STD's can increase the chance of contracting HIV 3 to 5 fold.

**Access to Adequate health care**
Difficulty in accessing or affording health insurance is a problem many African Americans are confronted with. Inability to afford private health insurance leaves many without health insurance or utilizing governmental health care. Accessing health care in poorer neighborhoods can equate to less then adequate HIV care. There is a constant flow of continual research being conducted regarding many aspects of HIV and AIDS. Too often physicians in private practice or institutions that except Medicaid do not have the time and/or financial ability to travel to attend HIV conference throughout the country and abroad where cutting edge data is presented or take the time to read medical journals or online publications. Heavy patient loads also leave little time per patient to fully discuss problems, medications and address questions and concerns.

For this and many other reasons, many African Americans are left distrustful and frustrated with Medical care. These and many other issues not covered in this article contribute to the disparities that confront African American men, women and adolescents. More research needs to be conducted through the HIV Prevention Trial Network (HPTN) and other clinical trial networks in order to ensure that progress in this dynamic arena in the epidemic is being made.

* The majority of data in this article was compiled utilizing 2005 statistical information from the 33 U.S. States with mandatory HIV reporting. (Guest Writer: Jeannie Gibbs)

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**WIN PROJECT UPDATE**

On December 14, 2007, the WIN Project hosted the Women’s HIV and Health Policy Forum on Capitol Hill in Washington, DC at the Rayburn House Office Building. There were 40 people in attendance, including Congressional staff, community healthcare providers, and representatives from national organizations addressing policy related to women and HIV/AIDS. The purpose of the forum was to examine the healthcare needs of women with the disease through a research, domestic and international panel of speakers.

The forum began with Dr. Gene Copello, Executive Director for The AIDS Institute providing an overview of the agenda. Jeanne White-Ginder, mother of Ryan White and Board Member of The AIDS Institute, highlighted the importance of addressing women’s needs and bringing them to the forefront in the fight against HIV/AIDS.

The research agenda comprised of Dr. Amy R. Knowlton, Associate Scientist, Department of Health, Behavior & Society, Johns Hopkins Bloomberg School of Public Health, who presented on “Informal Care Giving & HIV Medical Adherence”, Dr. Jacquelyn C. Campbell, Anna D. Wolf Chair & Professor, Johns Hopkins University School of Nursing, Johns Hopkins Bloomberg School of Public Health who presented on “Global Perspectives on Violence Against Women & Women’s Health”, and Dr. Sudha Sivaram, Assistant Scientist, Johns Hopkins Bloomberg School of Public Health, who presented on “Women and HIV Prevention: Are We There Yet?”. The Plenary luncheon speaker was Dr. Debbie Hagins, Clinical Director of Outpatient Services, Chatham County Health Department, Savannah, Georgia, who provided a comprehensive overview of the recruitment and retention strategies for the GRACE Study. Grace (Gender, Race and Clinical Experience) is a unique clinical trial in treatment-experienced women with HIV.


The domestic panel was comprised of Nancy Bernstine, Executive Director with the National AIDS Housing Coalition, who presented “What We Know, Where We Go: HIV/AIDS Housing”, Monica Ruiz, Acting Director of Public Policy, amFAR, The Foundation for AIDS Research, who discussed “Women and HIV/AIDS: Risk Factors and Opportunities for Prevention” and Kellye McKenzie, Manager, Racial and Ethnic Health Disparities, National Alliance of State and Territorial AIDS Directors (NASTAD), who presented on “African American Women and HIV/AIDS: Confronting the Crisis and Planning for Action.”

Violence, increased risk factors, barriers to treatment and care are many examples of the issues that contribute to the spread of the disease as well as impact women with HIV/AIDS. These common themes continue to emerge, emphasizing the need for ongoing development of comprehensive strategies addressing the needs of women with and at risk of HIV/AIDS.

For more information on The WIN Project or future program activities, please contact WIN@theaidsinstitute.org. (Michelle Scavnicky)

**For more information on the WIN Project:**
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Suzanne Miller at
SMiller@theaidsinstitute.org
NASTAD Efforts to Address HIV/AIDS Among African American Women

In March 2007 NASTAD conducted a regional forum entitled, African American Women and HIV/AIDS: Confronting the Crisis and Planning for Action, (Link to: http://www.nastad.org/Docs/highlight/20071115_RF%20AA%20Women%20Summary_FINAL.pdf) in Chicago with eight Midwestern jurisdictions. The forum was part of NASTAD’s ongoing Regional Forum Series to Address Racial and Ethnic Health Disparities. (Link to http://www.nastad.org/Programs/communitiescolor) The purpose of the African American women’s regional forum was to: (1) provide a platform for participants to share strategies and lessons-learned around the implementation of effective HIV/AIDS programs targeting African American women, (2) engage participants in dialogue about the socio-economic and psychosocial factors impacting African American women, and (3) support teams in the development of a one-year action plan to address African American women in their jurisdiction. Each participating jurisdiction brought a team to the meeting ranging in size from five to ten members and comprised of AIDS Director or senior designee, staff from health department funded community based organizations providing services for African American women, clients/consumer of services provided by the participating CBO, and Community Planning Group Members. Participating jurisdictions included Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Wisconsin and the City of Chicago.

The forum provided a foundation for jurisdictions to strengthen partnerships and collaborate more effectively with a cross-section of stakeholders to implement prevention and care and treatment programs specifically targeting African American women. During the meeting, each team was responsible for developing a year-long action plan to identify and address priority challenges impacting African American women in their jurisdictions.

NASTAD developed a comprehensive technical assistance follow-up model to support team efforts to implement their action plans. To date, teams have achieved several successes including:

- Receipt of $10K grant from the MAC AIDS Fund to implement activities outlined in state action plan
- Development of state-wide needs assessment tool focused on African American women
- Presentation of action plan activities to community planning groups (CPG) and subsequent formation of African American women’s CPG subcommittee
- Commitment to replicate regional forum locally
- Brown bag series to address health and wellness, including HIV/AIDS, among women of diverse racial and ethnic backgrounds
- Multiple presentations on issues related to African American women and HIV/AIDS at statewide health conference

The March 2007 regional forum on African American women was such a success that it will be replicated in March 2008 with eight new jurisdictions in the Northeast. NASTAD has utilized findings and recommendations from the March 2007 meeting to craft an issue brief that assesses the landscape of HIV prevention and care and treatment among African American women in the United States, slated for release in March 2008.

NASTAD will use the findings from both African American women’s regional forums and other related activities, including a series of health department focus groups, to craft national recommendations for health departments on administering effective, culturally appropriate services targeting African American women. (Guest Writer: Kellye McKenzie, Senior Program Manager, Racial & Ethnic Health Disparities)

14th Annual Voices Conference
May 16–20, 2008

Join AIDS Alliance for Children, Youth & Families to collectively define change that will lead to:

- Improved living conditions to reduce human vulnerability and decrease HIV infections;
- Improved access to care and quality of care;
- Eradication of stigma in all forms

Come to Voices 2008 to hear from and talk with the leaders in HIV/AIDS care, prevention, research, and advocacy. Institutes, plenary sessions, and workshops will be led by the care providers, researchers, and consumer leaders who are making a difference across the United States. Attending Voices every year are people just like you! Joining us for Voices 2008 will be: social workers, nurses, physicians, and other health care providers; program directors and administrators; clinical researchers; and consumers — women, youth, and families living with and affected by HIV/AIDS, including caregiving men — and other advocates and grassroots leaders.

You can register at:
www.aids-alliance.org

Education News

Parents Responsible for Teaching HIV/AIDS Prevention? Is it really their job?

The Centers for Disease Control and Prevention (CDC) reports that early, clear parent-child communication regarding values and expectations about sex is an important step in helping adolescents delay sexual initiation and make responsible decisions about sexual behaviors later in life. In addition, CDC suggests that parents are in a unique position to engage their children in conversations about HIV, STD, and teen pregnancy prevention because the conversations can be ongoing and timely. However, there is still unformed youth making consequential decisions about sexual activity. Parents need to have the skills and tools available to begin important discussions around sexual behavioral risk with their children. As simple as it may seem, the more difficult it is for parents to engage in conversations around sexual activity.
Programs that promote interaction among the family are critical in highlighting such important discussions. For example, studies have demonstrated that African American youth are at higher risk of contracting HIV and other negative health consequences. Therefore, development of prevention and intervention programs such as Why Parents Matter! is a unique way to address the importance of sexual risk prevention. The Parents Matter! Program (PMP) is a community-based family intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction among African American adolescents. PMP offers parents instruction and guidance in general parenting skills related to decreased sexual risk behavior among youth (e.g., relationship building, monitoring) and sexual communication skills necessary for parents to effectively convey their values and expectations about sexual behavior—as well as critical HIV, STD, and pregnancy prevention messages—to their children. Another reason for examining risk behavior in African American's is they represent one of the communities hardest hit by the epidemic.

The more comfortable parents are in discussing sexual risk behavior with their children, the more successful the results of delayed sexual activity among youth. It is important to seek creative ways to educate parents who can then begin prevention discussions with their children. Utilizing venues such as parent teacher associations or organizations as prevention education and training opportunities will equip parents with the information to disseminate to their children.

The AIDS Institute is a strong advocate for promoting comprehensive HIV education among youth. Engaging the family in discussions around prevention is one of the major components of a comprehensive risk reduction strategy targeting youth. To be successful in stopping the HIV/AIDS epidemic, parents and youth need to be involved in discussions that include such strategies for HIV/AIDS education and prevention. (Michelle Scavnicky)

Sources:

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The Campaign to End AIDS (C2EA) is a diverse, exciting new coalition of people living with HIV/AIDS, their advocates and their loved ones. Together, we’re demanding that our leaders exert the political will to stop the epidemic, in the U.S. and abroad, once and for all. In small towns and big cities across America, we’re mobilizing to ensure the best treatment and care for all HIV-positive people...and HIV prevention methods backed by good science.

www.C2EA.org

The State Roundup

District of Columbia

City to Spend $650,000 on Needle Exchange Programs

The District will invest $650,000 in needle exchange programs to combat the spread of HIV-AIDS in the wake of Congress’s decision to end a ban on the city’s use of public money for such efforts, D.C. officials said yesterday.

Mayor Adrian M. Fenty (D) and several D.C. Council members said the funding was an important step in a larger effort to reduce the rate of infection among residents. The city has one of the highest rates in the nation: One in 20 residents is thought to have HIV, and 1 in 50 residents is believed to have AIDS, according to a study released in November.

Needle exchange programs allow participants to trade used syringes for new ones. “This program goes to best practices to combat one of our greatest health problems,” Fenty said at a news conference at the headquarters of PreventionWorks!, which operates a needle exchange program and will receive a $300,000 city grant. The remaining $350,000 will go toward developing additional needle exchange programs, Fenty said.

For a decade, Congress had barred the city from using public money for such programs, which can be controversial because the syringes are used to inject drugs such as heroin. Congress removed the ban during its recent passage of an omnibus appropriations bill. Ken Vail of PreventionWorks! estimated that his organization serves about 2,000 people at 12 locations in the city and exchanged 200,000 syringes last year.

In a news release hailing the announcement, Del. Eleanor Holmes Norton (D-D.C.) said, “The District’s AIDS rate is artificially elevated” because of the previous congressional ban. “Now we have a lot of catching up to do.” Council member David A. Catania (I-At Large), chairman of the Committee on Health, said the public investment will pay off in the long run if the program is successful. “The cost of infection is immeasurably higher in terms of dollars and lives,” Catania said. Shannon Hader, head of the District’s HIV-AIDS Administration, said she expects the city to foster new needle exchange programs that could take several forms, including mobile clinics and outreach and fixed-site programs. (continued on page 18)
It was 1982 when Dr. Jean Malecki examined a dying 9-month-old baby and made the first pediatric AIDS diagnosis in Palm Beach County.

The parents, who had arrived recently from the Caribbean, were sick, too. "Within six months, the child had died," Malecki said. "The whole family got wiped out by the disease."

Malecki states this flatly because in the past 25 years, the Palm Beach County health director says, she has seen that flinching from the truth accomplishes nothing.

She had started work with the county health department's Belle Glade clinic in 1981, the year doctors in New York and Los Angeles linked a series of deaths to a plague that was dubbed "Gay Related Immune Disorder."

The new acronym came in time to describe what had happened to Malecki's tiny patient, who had gotten the virus from his mother, who in turn likely had caught it from her husband: Acquired Immune Deficiency Syndrome.

Today, the United States is home to more people living with AIDS and HIV, the virus that leads to AIDS, than any other leading industrialized nation. Its numbers are at least triple those of all of the runners-up but one: the Russian Federation.

With more than 105,000 people diagnosed with AIDS in Florida since the beginning of the epidemic, Florida's AIDS case numbers are the third-highest in the nation. The rate of HIV/AIDS among children in Florida is second only to that of New York, and 80 percent of the nearly 2,000 pediatric HIV/AIDS patients in Florida are black.

Palm Beach and St. Lucie counties have the highest rates of infection among black residents in the state and fall below only Washington, D.C., nationally. While black residents make up 15 percent of Palm Beach County's population, they make up 65 percent of people living with HIV/AIDS here.

Even as AIDS has highlighted disparities in access to health care in the world's wealthiest nation, leaders here have failed to respond to the disease as a sexually transmitted epidemic, Malecki says.

She points to a health education program for local schools that reveals how to avoid acne but not how to avoid HIV.

The 120-page report released in November found that HIV was spread through heterosexual contact in more than 37 percent of the District's cases detected during that period, compared with the 25 percent of cases attributable to men having sex with other men. (By David Nakamura, Washington Post Staff Writer)

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ARIZONA

Hispanic HIV/AIDS Program Salvaged

Hispanic non-profit Chicanos Por La Causa Inc. has reversed its decision to pull out of a program that helps people with HIV and AIDS.

The organization will continue to offer the Ryan White CARE program through February 2009 to its clients, who are mostly Latino and among the fastest-growing groups that are contracting the disease.

The turnaround came after Maricopa County Supervisor Mary Rose Wilcox and state Rep. Robert Meza, D-Phoenix, promised to raise about $43,000 from private donors to keep the program going. Meza also works in business development and community outreach for the non-profit organization.

Earlier this week, the Chicanos Por La Causa said it was pulling out of the program because it was losing too much money on it.

It is one a handful of organizations that specialize in helping Latinos, especially immigrants and Spanish-speakers, manage the disease. More than 12,000 Arizonans have HIV or AIDS, and Hispanics make up about 23 percent of the state's known cases, according to the Arizona Department of Health Services. An additional 4,000 people may have the disease but do not know it.

"It saves the program in the short term," said Edmundo Hidalgo, president and CEO of the non-profit. "We are collaborating with other providers to be able to save the program long term. It's unfortunate that this is the kind of crisis it takes to bring the attention to it (HIV/AIDS)."

Chicanos Por La Causa has offered HIV/AIDS care since 2001 and is scheduled to receive $284,992 in Ryan White money this year. It helps clients learn and manage the disease and connect them with behavioral-health services.

The group has about six months to raise the money and is talking to potential donors.

"It would be really remiss not to have a culturally diverse program like CPLC doing this," Wilcox said. "The program is so fundamentally important to our community and the culturally diverse program they offer is necessary."

(By Yvonne Wingett, The Arizona Republic)
'Get tested and live'
An often lone exception to that, she says, has been Bishop Lewis White, who with his wife, Sandra White, and their United Deliverance Church, has taken education, prevention and care into the county's abandoned streets.

The bishop's newest set of wheels is a used moving van decorated with a painting of a sickly figure struggling to emerge from a half-open coffin. "You don't have to let the lid close on you. Get tested and live," urge letters painted on the side of the van. "1 in 42 blacks have HIV/AIDS in Palm Beach County, compared to 1 in 503 whites and 1 in 252 Hispanics." The largest letters advertise: "FREE CONDOMS HERE."

The pastor calls the truck that he bought late last year his "traveling billboard." It was White's response to a statewide report showing the HIV epidemic's disproportionate impact on black communities in Palm Beach County and the Treasure Coast. It is also part of an approach that sets him apart from many other area pastors who, he says, won't talk about the epidemic because they won't talk about sexuality and condom use.

"Other pastors have said I'm promoting sex when I hand out condoms. I'm sorry to tell them that is not true. People are having sex with or without condoms. I'm promoting life," White responds. "I'm here for a purpose: not to judge you on who you have sex with, but to judge how careful you are when you have sex." That approach, as well as his other vehicle, an old red school bus that he turned into a mobile HIV testing site, has helped White, his wife and staff members from United Deliverance Church find a higher proportion of HIV-positive people than any local testing facility.

And in the seven years since he and his wife mortgaged their home to buy the first bus and take their fight against the epidemic to the streets, they have learned how the epidemic works, both say.

'So many people in the cracks'
Poverty, homelessness and unemployment are driving the spread of HIV in communities where conditions have only worsened in recent years, he said. Jobs that pay enough for workers to afford stable housing are scarce for the people he sees. And with few prospects, young women turn to trading sex for survival.

"They go out there and find a man, and he gives them $20 for just 10 minutes," he said. "They are getting younger and younger on the street, selling their bodies. We have lost so many people in the cracks because we have nowhere to put them." In that environment, people recently diagnosed turn to the church, and its purple-and-green painted United Deliverance Resource Center, for help. Staffers there have long referred new patients to one of the area agencies, including the Comprehensive AIDS Program and Compass, the county's gay and lesbian community center, both of which get federal "Ryan White" money for HIV/AIDS care.

United Deliverance is the only black church to work cooperatively with Compass, in a relationship that has helped both in the past several years, prevention manager Chris Lacharite said.

While a unique alliance, it is a natural one, Lacharite said: "We share the same philosophy of getting people to know their status and linking them to care."

But in 2006, the federal government cut money for services linking patients to care by an unprecedented 13 percent, taking $1.2 million from supplements for groceries, transportation and case management, for an estimated 800 people. The reduction was followed by an additional half-million-dollar decrease this year.

While Compass can still help those patients get care, the effect of the recent cuts as well as reductions in Medicare has been harsh, Lacharite said. The most immediate impact has been on money for food, with cuts tightening restrictions on who can get help in finding enough to eat, Lacharite said.

Patients on the lifesaving anti-retroviral drugs need to take the medicine with food and eat regularly, a challenge when the debilitations and demands of the illness put full-time work out of reach. "We have people who need it," Lacharite said. "But we have to give it to the neediest of the needy."

Another effect of the federal cuts was to eliminate money for substance abuse treatment for the first month of this year's funding, before federal officials reversed a decision to pay only for outpatient care, Lacharite said. The amount available for addiction treatment remains inadequate, he and others say.

'I'll pray with them'
At the Palm Beach County Jail, nearly all of the HIV patients he sees have drug addictions, says Dr. Pierre Dorsainvil, medical director of that facility. That is because drug addictions lead to other problems, including trading sex for drugs and being vulnerable to sexual assaults, AIDS experts agree. Once in jail, inmates have access to treatment for addictions. Dorsainvil, an infectious disease specialist who grew up in Haiti before moving to the U.S. at 18, also treats a number of Haitian-born HIV patients at his Delray Beach practice. "I enjoy working with HIV," he said. "Most of the patients I meet think no one cares about them. When I see my patients, I'm not afraid to cry. If they want to cry, I'll cry with them. If they want to pray, I'll pray with them."

Dorsainvil wonders, though, about the patients he does not see. "There's a lot of patients we don't know about because of their immigration status," he said. He visits Haiti, where he has a clinic and volunteers through the South Florida-based nonprofit Health Through Walls to serve prisoners in the National Penitentiary there, and contends that the line between that country's epidemic and the U.S. epidemic is perforated by immigration.

Dorsainvil and others say that as Haiti's numbers drop, if numbers here rise correspondingly, it would be hard to tell, as fear of deportation keeps immigrants from seeking medical care.

Immigration policy standing between jobs and those fleeing strife and poverty in Haiti also contributes to HIV risks, driving some into selling sex, Haitian doctor and AIDS researcher Jean "Bill" Pape has pointed out.

But across the spectrum of his patients, Dorsainvil says, the biggest need is education. As treatment has improved in recent years, he sees fear of infection or of infecting others decreasing.

(By Antigone Barton, Palm Beach Post Staff Writer)
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