National HIV Testing Day is June 27

How important is HIV testing and counseling? It is estimated that about 250,000 people in the United States are HIV positive but do not know it. Every 13 minutes a person becomes infected with HIV in our country and every 30 minutes someone dies of AIDS in the U.S. Over 1 million Americans are living with HIV/AIDS. Even with all our advances in disease detection and medical treatment, these remain staggering numbers.

HIV testing and counseling are very important. Everyone living in America should be encouraged to know his or her HIV status. Knowing one’s HIV positive status is an important public health measure as people who know they are HIV positive are more likely to avoid high risk behavior. Also, the importance of beginning medical therapy to address HIV is crucial – and that cannot happen if one does not know he or she is HIV positive. Likewise, important information is provided if one tests HIV negative about how to maintain a negative status.

June 27 is an important reminder to all of us about the importance of HIV testing and counseling as the annual National HIV Testing Day. But it is only one day out of the year. Everyday should be seen as an opportunity for people to learn their HIV status. This June 27 I hope we can all commit to sharing the message with others that knowing their HIV status is important.

The AIDS Institute commends the National Association of People with AIDS (NAPWA) and the U.S. Department of Health and Human Services for their coordination of National HIV Testing Day. We join them in sending out the message about the importance of HIV testing and counseling.
Louisiana: The Need for Unity in the Community

The State of Louisiana, which is characterized as primarily being very rural with urban settings in New Orleans and Batten Rouge, is an interesting case study for the HIV/AIDS epidemic. Another unique challenge is that although the state’s population is 32% African American, 72% of its new HIV diagnoses were found in that same segment of the population in 2007.

Unfortunately, these same demographic and epidemiological dichotomies are visible in the local community’s advocacy efforts. For example, the Louisiana AIDS Advocacy Network (LAAN), which is an outstanding model of community partners coming together for advocacy work, has had difficulty engaging both rural organizations and organizations that typically focus on the needs of the African American population. Both types of ASOs are typically overworked and under funded compared to their respective counterparts, and thus engaging in advocacy work, which can all too often feel like a tangential task, is even more burdensome.

For example, Brotherhood, Inc., which is an organization that focuses on the needs of the black community in New Orleans, lost over 70% of its staff after Hurricane Katrina riveted through the city and has yet to recover from that devastation. A significant part of that agency’s focus is prevention outreach. The state, however, only has 2.5 million dollars to spend on its prevention efforts. Brotherhood Inc. clearly could use an increase in the prevention budget, but struggles to keep its head above water and does not have the capacity to take on advocacy work.

The important fact to remember is that in any discussion of a better tomorrow advocacy work is a critical element in achieving those dreams. Furthermore, advocacy in turn requires a united community of HIV/AIDS advocates in order to illustrate that the requests being presented are in fact needed. (Jason Kennedy)
June 27 is National HIV Testing Day

Started by The National Association of People with AIDS (NAPWA) in 1995, National HIV Testing Day (NHTD) presents an opportunity for local organizations across the nation to engage with community members to promote early diagnosis and HIV-testing. The Centers for Disease Control and Prevention (CDC) estimates that 250,000 of the one million-plus people living with HIV/AIDS in the United States are unaware of their status. The lack of access to treatment and care along with social stigma can make living with HIV difficult. With early diagnosis, uncertain individuals will know their HIV-status and could be placed into appropriate treatment and care much sooner. During NHTD, NAPWA works with partners, which include thousands of community-based organizations, businesses, health departments, elected officials, media, and individuals to encourage routine HIV-testing and to promote culturally-apt messages for those affected by and living with HIV/AIDS.

According to the U.S. Department of Health and Human Services (HHS), HIV, the virus that causes AIDS, is hitting Americans hard. More than 40,000 Americans are infected each year. In the U.S., many more men are infected with HIV/AIDS than women. In 2005, almost three-quarters of all HIV/AIDS diagnoses were for males. The largest numbers of HIV/AIDS diagnoses in 2005 were in men who have sex with men, followed by adults and teens infected through heterosexual sex. People of color are disproportionately affected by the disease. Again, in 2005, African Americans, who make up approximately 13% of the U.S. population, accounted for almost half of the estimated number of HIV/AIDS cases diagnosed. AIDS is now the leading cause of death for African American women ages 25 to 34.

The AIDS Institute joins NAPWA in encouraging you to take action this National HIV Testing Day and do the following:

• Get tested for HIV – Know Your Status
• Practice safe methods to prevent HIV
• Decide not to engage in high risk behaviors
• Talk about HIV prevention with family, friends, and colleagues
• Provide support to people living with HIV/AIDS
• Get involved with or host an event for National HIV Testing Day

ACTIONLINK: Have you been tested for HIV? Are you aware of your status? What steps can you take to promote HIV testing and awareness in your community?

ACTIONLINK: What do you see as the most important successes or lessons learned from the AIDS pandemic that can be applied to society as a whole?

DANA VAN GORDER: As mankind becomes increasingly technologically sophisticated, we are at risk of believing that we are beyond the possibility that we face the sort of destructive epidemics like HIV/AIDS that have episodically annihilated huge numbers of people globally. The tragic experience of HIV/AIDS must serve as a reminder that we are still subject to these kinds of ravages. Indeed, as global population threatens to outstrip the ability of the planet to sustain it, we are potentially even more vulnerable to massive epidemics than we have been throughout human history. Who those epidemics might affect we cannot tell. It therefore behooves all of society to respond as aggressively and compassionately as possible to the HIV/AIDS epidemic as a model for the response that may be required to a similar, future global medical crisis.

REBECCA HAAG: If we are to make progress in stopping the spread of new infections and ensuring access to care and treatment for all those infected, the AIDS response in any country must be based on goals and objectives that are measurable, include timelines, set responsibilities, and hold authorities accountable for results. Where countries have created National plans that include community input, mobilized all sectors, and rallied public support through political leadership, we have achieved progress. Without a plan, country responses have failed to succeed. This is relevant to many complex issues.

ACTIONLINK: Over the next few years what is the major challenge you see for the AIDS community?

DANA VAN GORDER: If we wish to move from managing the current epidemic to eradicating it, I believe that ASO’s and the nation’s public health leadership must come to widespread agreement about and implement an aggressive, focused, and strategic blueprint to: assure that the 25% of HIV-positive people who do not know their serostatus are tested; eliminate barriers that have prevented the 20% of HIV-positive people who are not receiving care and treatment from doing so; adding biomedical prevention such as PrEP to behavioral prevention in order to virtually eliminate HIV incidence; address disparities in health outcomes in part by demanding universal healthcare or entitlement status for the Ryan White Program; and investing adequately in promising research to produce a cure for HIV infection, in addition to drugs that manage it. (continued on page 5)
REBECCA HAAG: The AIDS community must rally additional public support and involve more sectors and opinion leaders in our struggle. Particularly in the U.S. we talk too often among ourselves and too little to other constituency groups that are natural allies and supporters. We must develop clear concise messages that engage others in our struggle to stop this terrible disease. We must do better market research so we can understand the current attitudes about HIV in our country and we must make our issues relevant to the many communities affected.

ACTIONLINK: It’s often said that more unity is needed in addressing AIDS. What is your view of this and how best can unity be achieved?

DANA VAN GORDER: Never before has there been a domestic epidemic as socially, politically and culturally complex as HIV/AIDS. We have made enormous progress against this disease. And yet, like many of the nation’s most threatening problems, I agonize over the fact that there is not greater cooperation, consensus and coordination among ASO’s to deepen our impact on the epidemic. I have the greatest of hopes that the HIV community will come together in coming years, ideally as part of the current call for the next President to develop a National AIDS Strategy, to coalesce as never before on a set of strategies that will address the challenges listed above. All of us must be willing to drop our stakes in the interest of a more effective response to this unnecessary epidemic.

REBECCA HAAG: We can only achieve unity if we can agree to a set of goals and objectives. We get caught up in short term tactical differences, when I believe that the majority of the AIDS community agrees on 95% of the important issues. We all want to end the spread of new infections, ensure access to care and treatment, and eliminate stigma and discrimination. Different geographic areas and communities require different strategies and tactics to achieve these objectives. We try to force a standard approach which will not work. Let’s rally for additional funds to address the growing problem and give more flexibility to local states and communities to invest in the most productive way.

ACTIONLINK: If the next President of the United States asked to meet with you, what is the main message you would want to convey?

DANA VAN GORDER: There are two ways for the United States to manifest its values and keep itself safe from harm. One is to invest massively to defend ourselves from people who find our economic and cultural values deeply problematic. The other is to use those resources to build a culture with atmosphere. CPIC provides the opportunity to benefit from descent throughout the world in a professional, culturally based atmosphere. CPIC provides the opportunity to benefit from knowledge, access to testing, counseling, educational practices, life skills, and medical care for those who lack medical and financial resources or health insurance. It adheres to the principle that all persons are created for a purpose regardless of physical appearance and human weaknesses.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) in its 2007 AIDS Epidemic Update reports that adult HIV prevalence in the Caribbean is estimated at 1.0%. Prevalence in the Caribbean is estimated at 1.0%. Prevalence in this region is highest in the Dominican Republic and Haiti, which together account for nearly three quarters of the estimated 230,000 people living with HIV in the Caribbean. This includes the approximately 17,000 people who were newly infected in 2007. An estimated 17,000 people in the Caribbean died of AIDS in 2007, and AIDS remains one of the leading causes of death among persons 25 to 44 years of age. (continued on page 6)
The primary mode of transmission in this region is sexual intercourse, with unprotected sex between sex workers and clients being a significant factor. According to the Pan American Health Organization (PAHO), HIV prevalence among female sex workers in the Dominican Republic is at 3.5%, 9% in Jamaica, and 31% in Guyana. Haiti still accounts for the largest HIV burden in the Caribbean. A national population-based survey estimated adult national prevalence in Haiti to be 2.2%. Unsafe injecting drug use is responsible for a minority of HIV infections in the region, but contributes significantly to the spread of HIV in Bermuda and Puerto Rico. Very high HIV prevalence is still being found in among injecting drug users in Puerto Rico, where the rate of HIV infection (26 per 100,000) is twice that of the U.S. mainland and where more than two-thirds of HIV infections have been among men. Unsafe sex between men is a significant factor in this region but is largely hidden because of associated stigma. Little research has been conducted in the Caribbean among men who have sex with men, but the available data from the Caribbean Commission on Health and Development suggest that about 12% of reported HIV infections are the result of unsafe sex between men.

The AIDS Institute commends The Caribbean Peoples International Collective for establishing the Caribbean American HIV/AIDS Awareness Day. We pause to observe the first Annual Caribbean American HIV/AIDS Awareness Day on June 8, 2008 and join in its mission to “Beat the Odds.” We join CPIC in renewing our commitment to improving health, ending the spread of HIV and ensuring quality of life to those with HIV regardless of their country of origin or immigration status. We do so whether we are Caribbean, Latino, African American, Asian, White or Native American.

**National Rural Health Association Annual Conference: May 7th – 10th New Orleans, Louisiana**

The National Rural Health Association is a national nonprofit membership organization with a mission to provide leadership on rural health issues. The NRHA membership is made up of a diverse collection of individuals and organizations, including providers, administrators, researchers, policy analysts, educators, and state employees, all of whom share the common bond of an interest in rural health. For more information on NRHA, its mission, services, and or information that they provide please access their website at www.nrharural.org.

The association is an excellent source of information pertaining to the unique challenges faced by rural healthcare communities. The conference more specifically provides attendees the opportunity to integrate their work with broader healthcare efforts, which is critical in rural areas where there is a limited healthcare infrastructure in place. There are two internet-based resources that may prove to be of assistance in such an endeavor.

**The Rural Health Research and Policy Center:** A Gateway to Rural Health Research. The Gateway is designed to help policy-makers better understand the problems that rural communities face in assuring access to health care and strengthening the health of their residents. The centers work to understand the ways in which the health of rural Americans can be improved, analyze the implications of federal and state policy options and communicate research results to policymakers and others who may take action based on results research. The Gateway is available online at www.ruralhealthresearch.org

**The Rural Assistance Center:** is a product of the U.S. Department of Health and Human Services’ Rural Initiative and was established in December 2002 as a rural health and human services "information portal." RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. RAC is available at www.raconline.org (Jason Kennedy)

**United Nations Discusses Progress**

The United Nations General Assembly held a special session on HIV/AIDS June 10-11 in New York City with a number of important pre-session side events occurring June 9. This meeting was convened to assess progress made in achieving the United Nation’s overall goals intended to address the HIV/AIDS pandemic. Over 150 nations and more than 500 nongovernmental organizations participated in the United Nations High Level Meeting on HIV/AIDS.

The AIDS Institute participated in several ways. Dr. Gene Copello, Executive Director, was appointed a member of the United States government delegation, headed by Ambassador Mark Dybul. The delegation consisted of a number of community-based representatives as well as government officials from the State Department and Congressman Henry Waxman’s office was also represented in the delegation. On June 10, Dr. Copello and Dr. Eric Goosby of Pangaea Global AIDS Foundation, based in San Francisco, another community member of the US delegation, officially represented the United States during a panel session focused on countries with concentrated HIV epidemics. Other community members of the delegation included Regan Hoffman, Editor-in-Chief of POZ magazine, and Kay Warren of Saddleback Church based in southern California.

James Sykes, Global Program Coordinator, represented The AIDS Institute in the agency’s capacity as a registered UN nongovernmental organization for the special meeting. This included participation in an all day civil society caucus on June 9 and a civil society hearing on June 10. In addition, The AIDS Institute partnered with other organizations in hosting two side events.
On May 12th, The AIDS Institute held a Congressional briefing, “Preventing HIV/AIDS in the United States: A Focus on CDC’s HIV/AIDS Prevention Programs.” The goal of the briefing was to bring more attention on the need for more HIV Prevention efforts in the U.S., and to increase funding for CDC’s HIV/AIDS Prevention Programs, which has been cut in recent years. The briefing featured presentations by: Dr. Rich Wolitski, Acting Director, Division of HIV/AIDS Prevention at CDC; Julie Scofield, Executive Director, National Alliance of State and Territorial AIDS Directors (NASTAD); Suzanne Miller, Public Policy Associate, The AIDS Institute; and Dr. Marjorie Hill, Chief Executive Officer, Gay Men’s Health Crisis (GMHC). Carl Schmid, Director of Federal Affairs for The AIDS Institute, moderated the briefing. The briefing was well attended by Congressional staffers, several media outlets, and fellow community advocates. The event was broadcast live on CSPAN, which repeated the event several times, and it was also webcast by Kaiser Family Foundation.

Carl Schmid opened the briefing by highlighting the need to refocus efforts and attention on the domestic HIV/AIDS epidemic. He cited a recent study showing the cost of new HIV infections in 2002 to be over $36 billion, including nearly $7 billion in direct medical costs, and $30 billion in loss of productivity. Dr. Wolitski focused his presentation on providing a full picture of the current epidemic, as well as highlighting CDC’s domestic HIV/AIDS prevention priorities, and current prevention challenges. Julie Scofield discussed how CDC spends its budget and how prevention programs are implemented. She noted that funding for HIV/AIDS at CDC has steadily declined since 2002. She also reported that that only four percent of total funding for domestic HIV/AIDS is directed towards prevention.

Suzanne Miller’s presentation focused on the analysis The AIDS Institute conducted on CDC’s HIV Prevention Interventions (see separate article). This analysis found that there is a lack of adequate intervention for many high risk groups, particularly for men who have sex with men (MSM). Ms. Miller called upon the Congress to adequately fund the Division of HIV/AIDS Prevention at CDC so that they develop more targeted Interventions for high risk populations. (continued on page 8)
In her remarks, Dr. Hill focused on the need for a more comprehensive and holistic approach to HIV prevention, by integrating services to address HIV and other co-morbidities such as hepatitis, STDs, substance abuse and mental health issues. She also noted the need for CDC to develop and support Community Level and Structural Level Interventions, because HIV infection rates in vulnerable populations cannot be explained by individual behavior alone. Dr. Hill denounced ineffective abstinence-only-until-marriage programs, and called for evidence-based Interventions to be implemented, instead.

To view the entire event and access panelists’ presentations, please visit http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2609.

Earlier that morning, Carl Schmid appeared live on the Washington Journal program of CSPAN, highlighting the need for greater domestic HIV/AIDS prevention efforts and responding to viewer call in questions. While there has been great focus and resources dedicated to the global HIV/AIDS epidemic in recent years, Mr. Schmid called for a refocusing of attention to the crisis here at home. While care and treatment efforts remain critical, Mr. Schmid noted, “Our country is failing to focus on prevention.” He also focused on the need for comprehensive prevention education, and noted the inadequacy of abstinence-only-until-marriage programs as effective HIV prevention. He also called for more research on the racial disparities that exist with HIV infection, and more targeted prevention efforts for different high risk and highly impacted populations. (Suzanne Miller)

Rep. Lofgren Introduces Bill Mandating Standards of Care for Immigration Detainees

Rep. Zoe Lofgren (D-CA) recently introduced H.R. 5950, the Detainee Basic Medical Care Act of 2008, which would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees. The issue of detainee healthcare has been a particular concern for HIV/AIDS advocates after Victoria Arellano, a transgender immigrant with HIV/AIDS, died in Immigration and Customs Enforcement custody last year in Southern California. Arellano died after ICE agents denied her access to AIDS medication that would have saved her life.

The procedures mandated by the bill must take into account all detainee health needs, including primary care, emergency care, chronic care, prenatal care, dental care, eye care, mental health care, medical dietary needs, and other medically-necessary specialized care. The bill would also require the Secretary to report all detainee deaths to the Inspector Generals of both the Department of Homeland Security (DHS) and the Department of Justice (DOJ) within 48 hours. Additionally, the Secretary would be required to submit a report to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives containing detailed information regarding the death of all immigration detainees in the Secretary’s custody during the preceding fiscal year.

“This legislation will help guarantee that minimal standards of care are put into place,” noted Rep. Zoe Lofgren. “We are not talking about Cadillac health care here, but the government is obligated to provide basic care. Many of those in immigration custody are there for minor violations, many for administrative and paperwork related mistakes. Their detention should not be a death sentence.” Lofgren is Chair of the House Judiciary Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law. (Carl Schmid)

The AIDS Institute Releases an Analysis of CDC’s HIV Prevention Interventions Portfolio

The AIDS Institute recently released an analysis of the HIV Prevention Interventions included in CDC’s Compendium of Evidence-Based Interventions. The Compendium, which was recently updated for the first time since 2001, includes 49 Interventions with the best evidence of effectiveness at either reducing HIV/STD incidence or reducing HIV related risk behaviors. CDC funds health departments and community based organizations (CBOs) to implement these Interventions to various target populations and community based settings. While CDC disseminates other prevention programs to health departments and CBOs, such as HIV counseling and testing and social marketing campaigns, the behavioral Interventions included in the Updated Compendium are the most comprehensive and targeted prevention tools, and are the framework for HIV prevention in the U.S. The AIDS Institute analyzed the specific Interventions included in the Compendium to see how well they met the needs of populations at highest risk for, and greatly impacted by HIV/AIDS. The results of this analysis showed that there is a lack of specific Interventions for numerous target populations and settings.

In conducting the analysis, The AIDS Institute focused on the following categories and target populations of different Interventions: gender; race/ethnicity; sexual orientation; drug users; incarcerated populations; People with HIV/AIDS (PWH/A); high risk youth; age; relationship status; and language. The results of our analysis shows that there are critical research gaps and that the Updated Compendium fails to include targeted Interventions for numerous populations that are high risk and greatly affected by HIV/AIDS.

In regards to gender, 28 of the 49 Interventions are targeted to men, who accounted for 73% of all HIV/AIDS diagnoses in 2006. While 21 of the 49 Interventions are targeted to women, there are no Interventions for transgendered individuals, in particular transgendered women, who are at high risk for HIV infection. The majority of Interventions (38) specifically or predominately target racial/ethnic minorities. While there are specific Interventions for African American women, African American men, and Hispanic women, there are none for Hispanic men. In 2006, non-whites accounted for 70% of all HIV/AIDS diagnoses. While men who have sex with men (MSM) accounted for 71% of all HIV infections among males in 2005, only 4 of the 49 Interventions are targeted to MSM. Furthermore, none of those 4 Interventions are specifically targeted to African American or Hispanic MSM, who are disproportionately impacted by HIV/AIDS.
While there are 9 Interventions targeted to drug users, including injection drugs, crack cocaine, heroin and alcohol, there are no Interventions for crystal methamphetamine users, which are at high risk for HIV infection, particularly in some MSM communities. There are 2 Interventions targeted to incarcerated males, who also have increased risk of HIV infection, and 6 Interventions targeting PWH/A. There are no Interventions for incarcerated females.

In regards to age, there are 13 Interventions targeting high risk youth, however, there are no Interventions specifically targeting people over age 50, who accounted for 15% of all new HIV/AIDS diagnoses in 2005. There are 5 Interventions that can be delivered in Spanish. Hispanics accounted for 18% of all HIV/AIDS diagnoses in 2006, and language is a critical factor in accessing culturally competent HIV prevention messages.

As The AIDS Institute’s forthcoming paper on this issue explains in further detail, CDC’s Updated Compendium fails to address numerous subpopulations at high risk of HIV, particularly MSM, and MSM of color. In addition, there are also no targeted Interventions for sex workers, veterans, and the homeless. There is also a strong need for more diversity in regards to Intervention settings. As the epidemic has shifted geographically, there must be more Interventions that target rural settings. In addition, faith settings and faith communities have a critical role to play in HIV prevention, and should be incorporated as Intervention settings.

The CDC has indicated the Updated Compendium will be updated periodically as Interventions are evaluated and deemed effective. The AIDS Institute urges CDC to conduct the necessary research and evaluations to fill in the critical gaps. Without the necessary Interventions, it will be increasingly difficult to decrease the number of new HIV infections in the United States. (Suzanne Miller)

CBO Calculates Costs of Lifting the HIV Entry Ban

The Congressional Budget Office (CBO) threw a potential monkey wrench into passage of lifting the HIV Entry Ban as part of the PEPFAR reauthorization bill in the Senate. According to their calculation, lifting the ban would cost the federal government $83 million over the 2010-2018 period due to the cost of providing federal disability, health, and nutrition benefits to those immigrants and their children. With a cost now associated with lifting the entry ban, any Senator can raise a point of order and 60 votes would be required to overturn the objection and keep the provision in the bill.

Sens. John Kerry and Gordon Smith, the principal proponents of lifting the ban in the Senate, along with HIV/AIDS organizations, including The AIDS Institute, took strong objection to the CBO analysis. In a letter to the CBO, the Senators wrote, “CBO assumptions appear to overlook the requirement under current law that an Affidavit of Support is required for all immediate relatives. The Affidavit of Support is basically a contract between the government and the sponsoring family member (or employer) that the sponsor will assume any extra costs to the US.

If an intending immigrant becomes a public charge before the contract expires, the government can sue the sponsor to recover the cost of the (means-tested) public benefits that the immigrant receives (such as Medicaid and food stamps). Additionally, Gary J. Gates, PhD, Senior Research Fellow, The Williams Institute, UCLA School of Law at the request of Immigration Equality performed an analysis on the projected positive employment income tax revenues the federal government would receive if the entry ban was lifted. Dr. Gates estimates the revenue to the federal government to be $67-$100 million for the years 2010-2018. This would fully offset the projected costs that the CBO estimated.

Sens. Kerry and Smith’s request to CBO to revise its cost analysis is still pending. In an effort to help educate Congress and the public about the HIV entry ban, well known political pundit and author Andrew Sullivan penned an May 14th op-ed in the Washington Post titled “Phobia at the Gates” that related his own experiences as an HIV positive immigrant. Sullivan wrote, “Making HIV the only medical condition that legally prevents someone from immigrating or even visiting is a signal to people with HIV that they have something to be ashamed of. That stigma is one of the greatest obstacles to tackling HIV across the world. The United States has done much to reduce this stigma; it makes no sense to perpetuate it in its own immigration policy. People with HIV are no less worthy of being citizens of the United States than anyone else. All we ask is to be able to visit, live and work in America and, for some of us, to realize our dream of becoming Americans -- whether we are HIV-positive or not.” (Carl Schmid)

Recently, The AIDS Institute, through its United Faith Action Network (UFAN), has partnered with Christian Connections for International Health (CCIH). Founded in 1987, the CCIH promotes networking among a broad range of Christian programs and individuals working internationally. Worldwide it has over 100 organizations members and many more affiliates. CCIH is committed to forming an information forum for sharing HIV/AIDS information among faith communities. The coalition provides resources in the form of annual conferences and a student mentoring program, to name but two. This past May The AIDS Institute's UFAN program conducted a workshop on global AIDS policy at the coalition’s annual international conference. For more information, check out the CCIH website at www.ccih.org.

In addition, The AIDS Institute’s UFAN program is working closely with The Rev. Dr. Carolyn Boyd, Director of Faith and Community-Based Outreach with Global AIDS Alliance (GAA). Dr. Boyd, who has been with GAA since February, and The AIDS Institute's Global Program Coordinator, James Sykes, will be aligning goals and interests by reaching out together to people of faith in a variety of settings. For more on the Global AIDS Alliance and the Office of Faith and Community Outreach see their website at www.globalaidsalliance.org.

(Brock Thompson)
Reverend Edwin C. Sanders, II

The Reverend Edwin C. Sanders, II, is the Senior Servant and Founder of the metropolitan Interdenominational Church, a congregation that has attracted a broad cross-section of people. Metropolitan has outreach ministries in the areas of substance abuse, advocacy for children, sexual violence, and harm reduction, in addition to providing services to persons infected with, and affected by, HIV/AIDS through the First Response Center, which Rev. Sanders founded in 1992.

Rev. Sanders is a graduate of Melrose High School in Memphis, Tennessee. In 1969, he received the Bachelor of Arts Degree in Anthropology from Wesleyan University in Middletown, Connecticut. He specialized in Cultural Anthropology, and his thesis was entitled, “The Black Church as a Revolutionary Institution.” Rev. Sanders’ professional life also began at Wesleyan, as Co-Director of the African American Institute, and he is a former member of the Wesleyan University Board of Trustees. He has done graduate study at Yale University Divinity School and as a special student at Vanderbilt University Divinity School. The opportunity to travel extensively throughout Europe and Africa was afforded Rev. Sanders as one of the first fellows of the Thomas J. Watson Foundation.

Until recently, Rev. Sanders served as Pastoral Counselor for the Meharry Medical College Alcohol and Drug Abuse Program in Nashville, Tennessee, where he was responsible for the spiritual component of all programs. This work was primarily built around the conducting of group and individual therapy sessions. Also in Nashville, Rev. Sanders has served as Director of the Southern Prison Ministry, and also as the Dean of the Chapel at Fisk University.

Rev. Sanders holds membership in the Nashville Branch of the NAACP, and the Interdenominational Ministers’ Fellowship (former President). He is a member of the Alcohol and Drug Council of Middle Tennessee, and has served as a Commissioner for the Tennessee Human Rights Commission. He is past Chairperson of the Ryan White Community AIDS Partnership, and is still an active member of the consortium. In April 1998, he was appointed to the CDC Advisory Committee on HIV and STD Prevention by Donna Shalala, then Secretary of Health and Human Services.

BACKGROUND
The Caribbean AIDS Telecommunications and Information Network (CATIN) was established in 1996 with resources from the US Centers for Disease Control and Prevention (CDC), The Canadian International Development Agency (CIDA) and the UK Department for International Development. Its role will be to provide critical health information on HIV / AIDS / STI’s to member countries and to coordinate and promote prevention and control programmes in conjunction with regional National AIDS Programmes (NAP) within each participating country.

GOAL
To improve the health status of participating countries through an increased awareness on the impact and prevention of Sexually Transmitted Infections / HIV and AIDS.

CATIN NETWORK
The network is currently operational in ten selected CAREC member countries namely Anguilla, Antigua and Barbuda, British Virgin Islands, Barbados, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, Guyana and Turks and Caicos The appointed CATIN team will provide leadership, focus and coordination for all health education / promotion efforts of STIs and HIV/AIDS programmes in the region. The network continues to expand to embrace ultimately all 21 CAREC member countries. COORDINATING AGENCY CAREC’s Special Programme on Sexually Transmitted Infections (SPSTI) serves as the coordinating agency and focal point for the Network. Its mandate will be to provide leadership, focus and coordination of the information support functions for health education and promotion efforts for the prevention and control programmes respectively.

CATIN Participating Countries
Anguilla, Antigua and Barbuda, Aruba, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Netherlands and Antilles, St. Kitts and Nevis, St. Lucia, St. Vincent, Surinam, Trinidad and Tobago, Turks and Caicos. (www.catin.org)
In the spring of 1998 he was a participant in the “Healthy 2000” Progress Review conducted by Dr. David Satcher, then United States Surgeon General. Rev. Sanders was a presenter at the 12th World AIDS Conference in Geneva, Switzerland, in the summer of 1998, and the 13th, in Durban, South Africa, in the summer of 2000, as well as speaking regularly for conferences and other forums throughout the United States regarding HIV/AIDS and substance abuse issues. Rev. Sanders serves on the Boards of Directors of the Black AIDS Institute, the National Center for Primary Care, The National Black Leadership Commission on AIDS, and The Drug Policy Alliance, and he is the National Coordinator for Religious Leaders for a More Just and Compassionate Drug Policy. In 2002, he was appointed by President Bush to serve on the Presidential Advisory Council on HIV/AIDS. Also in 2002, Rev. Sanders was a candidate for Governor of the state of Tennessee, finishing third out of a field of fourteen candidates.

He is married to Denise Billye Sanders and has three children: Edwin III, Grace Louise, and Joseph Wesley.

James Sykes

James Sykes, is currently Global Program Coordinator with The AIDS Institute. Prior to becoming Program Coordinator, he served as Assistant to the Executive Director. James also served as Community Educator and was responsible for developing and implementing capacity building programs for organizations participating in the Pfizer Southern HIV/AIDS Prevention Initiative. James has more than 12 years experience in the HIV/AIDS arena. He began his career in HIV/AIDS as Medical Educator for the Tampa AIDS Network where he developed and implemented a pilot project that focused on improving compliance to primary care with African American clients. Later, James became Director of Community Health Services for the Tampa AIDS Network. He served on the Minority Affairs, the Rural Issues, and the Health Services Committees of the local Community Planning Partnership.

Previously, James served as Manager of the Health Education Department for the National AIDS Education & Services for Minorities, Incorporated in Atlanta, Georgia. He also served as Chair of the Interventions Committee for the Georgia Statewide Community Planning Group.

Mr. Sykes holds a master of public health (MPH) degree in community health education and bachelor’s degree in biology from the University of Tennessee, Knoxville.
Outlining goals and possible activities to be included in WHO

On July 31, 2007, the IGWG released an initial draft of its plan

- Transfer of technology
- Establishing monitoring and reporting systems
- Ensuring sustainable financing mechanisms
- Promoting research and development
- Prioritizing research and development needs

While examining 8 elements of a draft plan of action:

1. Conditions affecting developing countries disproportionately
2. Planning of action on essential health research to address "neglected tropical diseases" in developing countries.
3. Access to drugs for diseases such as HIV/AIDS and other health care infrastructure in many developing countries;
4. The AIDs Institute expressed concern that the draft was developed without the involvement or consultation of all stakeholders – especially, patient groups whose constituents represent the beneficiaries of any plan.

In early November 2007, the IGWG held its annual meeting in Geneva where the delegates negotiated the specific elements discussed in the draft. Concurrent to that November meeting, the International Alliance of Patients’ Organization (IAPO), which The AIDS Institute is a member and was a participant, held a seminar on public health and intellectual property in Geneva to educate patient groups on the draft recommendations. On May 24, 2008, the IGWG submitted its final report with recommendations to the 61st World Health Assembly. The AIDS Institute, represented by James Sykes, Global Program Coordinator, working with representatives from other IAPO member organizations and non-governmental organizations who shared similar concerns over the draft plan of action, spent the week of May 18 in Geneva lobbying health ministers from member states to reject the draft plan of action. The AIDS Institute is pleased to report that our efforts to modify the plan were successful in that almost all of the issues related to trade practices, etc. that had no place in the process or was counter productive were considerably modified or eliminated.

The recommendation that the WHO take a lead position on patent review along with a number of related issue areas that, in our opinion, the WHO does not have competence nor the jurisdiction to address were removed, as well as, the issue of "AIDS exclusivity." We are also pleased that the member states voted in support of the recommendation that the WHO conduct mapping of each developing country to determine the true research and development needs – what are the barriers to existing medicines and products. It must be noted that not all of the issues in the draft recommendations were resolved by the conclusion of the Assembly. The WHO Director-General, Dr. Margaret Chan, is considering organizing an "expert working group" to address those eight (8) remaining issues and to report out at the 2009 meeting of the Executive Board of the WHO. For now, IGWG has formally concluded and The AIDS Institute looks forward to providing input into the composition, governance, and area of expertise of the expert panel as we look to the 61st World Health Assembly 2010.

(Transcript of remarks by James Sykes, Global Program Coordinator, AIDS Institute)
In adults aged 15-59 the death rate was 9.8 per 1000 person-years. Sixty-five per cent of deaths in this age group were attributable to AIDS, and 60% of AIDS deaths were in women. Prior to the introduction of antiretroviral therapy the probability of death in the 15-59 age group was 43%, and the lifetime risk of death from AIDS for a child born in the study district was 37%.

After the introduction of antiretroviral therapy all-cause mortality declined by 10% in those aged 15-59, and AIDS-related mortality declined by 19% (95% confidence interval 0.58 – 1.12). There was no corresponding decline in mortality in those aged 60 and over.

The decline in AIDS-related mortality was greatest in those who lived within 1km of the tarmac road running north-south through the district. AIDS-related mortality had also been higher in this area prior to the introduction of antiretroviral therapy (RR 1.91, 95% CI 1.49-2.48). All-cause mortality fell by 35% and AIDS-related mortality by 33% in this zone among those aged 15-59 (RR 0.65, 95% CI 0.46-0.92, and RR 0.67, 95% CI 0.44 -1.03 respectively).

Among those who lived in more remote areas there was almost no change in AIDS-related mortality after the introduction of antiretroviral therapy. Of those who started treatment, 73% lived within 1km of the road. The authors estimate that around a third of those in the district who needed treatment were obtaining it, and the $3 cost of transport to the clinic may have been a substantial impediment. The monthly average income was estimated at $23 in 2004.

Ninety-nine adults started antiretroviral therapy during the eight months it was available in the district, and twelve died after starting treatment; a further eight deaths were identified in adults who had obtained antiretroviral treatment outside the district. Overall 8% of AIDS deaths occurred in those who received ART, and data from the Malawian Ministry of Health’s monitoring of the treatment programme showed that at the Karonga clinic the risk of death was 25% in the first six months after starting treatment. Only 19% of AIDS deaths occurred more than three months after treatment started.

The authors acknowledge that the sensitivity and specificity of the ‘verbal autopsy’ method used in this study in which a health assistant questioned the relatives of the deceased about the cause of death, is lower than attribution of cause of death based on HIV status. However information about HIV status became more common after the introduction of antiretroviral therapy; 30% of those who died in the area near the road had been tested for HIV after treatment became available, compared to 19% previously.

Although not all reductions in mortality were statistically significant, the findings nevertheless show, say the authors, that AIDS deaths can be averted by the rapid scale-up of antiretroviral therapy in resource-limited settings. (Keith Alcorn, www.AIDSMap.com)

Reference

Death rate in Malawi Falls by up to 35% due to free HIV treatment

The death rate among adults in rural Malawi has declined by 10% since the introduction of antiretroviral therapy, and in areas with the highest death rate, it may have declined by up to 35%, according to findings from a London School of Hygiene and Tropical Medicine study published in the May 10th edition of The Lancet.

The study also showed a much higher death rate and lower treatment access among those who lived in more remote areas, suggesting that the chief gap in equity of treatment access is between those who live in rural areas and those who live in larger villages or close to highways, rather than along the lines of gender.

Free antiretroviral therapy began to be introduced in Malawi in 2004 with support from the Global Fund to Fight AIDS, TB and Malaria; by the end of 2006 just over 81,000 people had been enrolled on treatment, a substantial achievement in one of the poorest countries in Africa.

Prior to the introduction of free antiretroviral therapy in Malawi, males aged 15 had a 43% probability of dying before they reached the age of 60, and 63% of the deaths in this age group were attributable to AIDS. Adult HIV prevalence has stabilized around 14% over the past ten years.

Researchers from the London School of Hygiene and Tropical Medicine evaluated the impact of antiretroviral therapy on mortality in the northern district of Karonga, on the shores of Lake Malawi. The study utilized demographic data collected in the Karonga prevention study, a door-to-door census in 2002, and information on mortality from 230 population clusters followed up between 2004 and 2006.

Causes of death were established with a semi-structured questionnaire administered by a health assistant whenever a death occurred in each of the population clusters, which numbered 15-60 households each. Questionnaire results were then reviewed by three doctors and clinical officers to determine the most likely underlying cause of death. Antiretroviral therapy in the district became available in 2005 with the opening of a free clinic.

Results
Between 2002 and 2006, 916 deaths were recorded among a total population of 39,321 individuals followed for a total of 81,278 person-years.
**HIV/AIDS and Chronic Kidney Disease**

**What is HIV/AIDS?**

Human immunodeficiency virus (HIV) is a replicating virus or retrovirus that can lead to acquired immunodeficiency syndrome (AIDS). AIDS is a health condition that causes the immune system to fail, which leads to a number of life-threatening infections and complications. HIV is transmitted when infected body fluid such as blood, semen, vaginal fluid and breast milk come into contact with a mucous membrane or the bloodstream of another person. While HIV and AIDS medicines help slow the progression of the virus, there is no cure for HIV or AIDS.

**How does HIV/AIDS affect the kidneys?**

HIV-related kidney problems are commonly known as HIV-associated nephropathy (HIVAN). Up to 30 percent of people with HIV or AIDS have protein in their urine, a sign of abnormal kidney function, and about 10 percent of people with HIV develop kidney disease. This means HIV patients make up 1 to 2 percent of the end stage renal disease population.

Renal problems related to HIV can be caused directly by the HIV virus when it enters the kidneys and multiplies or by the medicines patients must take to manage HIV. Highly active antiretroviral therapy (HAART) and other HIV treatments have side effects that can sometimes be toxic to the kidneys, including:

- lactic acidosis — a build up of lactic acid in the body
- crystal-induced obstruction — a build up of crystals in the kidneys
- interstitial nephritis — a disorder in which tissues surrounding the kidneys become inflamed
- electrolyte abnormalities — abnormalities in the body's levels of sodium, potassium or calcium

**Getting tested for chronic kidney disease (CKD)**

Most chronic kidney disease symptoms show up only after a large part of your kidney function has been lost. These symptoms can include leg or facial swelling, changes in urination, fatigue and loss of appetite. Because CKD symptoms can be confused with other health problems, it’s often difficult to quickly diagnose kidney disease. The most common test to see if the kidneys are working like they should is a urine test where a dipstick is used to check levels of protein, sugar, ketones, blood, nitrites and red and white blood cells. Nearly one-third of all people with HIV have high levels of protein in their urine, which can be a sign of possible kidney trouble. If protein is detected, your doctor may order more detailed kidney tests such as blood urea nitrogen (BUN) or creatinine clearance tests.

A BUN test is a blood test that checks for nitrogen in the blood. Nitrogen is produced by the body when protein is metabolized. Since nitrogen is normally removed from the body by healthy kidneys, high levels of nitrogen in the blood can mean the kidneys are not working as they should. A creatinine clearance test is a combination of a blood test and a urine test that measures the kidneys’ ability to get rid of waste. Creatinine is created by the body when muscle is broken down. If this test shows low levels of waste in the blood and urine, it may mean the kidneys are not working like they should. (continued on page 15)

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**Why Older Adults Need HIV Prevention: The Ignored Population**

According to the Centers for Disease Control and Prevention (CDC), there has been an increase in the number of individual’s aged 50 years and older living with HIV/AIDS. In 2005, the CDC reported that persons aged 50 and older accounted for 15% of new HIV/AIDS diagnoses and 24% of persons living with HIV/AIDS. The later is an increase from 17% in 2001. The increase in data suggests a significant impact in this vulnerable population that is twofold: individuals living with HIV/AIDS over 50 who are aging with the disease and individuals over 50 at risk of contracting HIV infection.

Potential risk factors including sex, drug use, lack of knowledge about HIV/AIDS, race and ethnicity increase the risk of infection of HIV for persons over 50 years of age. However, many of the same risk factors for HIV infection are true for younger persons as well. People over 50 also experience similar social barriers including ageism, stigma, discrimination, misinformation of knowledge about HIV/AIDS, misconceptions, underestimation of risk, misdiagnosis which create additional challenges with being infected with the disease.

The treatment needs of the older adult and aging population are often unique. Adding the complex healthcare needs of an individual living with HIV/AIDS creates more challenges. Upon review of the literature, The AIDS Institute (TAI) identified that there are minimal resources geared towards this growing and vulnerable population. Therefore, TAI encourages the development of prevention and intervention programs that creatively address the needs of this target population. In addition, TAI emphasizes the need for continued future prevention, intervention, medical and social research for older adults. By heightening awareness around the prevention and intervention efforts, the goal is to keep older adults from becoming infected. The call for increased medical research draws attention to implementing future strategies to meet the unique needs of individuals living with disease.

(Michelle Scavnicky)

Reference:
The Center for Disease Control and Prevention (CDC).
Persons aged 50 or older. Retrieved from http://www.cdc.gov/hiv/topics/over50/
Treatment for chronic kidney disease (CKD)

HIV-positive patients who have or are at risk for chronic kidney disease should have their treatment tailored to their needs and circumstances. Some treatments for chronic kidney disease include managing phosphorus levels, reducing blood pressure, managing fluid balance and/or antiretroviral therapy. The six classes of antiretroviral medications approved by the Food and Drug Administration are: Nucleoside reverse transcriptase inhibitors (NRTIs), Non-nucleoside reverse transcriptase inhibitors (NNRTIs), Protease inhibitors (PIs), Entry inhibitors, Fusion inhibitors and Integrase inhibitors.

- Nucleoside reverse transcriptase inhibitors (NRTIs) bind to and disable reverse transcriptase, a protein that HIV needs to make more copies of itself.
- Non-nucleoside reverse transcriptase inhibitors (NNRTIs) create faulty versions of building blocks that HIV needs to make more copies of itself. When HIV uses one of these faulty building blocks instead of a normal building block, reproduction of the virus is stalled.
- Protease inhibitors (PIs) disable protease, a protein that HIV needs to make more copies of itself.
- Entry inhibitors work by blocking HIV entry into cells.
- Fusion inhibitors work by blocking HIV entry into cells.
- Integrase inhibitors disable one of the proteins that HIV uses to insert its viral genetic material into the genetic material of an infected cell.

HIV-positive people with end stage renal disease (ESRD) who are on dialysis may want to consider a kidney transplant. Doctors can help HIV-positive patients with chronic kidney disease and end stage renal disease determine a treatment regimen that manages both HIV and kidney disease.

Summary

People with HIV or AIDS are at risk of developing kidney disease because of the progression of the AIDS virus and the side effects of the medicines they may be taking to slow this progression. There are several questions HIV- or AIDS-infected people can ask their health care providers about chronic kidney disease (CKD) to help detect kidney problems or health risks early. These questions include:

- Should I be tested for kidney disease?
- What kind of test would be best for me?
- Will my HIV treatment change if I have kidney disease or am at risk for kidney disease?
- How often should I have my kidneys tested to make sure they are healthy?
- What can I do to decrease my risk for kidney disease?

(www.davita.com)

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BACKGROUND

Policies purporting to assist women who are made vulnerable by gender inequality are failing to address the nuanced dynamics that result in increasing rates of violence against women and HIV&AIDS.

- UNHCR has documented 24 suicides of Bhutanese women in refugee camps in Nepal since 2001, four times the suicide rate in the local population. They point to the emphasis on “family reconciliation” in dealing with domestic violence, as a possible driving factor.
- In an interview with the Center for Public Integrity, the Commission of Women Victims for Victims (KOFAVIV) in Haiti stated, "ABC works in a context where women are able to exercise their sexual rights, but women in Haiti are victims of a wide range of violations. Many of the victims of KOFAVIV who are HIV-positive contracted the virus through rape."
- The US government has failed to address racial disparities in HIV&AIDS. Though African American women and Latinas only comprise 25% of the population of women, they make up 81% of women living with HIV&AIDS.
- Because rape and sexual violence were so rife during the war, Sierra Leone has seen a sharp rise in cases of HIV&AIDS and other sexually transmitted infections. According to UNAIDS, of the 170,000 people between the ages of 15 and 49 estimated to be living with the virus in Sierra Leone in 2001, some 90,000 were female. Yet UN agencies and national governments have failed to provide proper measures to address the widespread practice of using women and girls as weapons of war.

The interlinked pandemics of violence against women and girls and HIV&AIDS affect thousands of women worldwide. Though more research is needed, it is clear, from the studies that have been done and from the experiences of women with whom ActionAid works in 49 countries, that these pandemics are mutually exacerbating. Women who are HIV positive are more likely to experience violence and women in violent situations are more vulnerable to risk of HIV infection.

(continued on page 16)
STRATEGY
Globally, ActionAid addresses women’s rights through supporting direct service and advocacy initiatives towards, women’s political participation and decision making, economic empowerment including land rights, food rights, right to education, universal access to prevention care, and treatment of HIV&AIDS, etc. In the US, given the political positioning of the US government, ActionAid USA focuses primarily on policy change. ActionAid promotes progressive policies and seeks to eliminate damaging policies, as it relates to women’s rights by working with women’s groups worldwide to ensure that policies and programs that national governments, as well as bilateral and multilateral entities such as the UN agencies, are accountable to women, with a focus on violence against women and HIV&AIDS.

ActionAid advances policy change by implementing a multifaceted program which is comprised of four primarily foci: 1) Working with women’s groups to increase capacity and political influence of most affected persons to speak truth to power. 2) Educating, mobilizing, and organizing the US public so that there is a broader base of support for the truth telling and demands of the most affected women. 3) Conducting research and policy analysis to establish the evidence base for the need for policy reform regarding violence against women and HIV&AIDS and the multiple driving factors of the pandemics. 4) Educating policy makers and practitioners based on the experiences and demands of the most affected women as well as results of the research and policy analysis.

ACTIVITIES
Between June and August, ActionAid will be engaged in advancing these objectives through the following activities:

Women of Color and Climate Change Organizing Retreat (June 6-9)
Hosted by Movement Generation for Change, ActionAid will be bringing the connections to global social movements to this critical conference which will examine the differential impact of climate change on women of color and develop an action plan for activists. Climate change affects both violence against women and HIV&AIDS in multiple ways including differential vulnerability for women in situations of insecurity caused by disaster, as well as a multitude of other ways including deteriorating access to food and economic degradation.

UN General Assembly Special Session on HIV&AIDS (June 10-11)
- Release of research and policy analysis report: “Tackling Violence Against Women and HIV&AIDS: Multi-Driver Pandemics Demand Comprehensive Solutions”
- Hosting an organizing convening of women of color from the US with women from the global south to discuss common causes and common solutions for violence against women and girls and HIV&AIDS.
- Media campaign featuring placement of interviews live from UNGASS on various radio programs, as well as blogging, to use this event as a platform hook with the media to raise awareness of VAWG and HIV&AIDS in the general public.

UN Division on Economic and Social Affairs Convening on Aid Effectiveness (June 12-13)
- ActionAid is working with CIVICUS on coordinating civil society engagement in developing a framework/infrastructure for monitoring, assessing and improving models of conducting aid programs, such as initiatives addressing HIV&AIDS and violence against women and girls.

Racism and Globalization Conference (June 27-29)
Whether it is Dalit women in India, Indigenous women in Guatemala, Black Women in South Africa, Afro-descendant women in Brazil, or a variety of women of color groups in the United States, worldwide, race, ethnicity, indigeneity, or country of birth impacts one’s social, economic, and health status. At this conference ActionAid will join with hundreds of activists to strategizing on addressing how globalization is exacerbating these dynamics with special attention on how this increases risk for women.

Accountability to Women Project Training and Strategy Session (July 21-25)
ActionAid programs in the United States, Sierra Leone, India, Malawi, Nepal, and Haiti are collaborating to implement a model program for engaging civil society groups of women to conduct policy impact monitoring and budget tracking of public and private financing that purports to address violence against women and HIV&AIDS. In July, we will be taking stock of the baseline research which has been done and developing a 3 year plan that has the aim of having an institutionalized infrastructure for civil society engagement in assessing the effectiveness of financing for gender equality.

International AIDS Conference and Ecumenical Advocacy Alliance Pre-Conference (July 31-August 8)
- At these conferences ActionAid will be presenting four workshops: Emerging Technologies for HIV Prevention, Male Involvement in Violence Against Women and Girls and HIV&AIDS Programming, Linking Black American Churches with Churches in Africa and the Caribbean to Address VAWG and HIV&AIDS, and Women of Color United: A Model for Linking Women of Color in the US with Women in the Global South to Address VAWG and HIV&AIDS.
- ActionAid and UNIFEM are co-launching a Joint Report: Promising Practices: A Review of Programs Addressing the Intersection of Violence Against Women and Girls and HIV&AIDS.
- Media campaign featuring placement of interviews live from IAC on various radio programs, as well as blogging, to use this event as a platform hook with the media to raise awareness of VAWG and HIV&AIDS in the general public.

Democratic National Convention (August 25-28)
- ActionAid and Women of Color United: A Coalition to End Violence Against Women and HIV&AIDS are collaborating on the 41 Million Strong Campaign which engages the political power of women of color in the US to ensure violence against women and HIV&AIDS are issues on the agenda for Election 08 and beyond. At the DNC (and at the RNC in September) the campaign will be tabling with materials and also work to ensure that a critical mass of women of color are present at both conventions to represent the VAWG and HIV&AIDS related demands of women worldwide for attendees at both conventions who are actively engaged in advancing agendas for the next administration.
- Media campaign featuring placement of interviews live from the DNC on various radio programs, as well as blogging, to use this event as a platform hook with the media to raise awareness of VAWG and HIV&AIDS in the general public. (continued on page 17)
WHAT CAN YOU DO
Please visit ActionAid’s website www.actionaidusa.org where you’ll find many ideas and tools for you to become engaged in efforts to advance women’s rights in the US and globally. On the website you can:

• Find 41 Million Strong Campaign materials you can use such as the Voter Registration/Get Out the Vote Toolkit, or our Side By Side Comparison of Presidential Candidate Positions on Issues Surrounding Violence Against Women and HIV&AIDS.
• Read articles/research as well as read about the work of ActionAid in addressing violence against women and girls and HIV&AIDS.
• Sign up on the mailing list to receive information updates and action alerts.
• Find actions you can take such as sending a letter to your editor, making a phone call, setting up an in person visit, or writing to your congressional representative etc

Our website is still under development so for information on items referenced above that have yet to be posted, please write to womensrights@actionaid.org and someone will respond promptly with the requested information. (Guest Writer: Jacqueline Patterson, Women’s Rights Policy Analyst with ActionAid USA)

STATE ROUNDUP

SOUTH CAROLINA
Money Allocated to Treat HIV/AIDS
S.C. Lawmakers OK $2.4 Million for Drug Assistance

For the second year in a row, lawmakers have approved new funds to provide lifesaving medicines for people with HIV/AIDS who have little or no income or health insurance. The $2.4 million allocated to the mostly federally funded AIDS Drug Assistance Program run by the health department follows a $4 million allotment last year. “I made it through (a period of sickness) because of what you have done. I got the medications I needed,” Deandra Lawson Smith, who has been living with HIV for 20 years, told lawmakers Wednesday. The money will help stave off a waiting list like the one that grew to 567 people after federal funding cuts last year. The program again faces federal cuts and rising costs.

In the long run, spending money to keep people healthy helps save the state billions. An economic impact study by infectious disease specialist and researcher Dr. Kent Stock showed that in 2002, HIV/AIDS cost South Carolina $6.5 billion in treatment and lost wages. People who are healthy can work and contribute to the state’s economy. In addition, HIV medications lower the risk that an infected person will pass the disease on to others. “We have finally, as a state, come to grips with HIV/AIDS and are willing to put resources to stem the spread of this disease,” said Rep. Joe Neal, D-Richland, who has championed efforts in the State House to fund HIV prevention and treatment.

The state’s contribution has risen sharply from 5 percent of the drug program’s budget in 2007 to 19 percent, a figure closer to — if less than — what neighboring states provide for their programs. “In all honesty, we had a lot of catching up to do,” said Dr. Helmut Albrecht, chief of Infectious Diseases at USC School of Medicine. “This is just bringing us up to where we should be.”

About 100 people a month apply for help from the drug program, said director Sonya Bayone. Higher drug prices, new national recommendations that people with HIV start treatment sooner, and increased efforts to get people tested for HIV all have contributed to rising costs for the drug program. About 800 South Carolinians a year are diagnosed with HIV/AIDS, and for the last 10 years, the state has ranked in the top 10 among all states for HIV infection rates.

(continued on page 18)

WEBSITE OF THE MONTH

www.sfaf.org

Established in 1982, the San Francisco AIDS Foundation is one of the oldest and largest community-based AIDS service organizations in the United States.

The mission of the agency is to end the pandemic and the human suffering caused by HIV. The AIDS Foundation works to achieve that goal by providing direct services to thousands of people living with or at risk for HIV/AIDS, supplying information about HIV treatment and related issues, promoting HIV prevention and awareness in the community, and advocating for sound HIV/AIDS policies at all levels of government.

SFAF Provides:
Services for Clients
Education and Information
Advocacy and Public Policy Efforts
Global AIDS Programs

(continued on page 18)
The S.C. HIV/AIDS Care Crisis Task Force — a group of community organizations, people living with HIV/AIDS, physicians, pharmaceutical representatives and health officials — formed in 2006 to educate lawmakers about HIV in South Carolina and press for money to end the waiting list.

The group already is looking past its current success to the next needs, including increased demand as testing initiatives around the state identify more HIV-positive people. “There are (Chamber of Commerce) initiatives talking about going from ‘Good to Great.’ What that requires is a healthy work force,” said Bambi Gaddist, executive director of the S.C. HIV/AIDS Council.

“A health agenda is important for economic stability. In the past, we have left HIV off. It’s important that we place HIV on that health agenda.” (By Czerne M. Reid, www.thestate.com)

UTAH

Records Show State-Mandated HIV Testing of Prostitutes and Clients is Sporadic

Latisha Patwardhan enters court at the Matheson Courthouse in Salt Lake City during her preliminary hearing on prostitution charges March 13. The charges were enhanced because she is HIV-positive. Latisha Patwardhan's latest prostitution bust raises a troubling question: How long was she working while HIV-positive?

Although state laws require testing for anyone who buys or sells sex, the answer isn't clear. Patwardhan first was convicted of sexual solicitation in 2002, just months after her 18th birthday. She was diagnosed as HIV-positive in 2007 through a screening ordered after her fourth solicitation bust - five years and three convictions after her only other test on record.

Now the 23-year-old is awaiting sentencing for her sixth conviction - one of just two prosecutions statewide for soliciting with HIV in the past five years.

The rarity of such cases may have to do with the rarity of the crime. But a review of court records and procedures shows inconsistencies in execution, record-keeping and communication among criminal justice and health agencies charged with enforcing Utah's stringent laws on prostitution and HIV.

Falling through the cracks

Public health departments have committed substantial resources to conducting court-ordered HIV tests since 1993, when state law made them mandatory for all convicted sex workers and johns.

"We almost need a full-time person to do this and make sure people don't fall through the cracks," said Lynn Beltran, STD and HIV program manager for the Salt Lake Valley Health Department. "Last month, we ended up doing about 20 . . . and I'm quite sure there are way more at times."

Beltran estimated solicitation is in the background of one-fifth to one-fourth of those who account for new HIV cases in recent years. There were 97 last year in Salt Lake County. Salt Lake City police, who handle most of the county's solicitation cases, have a total of 14 positive results on file for past offenders. In many cases, it is not clear whether the test is ordered at all. In nearly 40 percent of solicitation and prostitution convictions handled in state courts in 2006 and 2007, there is no record of HIV tests being ordered, read by a judge, or filed, court dockets and case files indicate. Among those cases are two solicitation convictions Patwardhan incurred before the 2007 case where a HIV test was ordered - one in 2004 and one in 2006. Patwardhan declined to comment. "I don't know if it necessarily is always implemented," said Salt Lake City prosecutor Sim Gill.

More diligence is needed

When a test is administered, the fate of the result is not always clear. Vice officers in the Salt Lake City Police Department say they receive the results from prosecutors and file them to screen for future cases. However, a vice sergeant said he noticed last year that the department had received no HIV test results for three years. "I called the prosecutor's office, and a week later we got a notification," said the sergeant, who asked that The Tribune not name him because he is involved in undercover operations. The result the sergeant received was Patwardhan's. Gill said he believed police agencies were collecting results independently from the courts but added his office in recent weeks began to keep a databank of positive HIV results for their own reference. There has been one positive result since the office began collecting data in mid-March. "We need to be much more diligent on it," Gill said. Even when the results make their way to the police department, other factors stand in the way of their use in future cases. Aliases are common among sex trade offenders - typically transients whose lives seldom require them to commit to an identity, the sergeant said. "We have some prostitutes with 10 different names," he said. Also, a positive HIV result stays within whichever police department handled that case. If an offender leaves that jurisdiction and is arrested elsewhere, there is no way to know about or access that record, the sergeant said. "There's a breakdown in making sure there is a centralized database [by] which law enforcement can gather that information," Gill said.

Treating vs. punishing

Ultimately, Beltran said, HIV-enhanced prosecutions are most effective not because they necessarily deter infected offenders, but because the law requires HIV counseling and drug treatment for felony prostitution convictions. While offenders receive a half-hour session on HIV prevention at the time of their tests, and while rehab may be ordered in any prostitution or solicitation case, offenders typically need more intensive help to reverse whatever led them to perform sex acts for $20. "There is a strong intersection with drug addiction: . . . mental health issues, a lack of other options, a lack of skills. A lot of the research shows a lot of the women have had their sexual boundaries violated at some point, usually during childhood," Beltran said. "We don't have the funding to . . . enroll that person in a lengthy program." The irony, Gill said, is that the cost of treating most prostitution and solicitation offenders is less than the cost of punishing them. "We're talking about a criminal justice response to what is otherwise a public health issue," he said. "Where we introduce a nonjudicial intervention, we're going to be dollar-for-dollar much farther ahead."

(By Erin Alberty, The Salt Lake Tribune)
DISTRIBUTION OF COLUMBIA

More Money for Needle Exchanges With Congressional Ban Lifted, City to Provide Funding

Needle-exchange efforts in the District will expand significantly by summer as $494,000 in city funding -- the first local appropriation allowed in a decade -- begins flowing to four organizations on the front line of the fight against HIV/AIDS.

Last summer, Congress lifted a ban prohibiting the city from spending its tax dollars to provide drug addicts with clean needles, an approach that jurisdictions across the country have taken to stop the disease’s transmission through shared, potentially contaminated syringes. No other city or state faced the same restriction, which dated to 1998. More than half the money will go to PreventionWorks!, the sole group involved in such work during the ban, often despite tenuous private funding. It now will expand outreach to include more comprehensive disease screening of the people served through its mobile van.

Shannon Hader, director of the city’s HIV/AIDS Administration, said yesterday that the other nonprofit groups that were awarded grants bring “three very different” approaches to the initiative. Those recipients are Helping Individual Prostitutes Survive (HIPS), whose focus is men and women engaged in sex work in the District; Bread for the City, which assists the poor and homeless with a range of programs; and the Family Medical and Counseling Service, a more traditional health care provider in Ward 8. Each will build on the work it does with intravenous drug users, Hader said. The grants are expected to double next year and be continued through 2010. The District’s rates of HIV and AIDS infection are among the worst in the country, with intravenous drug users accounting for a sizable portion of new cases annually. (By Susan Levine Washington Post)

GLOBAL ORGANIZATION OF THE MONTH

www.pancap.org

PAN CARIBBEAN PARTNERSHIP AGAINST HIV/AIDS

PANCAP was established at the February 2001 Meeting of the CARICOM Heads of State and endorsed by the Nassau Declaration on Health 2001. PANCAP Member Countries are: Anguilla, Antigua & Barbuda, The Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, Netherlands Antilles, Puerto Rico, St. Kitts & Nevis, St. Lucia, St. Vincent & The Grenadine, Suriname, Trinidad & Tobago, Turks & Caicos Islands, US Virgin Islands.

The Partnership aims to scale up the response to HIV/AIDS in the region. Its specific mandate is:

• To advocate for HIV/AIDS issues at government and highest levels
• To coordinate the regional response and mobilize resources both regional and international
• To increase country-level resources, both human and financial, to address the epidemic

The PANCAP Structure has four (4) Elements:

• The PANCAP Membership,
• A Steering Committee
• A Coordinating Unit
• Technical Working Groups

The Partnership is tasked with supporting the priority areas of action specified in the Regional strategic Framework. The Membership includes; Member countries, UN agencies, bilateral and multilateral organizations, regional and international organizations, networks of people living with HIV/AIDS, academic institutions, the private sector, and faith-based organizations. The PANCAP Coordinating Unit (PCU) is the Secretariat/Coordinating Unit of PANCAP. It is located at the CARICOM Secretariat in Georgetown, Guyana and supported by PANCAP partners.

Project activities of the PCU include resource mobilization, coordination, advocacy, a Law, Ethics and Human Rights Project to develop and revise national policies to promote human rights and non-discrimination practices for persons infected and affected by HIV, and a project to promote information sharing among partners. To read more about PAN Caribbean Partnership against HIV/AIDS (PANCAP), please go to: http://www.pancap.org

STAFF AND BOARD

IN THE NEWS

Ivy Turnbull, Board Member - Has been admitted to the doctoral program in Law and Public Policy at Northeastern University in Boston, MA. She has also been selected for the Johnson & Johnson/UCLA Anderson School of Management - Health Care Executive Program that is co-sponsored by HRSA. The program is scheduled for June 22-July 3, 2008

The AIDS Institute has been selected as a program partner for the 2009 National HIV Prevention Conference, organized by the Centers for Disease Control and Prevention (CDC), to be held in Atlanta. This will include agency participation in the conference planning process.

Dr. Copello, Executive Director - has recently received two appointments. He is serving as co-chair of the Healthcare Reform Task Force of the National Physicians Alliance. In addition he was appointed as a member of the Campaign for Public Health Advisory Council. The Campaign for Public Health promotes awareness about the need for programs and services provided by the Centers for Disease Control and Prevention (CDC). It will be hosting a visit of Senate offices to the CDC in June in which Dr. Copello will participate.

David Reznik, DDS, Board Member – Published a CME presentation for The International AIDS Society-USA Cases on the Web (COW) called Managing Oral Health Problems in People with HIV Infection. It can be viewed at: http://www.iasusa.org/cow/cow-instructions.php?coid=91
GET INVOLVED - We Want To Hear From You!
Let us know what you think about ActionLink Journal.
The AIDS Institute is here for you! Is there a topic you want to see?
Article to suggest? Just want to share your opinions on the journal?
Please email us at ActionLink@theaidsinstitute.org with your comments and
your thoughts will be sent directly to our editors. Thank you!

Registration: Sign up for USCA 2008

The United States Conference on AIDS (USCA), set for September 18-21,
2008, at the Fontainebleau Hotel, in Miami Beach, Florida, is an event that
you cannot miss. This is the largest AIDS-related gathering in the United
States. Over 3,000 workers representing all fronts of the HIV/AIDS
epidemic—from case managers and physicians, to public health workers
and advocates, PLWHAs to policymakers—come together to build national
support networks, exchange the latest information and learn cutting-edge
tools to address the challenges of HIV/AIDS.

For more information, visit www.nmac.org

Inside the
next issue:
Upcoming Events at the
2008 International AIDS
Conference in
Mexico City