Is an HIV vaccine still important?
An overview
Spring always brings a feeling of renewal and energy. The month of May provides us with ample opportunities to renew ourselves in the battle against HIV/AIDS and related health concerns. This month we reflect on successes and ongoing challenges through awareness days dedicated to the Asian and Pacific Islander community, HIV vaccines, and hepatitis. You will find information on these themes in this issue of ActionLink. Likewise, you will read about the ongoing preparations for a Campaign to End AIDS (C2EA) caravan and several news items on the domestic and global front. Sometimes we hear that the AIDS movement is stagnant or complacent. That may be the case. But our challenge is to break through the stagnation and the complacency. May is a great month, with so much happening, to make the break through - even if only by taking a few steps. Attend one of the awareness day events, write your congressional delegation, send an email to the presidential candidates, volunteer locally, and share the importance of ending AIDS with a relative and the list of examples goes on. Wishing all of our readers high energy and a sense of renewal in our battle to end AIDS and promote a healthier world. May is a glorious month to think, feel, and take action.

A. Gene Copello

Important Dates and Activities in May

May - Hepatitis Awareness Month (World Wide)
May 11 – 17 - National Women’s Health Week
May 18 – AIDS Candlelight Memorial
May 18 - HIV Vaccine Awareness Day
May 19 - National Asian & Pacific Islander HIV/AIDS Awareness Day
May 19 – World Hepatitis Day (World Wide)
The annual Candlelight Memorial is a program of the Global Health Council, the world’s largest alliance of organizations and professionals involved in global health. Occurring the third Sunday every May, the Candlelight is among the oldest grassroots mobilization campaigns for HIV/AIDS awareness in the world and is led by coordinators, who host memorials for their communities. Since it began in 1983, the Candlelight Memorial has honored those who have been affected by the AIDS pandemic.

Candlelight Advocacy Platform
The Candlelight Memorial is committed to ending HIV/AIDS by raising awareness and advocating for the advancement of effective policies at all levels. The program has identified the following key issue areas as its platform around which it cultivates community advocacy through its events and activities:

- **Reducing Stigma & Discrimination**
  Communities around the world affected by the HIV/AIDS pandemic, particularly people living with the disease and other marginalized groups, often face debilitating social stigma and discrimination simply because of their association with the virus. The Candlelight Memorial urges leaders to fight discrimination through protecting the rights of affected groups and individuals, and fostering an inclusive human environment of both support and opportunity.

- **Ensuring Access to Treatment, Prevention & Care**
  Poor or marginalized communities have little access to basic AIDS services. The Candlelight Memorial urges leaders to ensure communities equal access to treatment (such as testing and anti-retroviral therapy); evidence-based prevention (such as education and condoms); and care and support (such as counseling and hospice). This requires meeting the needs of orphans and vulnerable children, strengthening public health systems, and vaccine development.

- **Increasing Resources for HIV/AIDS, Malaria, Tuberculosis and Other Related Issues**
  The needs of communities affected by HIV/AIDS by far outpace the current resources allocated to meet them. The Candlelight Memorial urges leaders to fulfill their commitments to adequately address the scope and depth of AIDS, including other burdens accompanying or enhancing its spread such as TB, malaria, sexually-transmitted diseases and opportunistic infections, and other contributing social and economic challenges.

- **Promoting Greater Involvement by Affected Communities**
  Affected communities by HIV/AIDS are often neglected in the decision-making processes that aim to assist them in the first place. The Candlelight Memorial urges leaders to incorporate the voice of affected communities in the formulation of policy, as well as in the design and implementation of programs. Their experience and opinions are essential to the global dialogue about the disease. This includes promoting the empowerment of women and youth. (Global Health Council)
Is an AIDS vaccine still important? This question has come up frequently in recent months—in large part because of a series of disappointing setbacks in HIV prevention.

Last September, Merck & Co. and its collaborators, the National Institute of Allergies and Infectious Diseases (NIAID) and NIAID’s HIV Vaccine Trials Network (HVTN), announced that it would halt immunizations in STEP, the efficacy trial of Merck’s MRK-Ad5 vaccine candidate. The decision to halt the trial was made after an independent data and safety monitoring board (DSMB) looked at initial data and found that there was no difference between vaccine and placebo recipients, either in terms of viral load set point or in terms of rates of HIV infection.

Even though the trial halted early, it was a success in the sense that it provided a quick, clear answer about whether the vaccine worked. However, it was deeply disappointing that the vaccine did not work. After further data analysis were completed, there was the even more upsetting finding that the vaccine appeared to have increased risk of HIV infection among some vaccine recipients. (The vaccine itself did not cause HIV. No vaccines being tested can cause infection.)

The vaccine’s failure was met with great consternation and it triggered strong debate. There have been “Monday morning quarterbacks” who said that Merck’s candidate vaccine was predestined to disappoint, and there have been a range of calls for reinvigorated discussions about how the search for an AIDS vaccine should proceed. As part of this, some scientists said it was time to move away from large-scale clinical trials testing experimental vaccines in humans and toward more fundamental basic research to understand better the basic biology of the virus and its effects on the human immune system.

Much of this debate has been invigorating. But it has also generated some false dichotomies, like the “either/or” proposition of whether to keep on doing trials in humans versus returning to basic science. The reality is that the field should proceed using the combined strengths of basic science, animal studies and human trials to guide and shape its scientific strategy. Some naysayers called for the dismantling of the vaccine field altogether and would like to see the money spent instead on treatment and care for people with HIV. To this, vaccine supporters say, again, the false dichotomy of “either/or” is dangerous, and funding for vaccine research does not supplant research for treatment or other prevention areas. And if vaccine research funding was indeed pulled, there is no assurance that it would be redirected to care and treatment implementation.

There are also those who say it’s just not possible to make an AIDS vaccine—that the HIV virus is too smart and wily to ever outwit. We say these critics are speaking too soon. Here are some specific points to address these criticisms and answers to the question, “Why should the search for an AIDS vaccine continue?”

Because science says it’s possible
There are compelling lines of evidence that an AIDS vaccine is possible. For example, there are examples of humans infected with HIV who maintain viral loads at or below the limits of detection for many years without taking antiretrovirals. This small group of “elite controllers” suggests that it may be possible for the immune system to reach what Jonas Salk, discoverer of the polio vaccine, called a “peace treaty” with these viruses.

Research is ongoing around understanding the immune responses at work in elite controllers. We don’t have the answers, but we do have this intriguing evidence that tells us some people, through a combination of immune responses, genetic factors and other variables that we don’t yet understand, can control the virus on their own. This is one reason to hope that a vaccine is possible, even if it may be a long way off.

In addition, highly exposed, persistently seronegative individuals, like commercial sex workers who have been studied in Kenya, remain HIV negative over many years, despite repeated exposures. There are also infants born HIV negative in spite of in utero exposure, and infants who do not get infected during breastfeeding—all in the absence of antiretroviral treatment. Here, too, there is a suggestion that the body is defending itself successfully against infection.

One major question today is: what are the immune responses and other factors which provide this type of protection? Answering this question can help guide the design of more effective vaccine candidates. Today there are a range of studies underway to understand protective immune responses and the events that happen very early in HIV infection.
Because the epidemic demands it
An AIDS vaccine is too important to give up on. Right now, tens of millions of people are at risk of becoming infected with HIV. The history of other epidemic diseases like smallpox and influenza tells us that an effective vaccine is an essential tool to quelling the epidemic. The first AIDS vaccines to show benefit may not look much like the highly-effective smallpox vaccines. They may slow disease progression instead of preventing infection. But they’re still a potentially powerful tool. As much as the epidemic demands that the search continue, it also demands that we do more to implement proven prevention strategies including male and female condoms, STI treatment, clean needles, risk reduction counseling, prevention of parent-to-child transmission and HIV treatment. These tools, which we have today, are still not available to the vast majority of those who need them.

This is a top priority given the epidemic today
There are more than 4 million new infections every year. In South Africa, where three of this year’s HIV prevention trials (looking at vaccines, microbicides and the female diaphragm) have taken place, there are communities where nearly one-third of women between 25 and 29 are infected with HIV. In the United States, the rates of new HIV infections in young men who have sex with men (MSM) of color are comparable to those seen in the hardest hit developing countries. And for every one individual who starts on life-saving antiretroviral medications, there are six others who are newly diagnosed. These are mind-numbing, tragic figures. They remind us that there is only one viable answer to the question—"What do we do now?"—that has been posed by many observers inside and outside of the HIV prevention field in recent months.

To abandon prevention research is unthinkable and unconscionable. We must do more of everything, including improving the access to existing proven prevention strategies, such as male and female condoms, clean needles, prevention of mother-to-child transmission (PMTCT) and risk-reduction counseling. In December 2006, we learned that male circumcision showed strong protective benefits for HIV negative heterosexual men. This strategy must also be made available in communities where it can have an impact. At the same time, we must also do more to bring comprehensive care, treatment and support to people already living with HIV worldwide.

Because of what history tells us about vaccines
Will an AIDS vaccine be possible in the next ten, twenty, thirty years? In the lifetime of a physician who saw the first AIDS cases on the wards in the 1980s? Maybe not. Or in the lifetime of an infant born today, perhaps one who is protected from HIV infection through the use of antiretrovirals for PMTCT? We hope so. We wish the time horizons were shorter and hope we will figure out how to abbreviate them in the future. In the meantime, we must be as clear about the long haul of this endeavor as we are about its merit. Looking across the world at rates of new infections and at the human costs and dismal coverage of proven prevention strategies, we will say: We need an AIDS vaccine, no matter how long it takes.

Historically, it has taken decades—and more setbacks than advances—from the discovery of a virus or bacteria until an effective vaccine is licensed. Typhoid was discovered in 1884, but there was no vaccine until 1989. Malaria, discovered in 1893, still has no vaccine. The measles vaccine took 42 years to develop. In the 1930s, two experimental polio vaccines failed because they were determined to be unsafe, and polio vaccines were almost abandoned. At the time, we understood how to prevent infection by sanitation and avoiding public swimming areas, just as we know how to stop HIV infection today. We needed new tools then, and we need them now. Over the last 20 years, important steps have been made toward parsing the major challenges of AIDS vaccine research into concrete projects and generally constructive discussions of how to shore up the foundations of the AIDS vaccine search, including career paths for young investigators, adequate resources for non-human primate research, and bench to bedside stewardship of important projects.

As disappointing as recent failures are, donors, advocates, scientists and physicians, clinical trial volunteers and their families must all guard against “failure fatigue.” We must respond loudly and clearly to suggestions that enough money has been spent on vaccine research; that it would be easier and wiser to move on rather than press on. To do so would be to ignore the reality of the epidemic today, and to overlook the lessons from history about the long, slow process of vaccine discovery. We cannot afford to walk away from science, or from the generations to come. Rather than giving up hope, we must redouble our efforts in prevention research and stand firm in our commitment to scientific inquiry. Millions of lives—today and tomorrow - depend on it.

(Mitchell Warren, Executive Director, AIDS Vaccine Advocacy Coalition - AVAC)
The Campaign to End AIDS is hitting the road again and this time our destination is Oxford MS – September 24-26, 2008 - the site of the first National Presidential Debate for the Stand Against AIDS. AIDS activists from around the country want to make sure that people living with HIV/AIDS voices are heard as part of this election process and are engaging in a year long campaign to ensure that this happens.

Nine caravans travel different routes across the country raising awareness on issues like access to care, research based on science – not ideology, increased funding for prevention tools and an end to stigma. Caravans will begin in California, Washington State, Texas, Minnesota, Maine, Virginia and Florida.

As those of you who have been following C2EA, we believe that the AIDS epidemic is not just a public health issue, it’s a social justice issue. To that end we are very happy to announce our partnership with Mr. James Meredith, Civil Rights Activists, for this project. “This is really the same issue that Dr. King was dealing with when he got killed: poor people” says Meredith. “If the Campaign to End AIDS is successful, it will change everything by focusing on the conditions and the circumstances of the poor. This will be a thousand times bigger than the right to an education.”

In 1966, James Meredith embarked alone on the March Against Fear, a 220 mile walk from Memphis, Tennessee to Jackson, Mississippi. The March was intended to encourage African-Americans to register to vote and make an impact on elections. Now 42 years later, Meredith lives in Jackson, MS and is lending his support to another Mississippi March, The Stand Against AIDS, organized by C2EA. In addition to eight caravans traveling across the country, in the ninth caravan AIDS Activists in Mississippi will reprise Meredith’s walk going from Jackson to Oxford, MS. Once arriving in Oxford, C2EA will host a town hall meeting on HIV/AIDS, have a Rally to End AIDS and visually depict the importance of addressing the HIV/AIDS epidemic both domestically and globally.

One of C2EA’s main priorities is to demand that the United States develop a national strategy to end AIDS. The US requires that countries receiving PEPFAR (President’s Emergency Plan for AIDS Relief) dollars have a strategy with measurable outcomes to address the epidemic in their country, yet the US does not have such a plan.

To get connected with a Stand Against AIDS caravan, or host an event along the caravan routes with Stand Against AIDS contact: Larry Bryant, 1-877-END-AIDS, or bryant2@housingworks.org.

To sponsor an AIDS activist on one of the caravans, make checks payable to Campaign to End AIDS and mail to Campaign to End AIDS c/o Housing Works, 727 15th St., NW, 2nd Flr, Washington, DC 20005 (Guest Writer: Christine Campbell, Director, National Advocacy and Organizing, Housing Works)

Medicare advocates, including The AIDS Institute, are encouraging the Congress to include in their Medicare legislative package a provision that would allow ADAP expenditures to count in calculating True out of Pocket (TrOOP) expenses in the Medicare Part D Program. The provision was successfully included in the House CHAMP bill that passed last year. The Senate is now crafting their version of the bill, which should be on the floor early this summer. Therefore, current advocacy efforts in both Washington DC and the grassroots are centered on the Senate.

In addition to conducting numerous meetings on the Hill, the HIV/AIDS Medicaid and Medicare Working Group sent a sign on letter endorsed by over 80 organizations to the Senate Finance Committee and Senate leaders encouraging them to add the ADAP TrOOP provision to the Medicare package. In the letter, the community wrote, “Ensuring that ADAP expenditures count toward meeting Medicare beneficiaries TrOOP obligations will help individuals out of the enormous coverage gap or “donut hole” in the Medicare Part D program. It will also extend the reach of ADAP funds to meet the needs of low-income uninsured people living with HIV. As you know, other state contributions, such as State Pharmacy Assistance Program payments, count towards TrOOP. It is only fair to allow ADAP contributions to count as well.”

(Carl Schmid)
House Blocks Medicaid Regulations While President Issues Veto Threat

The AIDS Institute is working with the HIV Medicaid and Medicare Working Group (HMMWG), along with other Medicaid advocates to stop a number of Medicaid regulations issued by the Bush Administration that would limit Medicaid expenditures and increase the Medicaid cost burden for the states. The AIDS Institute is actively supporting H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008," which would place a one-year moratorium on seven Administration-imposed Medicaid regulations. The rules in question would affect: payments provided to public safety net institutions; coverage of rehabilitation services for people with disabilities; outreach and enrollment in schools as well as specialized medical transportation to school for children covered by Medicaid; graduate medical education payments; coverage of hospital clinic services; case management services that allow people with disabilities to remain in the community; state provider tax laws; and appeals filed through Health and Human Services (HHS). The bipartisan bill was introduced by Chairman John Dingell (D-MI) and Rep. Tim Murphy (R-PA).

In a letter to the House, the HMMWG wrote, "A number of the proposed policy changes would directly affect access to care for Medicaid beneficiaries with HIV/AIDS. Specifically, the restrictions on case management limit access to a critical benefit for people living with HIV/AIDS. Successful management of HIV disease requires coordination of a number of medical and non-medical interventions. Studies document that case management improves health outcomes and saves money by facilitating access to these services. Additionally, outpatient clinics in academic medical centers across the country provide medical homes to many people living with HIV/AIDS, who would otherwise be unable to benefit from expert HIV care in their communities. The proposals to restrict services covered by hospital outpatient clinics and to eliminate graduate medical education payments would erode the resource base needed by these clinics to care for these patients. In addition, they would disproportionately affect minority populations that rely more heavily on outpatient clinics for access to care. Further, the rehab option is a critical way that states provide evidence-based community mental health services which would be restricted by the proposed rehab rule. Given the high level of co-morbid mental illness among people living with HIV/AIDS, this is also a critical HIV community concern."

The bill passed the full House of Representatives on the suspension calendar on April 23, 2008 by a vote of 349 to 62. Prior to the House’s consideration, the Bush Administration issued a veto threat. The bill passed by enough members to sustain a veto.

On April 3, Senators John Rockefeller (D-WV), Olympia Snowe (R-ME), and Ted Kennedy (D-MA) introduced a similar bill, the Economic Recovery in Health Care Act (S.2819). Action now shifts to the Senate as they consider this matter. (Bernadette Laber)

Federal AIDS Policy Partnership Hosts Forum


The forum was educational in nature as all panelists worked to “demystify” surveillance data. Beyond the explanation and interpretation of data, the panel also worked to highlight the limitations of disease surveillance systems and the growing need to provide accurate and timely data to AIDS groups. An example to the limitations of surveillance data lies in the difference between anonymous and confidential testing. While some would be quick to use the words interchangeably, confidential testing data would be reported to local health departments while anonymous testing results would not be. Also, the issue that effective drug therapies delay the time between HIV infection and development of AIDS will place new challenges on surveillance systems, and the growing number of people living with HIV for long periods of time will affect surveillance data. The discussion surrounding HIV/AIDS surveillance data shifted to the challenges of measurement and the current data collection methods.

The forum was regarded as a great success with close to 175 people participating, either in person or by telephone conference. (Brock Thompson)
The AIDS Institute Comments on CDC’s Compendium of Behavioral Interventions

On March 26th, 2008, The AIDS Institute submitted public comment to the Presidential Advisory Council on HIV/AIDS (PACHA), regarding the lack of targeted HIV Prevention efforts for numerous populations, as evidenced in the CDC’s Compendium of Evidence-Based Interventions. The Compendium, which includes 49 Best-Evidence and Promising-Evidence Interventions to be implemented in community-based prevention settings, was recently updated for the first time in 6 years. The AIDS Institute is pleased that CDC has added 37 new Interventions and that 38 of the 49 specifically or predominately target minority populations, who account for 69% of all AIDS cases. In addition, we are pleased that the Compendium includes 21 Interventions targeting women, many targeting African American and Latina women specifically.

However, The AIDS Institute expressed disappointment with the fact that the Compendium fails to include targeted interventions for numerous populations and intervention settings. As Suzanne Miller, Public Policy Associate for The AIDS Institute stated, “although men who have sex with men (MSM) account for 53% of all new HIV/AIDS cases, only 4 out of 49 Interventions specifically target them. Furthermore, there is not a single intervention targeted specifically to either African American or Latino MSM.” In 2005, African American MSM accounted for 36% of all MSM with HIV/AIDS, and Latinos accounted for 19%. Earlier this month, the CDC reported that HIV cases among young African American MSM increased by 80% from 2001 to 2005. Ms. Miller continued, “given the overwhelmingly disproportionate burden of this disease on these populations, it is simply unacceptable that there are no Interventions that target these populations.”

In addition to MSM, the updated Compendium fails to address other subpopulations at high risk of HIV infection, including: sex workers; transgenders; individuals; persons over age 50, and veterans. In 2005, CDC reported that persons over age 50 constituted 15% of new HIV/AIDS diagnoses, and the rates of HIV among this population were 12 times higher for African Americans than for Whites. In addition, research suggests that veterans, who are at high risk for homelessness and substance abuse, including injection drug use, are also at high risk for HIV infection. There is also a strong need for more diversity in regards to intervention settings. For example, there are no interventions for faith-based and rural settings.

In closing her statements, Ms. Miller argued that while The AIDS Institute “respect[s] the rigorous scientific process of developing effective interventions, we strongly believe that prevention research efforts must be guided by priorities. CDC’s Compendium of Evidence-Based Interventions does not adequately reflect the realities of this epidemic and needs to better focus on the populations that are greatest affected, and at greatest risk for this disease.”

The AIDS Institute urges PACHA to call on CDC to prioritize prevention efforts for those that are greatest affected and at highest risk for HIV/AIDS. (Suzanne Miller)

The AIDS Institute Pushes For Increased Domestic HIV/AIDS and Hepatitis Funding

While the Congress has not yet agreed upon a budget to allocate funding to each of the Appropriations Subcommittees, The AIDS Institute, along with its colleagues, is meeting with key Congressional staffers to explain to them why domestic HIV/AIDS and Hepatitis programs need funding increases. Additionally, The AIDS Institute recently submitted written testimony to the House Appropriations Subcommittee on Labor, HHS, Education, and Related agencies.

In our testimony, The AIDS Institute presented the case for increased funding for the Centers for Disease Control (CDC) (both HIV and Hepatitis programs), Ryan White Programs, National Institutes of Health (NIH) and Substance Abuse and Mental Health Services Administration (SAMHSA), and for no funding for abstinence only until marriage programs at the Administration for Children and Families.

In the testimony, we wrote, “despite the growing need, several domestic HIV/AIDS programs have experienced cuts in recent years including HIV prevention funding at the CDC and some parts of the Ryan White HIV/AIDS Program…..This year, the President has proposed to cut CDC HIV Prevention even more, and increase Ryan White programs by a mere .004 percent, while cutting some parts of the program. The AIDS Institute asks you to reject these cuts and increase the entire program at the community requested level.”

The testimony made the point that investing in prevention today will save money tomorrow. "Every case of HIV that is prevented saves, on average, $1 million of lifetime treatment costs for HIV. One recent study concluded the cost of new HIV infections in the US in 2002 was estimated at $36.4 billion, including $6.7 billion in direct medical costs and $29.7 billion in productivity losses. Another study concluded preventing the estimated 40,000 new HIV infections in the U.S. each year would avoid obligating $12.1 billion annually in future medical costs.”

After learning there was an error in the Appropriations Committee charts that revealed that ADAP received $14 million less in FY08 than what was previously announced, The AIDS Institute sent a follow up letter to Chairman Obey and the Committee to inform members of the lower level of ADAP funding and therefore, the added need for increased funding in FY09. Due to the very small increase in ADAP in FY08, not one state received an increase in their FY08 ADAP funding award and 25 states and territories experienced decreases.

The House Labor HHS Appropriations Subcommittee is expected to mark up their bill in late May or early June. (Carl Schmid)

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!
President’s AIDS Council Calls for a National AIDS Strategy

After two days of presentations and discussions with government leaders in the fight against HIV/AIDS, the President’s Advisory Council on HIV/AIDS (PACHA) concluded on March 26th by passing two resolutions. The resolutions came from PACHA’s Domestic Subcommittee, chaired by The AIDS Institute’s Carl Schmid.

The first resolution called upon the President to develop a National HIV/AIDS Strategy, similar to a domestic “PEPFAR”, in order to create an HIV-free generation in the United States and to ensure the proper coordination of the necessary healthcare and treatment for those with HIV/AIDS. The PACHA resolution also calls upon the President to appoint a National HIV/AIDS Coordinator to oversee the Strategy’s development and implementation, and that the strategies contain measurable goals and outcomes.

The second resolution commended the HIV/AIDS Bureau (HAB) of the Department of Health and Human Services for their successful implementation of the Ryan White HIV/AIDS Treatment Modernization Act. Moreover, PACHA commended the Bureau for developing a comprehensive Severity of Need Index that seeks to improve the distribution of Ryan White HIV/AIDS Program funds in such a way that could help improve the healthcare and well being of more low-income people living with HIV/AIDS, and offering Technical Assistance to the Commonwealth of Puerto Rico in its ongoing challenges of implementing the Ryan White HIV/AIDS program in Puerto Rico.

Over the course of the two day meeting, PACHA heard from Kevin Fenton, Director of the Centers for Disease Control’s (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Carl Dieffenbach, Director of the Division of AIDS at National Institute of Allergy and Infectious Diseases/National Institutes of Health (NIAID/NIH), Ellen Stover, the Director of the Center for Mental Health Research on AIDS/NIH, Westley Clark, Director for Substance Abuse Treatment at SAMHSA, and Steven Young of the HIV/AIDS Bureau. The Council bid farewell to longtime PACHA member, Dr. Benny Primm, and welcomed new members Sharon Valenti RN from St. John Hospital in Detroit and Robert Kaufman of the law firm of Proskauer Rose in New York City. The next meeting of PACHA is scheduled for October 21 and 22, 2008. (Bernadette Laber)

amfAR Holds Congressional Briefing on HIV/AIDS in Correctional Settings

amfAR, The Foundation for AIDS Research and network partner for The AIDS Institute’s WIN (Women Informing Now!) Project, recently held a Congressional briefing entitled, HIV in Correctional Settings: Implications for Prevention and Treatment Policy. The audience heard from several public health and policy experts on this issue, as well as a former inmate and HIV prevention educator. The full panel of speakers included: Barry Zack, Independent Consultant on Correctional Health Programs and Research, and former Executive Director of Centerforce; Harold Atkins, former inmate and HIV Prevention Peer Educator at San Quentin State Prison; Dr. Josiah Rich, Professor of Medicine and Community Health at Brown University; and Darla Bardine, Associate Policy Director and Family Treatment Coordinator for The Rebecca Project for Human Rights.

Dr. Monica Ruiz, Acting Director for Public Policy at amfAR, moderated the briefing and opened the panel reporting several astounding facts about incarceration in the United States: The U.S. has the highest rate of incarceration in the world with 1 in every 100 adults currently confined in a jail or prison; in addition, 1 in 4 people living with HIV/AIDS will pass through a correctional setting each year, and 60% of state and federal prison inmates are African American and Latino. Each panelist discussed how the factors of homelessness, substance abuse and mental health are often both a cause and consequence of HIV infection and incarceration. Dr. Rich noted that addiction and mental illness too often go untreated during incarceration, and usually worsen upon an inmate’s release. With little or no housing options and an inability to find employment because of a felony conviction, former inmates often return to abusing drugs and alcohol and their mental illnesses worsen. Dr. Rich also reported that in the state of Rhode Island, 1/3 of people with HIV/AIDS were diagnosed in the prison system.

Dr. Rich and Dr. Zack discussed how the incarceration of African American men directly affects HIV infection in African American women. They both noted that while African American men have been demonized for contracting HIV while incarcerated and then transmitting the virus to African American female partners upon release, this has largely been a misconception. The link between HIV in African American women and the incarceration of African American men has more to do with sexual networks. Due to the fact that large numbers of African American men are incarcerated at any given time, this affects the male/female ratios in the African American community and creates a sexual network of fewer African American men than women, thus more women become at risk for HIV infection.

Ms. Bardine, of the Rebecca Project for Human Rights, further discussed women’s issues relating to incarceration. The Rebecca Project strives to reform child welfare, criminal justice, and substance abuse policies that impact the lives of vulnerable families. Ms. Bardine works with female inmates in the District of Columbia and coordinates a family centered substance abuse treatment program for women ex-offenders and their families post-release. The treatment program incorporates parenting classes, HIV education, individual therapy, substance abuse counseling, and vocational training. She noted that women ex-offenders with felony drug convictions are ineligible for TANF (Temporary Assistance to Needy Families) and other housing support programs and that nonviolent mothers of young children are the fastest growing segment of the prison population.

The WIN Project is pleased to highlight the work of its Network Partners and commends amfAR for this informative briefing on HIV in Correctional Settings, in particular for highlighting women’s issues within it. The WIN Project continues to address the needs of women as it relates to HIV, and highlight how the factors of incarceration, housing, substance abuse and mental health affect women’s health. (Suzanne Miller)
**HIV Medicaid/Medicare Working Group Action Alert**

**You Can Help Improve Treatment Access for People with HIV/AIDS With One Phone Call**

HIV/AIDS advocates around the country are working hard to convince Congress to pass a law that would close an important gap in treatment access for people with HIV/AIDS.

In 2008, many people who get their HIV drugs through the Medicare prescription drug benefit reach what is called the "donut hole" or coverage gap which can only be surpassed if they can afford a whopping $4,500 required for them to reach catastrophic coverage.

They reach the donut hole after their total drug costs reach $2,510. This happens for many people with HIV/AIDS within the first two months of their coverage. At that time, the individual must pay the full cost of their drugs or rely on another program, such as the AIDS Drug Assistance Program (ADAP). Once individuals have paid $4,050 out of pocket for their drug costs (referred to as true out of pocket costs or TrOOP), their Medicare Part D coverage resumes.

Current law doesn't allow ADAP spending to count towards TrOOP. This means that when an ADAP helps a Medicare beneficiary pay for their drugs during the coverage gap, the client remains in the coverage gap for the remainder of the year. People with HIV/AIDS who should be able to get the full benefit of Medicare Part D are then forced to rely on the under funded ADAP program, which in nearly all states also has a much more limited drug formulary. It also means that ADAPs around the country must spend money for these clients that could be used to expand access to other uninsured or underinsured individuals. If ADAP were allowed to count as TrOOP, it would save about $50 million per year.

The U.S. Senate will soon debate Medicare reform legislation and can play a major role in fixing this problem by including the ADAP as TrOOP provision. The House of Representatives has already approved this provision. The Senate needs to hear that this is a priority for people with HIV/AIDS and a fix that is badly needed. Please take the time to make these two important calls!

For more information, contact Ryan Clary at rclary@projectinform.org

**The HIV Medicaid and Medicare Working Group (HMMWG)**

HMMWG is a coalition of nearly 100 national and community-based AIDS service organizations that represent HIV medical providers, advocates and people living with HIV/AIDS and provide critical HIV-related health care and support services. For more information, contact the HMMWG co-chairs Laura Hanen with the National Alliance of State and Territorial AIDS Directors at 202.434.8091 or Robert Greenwald with the Treatment Access Expansion Project at 617.390.2584.

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**Scientists Test Device to Track Medication Adherence in Patients with HIV/AIDS**

Most of us have missed a dose of antibiotic or forgotten to take a daily vitamin. But when the stakes are higher — as they are for people with HIV/AIDS — a skipped pill could mean the difference between health and hazard for the entire population. Now, a breath monitoring device developed by scientists at the University of Florida and Xhale Inc. could help prevent the emergence of drug-resistant strains of HIV by monitoring medication adherence in high-risk individuals.

"For HIV, it's been shown that if you don't take a very high percentage of your medication, you may as well not take medication at all," said Dr. Richard Melker, a professor of anesthesiology at the UF College of Medicine and chief technology officer for Xhale.

Patients who take some but not all of their medication increase the likelihood the virus will mutate into a deadlier, drug-resistant form. Experts have tried literally hundreds, if not thousands, of ways to monitor drug adherence, ranging from daily log books to blister packs that record the time each pill is dispensed. Despite the money, time and effort devoted to these methods, Melker said only one works well: directly observed therapy, or DOT. "If you have a disease that is deemed to be a public health risk, authorities can put you into a program where you have to come to the clinic every day and be observed putting the pill into your mouth and swallowing it," Melker said.

But that process is inconvenient for patients, as well as for clinic personnel who have to track them down when they fail to show up. A breath-monitoring device developed by UF scientists and Xhale could change that, allowing patients to participate in a type of virtual DOT from home.

"The machine sits in your home and when it's time for you to take your medication, it makes a beeping noise. If you don't hit a button after about five minutes, it’s going to beeping louder and louder until you come," Melker said. "If you don't come after a certain amount of time, the machine can call the clinical trial coordinator and indicate that subject or patient didn't take the medication as prescribed."

The device, which is slightly smaller than a shoebox, records the results of each breath test, allowing patients to bring a memory card or USB key to the clinic once a month and receive a printout of their results. Eventually, the researchers hope to reduce the size of their detection device to fit inside a cell phone. But for now, they’re satisfied that the technology works. (continued on page 11)
"We wanted (patients) to swallow a chemical and have it transform into something else that's easy to monitor," said Matthew Booth, an assistant professor of anesthesiology at the UF College of Medicine and an investigator in the study. "When it hits the stomach lining and liver, an enzyme converts the alcohol to a gas that can be measured in the breath." To determine how well the byproduct could be detected, six healthy volunteers swallowed empty pills in which the capsules contained trace amounts of 2-butanol. After five to 10 minutes, the scientists could measure the volatile byproduct in the volunteers' breath using a small detector. The scientists say their device could also be used to monitor medication adherence in patients with other communicable diseases, such as tuberculosis.

"It is encouraging that the biological and chemical elements of the adherence system work as predicted. We were able to conclusively show who swallowed the capsules containing the 2-butanol. With further optimization, we are optimistic the device will perform very well," said Dr. Donn Dennis, the Joachim S. Gravenstein professor of anesthesiology at the UF College of Medicine and an investigator in the study. The researchers say the device may prove equally helpful for monitoring adherence in clinical trials. "If you enroll HIV/AIDS patients in a clinical trial and they don't take the medication, then you may not get adequate proof that the drug is effective," Melker said. "It might be effective, but some of the patients aren't taking it."

Phase 2 trials are often conducted in the community, rather than at research institutions, making it difficult for researchers to monitor adherence. As a result, many trials enroll a larger group of subjects than needed, in hopes they'll obtain enough data to determine the safety and efficacy of the medication.

"If we had a good way of doing DOT that's realistic, instead of having someone come to your house or you going to clinic every day of your life, then we would know whether these people stopped taking their medication and why. Right now, nobody knows any of that," Melker said. "The implications of being able to understand what normal human behavior is in a clinical trial and, of course, in the real world, are huge." (Source: University of Florida News)

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National Asian & Pacific Islander HIV/AIDS Awareness Day
May 19, 2008

A Community Ignored
The Struggle to Represent All Those Impacted by HIV/AIDS

Three decades into the AIDS epidemic, there are alarming disparities of infection rates among communities of color. Recent data compiled, reviewed and published by the Asian & Pacific Islander American Health Forum (APIAHF) indicates an alarming rise in Asian American, Native Hawaiian, and Pacific Islander infection statistics.

In my role as an HIV Program Coordinator, I deliver capacity building assistance to AIDS Services Organizations (ASO) to further their ability to combat this health crisis. The fact that HIV/AIDS is rarely perceived to be a disease that affects Asian Americans, Native Hawaiians or Pacific Islanders contributes to the difficulty in fighting HIV/AIDS. This is a growing problem within our community, however, and one that demands immediate attention and action.

APIAHF and the National Alliance of State & Territorial AIDS Directors (NASTAD) noted in their joint publication, Breaking Through The Silence, that there were 2,825 Asian Americans, Native Hawaiians, and Pacific Islanders living with AIDS in 2001. Four years later, this number increased by 54% to 4,356. This represents the largest increase among any group. Even more telling, between 2001 and 2004, the estimated annual percentage change for Asian American and Pacific Islander HIV diagnosis rates for males was 8.1% and 14.3% for females. These were the only statistically significant increases among any racial or ethnic group.

Many variables contribute to these disparities. Among them are cultural stigmas regarding HIV/AIDS; lack of access to healthcare for Asian Americans, Native Hawaiians, and Pacific Islanders; lack of appropriate HIV/AIDS materials for individuals with limited English proficiency; and data collection and reporting gaps in health statistics. These combined factors contribute to the alarming rates of HIV within the Asian American, Native Hawaiian, and Pacific Islander community and its devastating effects on our family and friends.

Cultural Stigma
Stigma and cultural barriers challenge efforts to mount strong HIV prevention responses in Asian American, Native Hawaiian, and Pacific Islander communities. Stigma exists in multiple layers as there is stigma against HIV; people living with HIV/AIDS; lesbian, gay, bisexual, transgender identity; and drug use. These layers of stigma contribute to a lack of HIV risk recognition, lack of access to services, and lack of ownership of HIV as a community issue. (continued on page 12)
Lack of Access to Healthcare
Currently, over 2 million Asian Americans, Native Hawaiians, and Pacific Islanders lack sufficient health insurance coverage. At least 17.7% of all Asian Americans and 21.8% of Native Hawaiian and Pacific Islanders are uninsured, compared to 11.2% of non-Hispanic whites. These statistics are even more severe for specific ethnic subgroups. For example, among Korean Americans and Vietnamese Americans aged 18-64, 52% and 32% are uninsured, respectively. Lack of access to healthcare makes it far more difficult for Asian Americans, Native Hawaiians, and Pacific Islanders to educate themselves on HIV prevention and can lead to risky behavior without knowledge of their HIV status.

Lack of Appropriate HIV/AIDS Materials
Key to Asian Americans, Native Hawaiians, and Pacific Islanders increasing their knowledge and awareness about HIV/AIDS treatment is accessing culturally appropriate educational materials in their own language. According to the 2000 U.S. Census, 46% of Asian Americans, Native Hawaiians, and Pacific Islanders are limited English proficient (LEP) and 31% of households are categorized as “linguistically isolated,” meaning no one in the household speaks English “very well.” Obviously, this inhibits a person from understanding the health risks of certain behaviors. If there are no language appropriate services, it is more difficult for them to seek out and receive sound medical advice. At APIAHF, we believe culturally appropriate language access is a basic right and that current health care services are deficient in providing linguistically and culturally appropriate medical information to our communities.

Data Collection
Historically, Asian American, Native Hawaiian, and Pacific Islander data have often been combined with other racial/ethnic groups into an “other” category or completely omitted from HIV/AIDS surveillance reports. Without an accurate picture of the impact of HIV/AIDS in our community, there is no statistical basis for a public health response. This perpetuates a disastrous cycle of misinformation. While new HIV/AIDS case numbers may be low in relation to other communities, the CDC’s Morbidity and Mortality Weekly Report states annual HIV/AIDS diagnosis rates are increasing among Asian Americans, Native Hawaiians, and Pacific Islanders faster than any other racial group. As these statistics imply, greater emphasis must be made to disaggregate this data in order to see the true picture and inform prioritization efforts for specific ethnic subgroups.

Clearly, there are great challenges facing Asian Americans, Native Hawaiians, and Pacific Islanders. Because the four areas mentioned above are so interwoven, APIAHF works closely with a variety of ASOs throughout the United States and Pacific Island jurisdictions to improve their infrastructure, sustainability and leadership. In doing so, we seek to build the capacity of the AIDS Service Organizations to serve their communities and to work together on multiple levels to address the inequities of access, treatment, education and data reporting. At APIAHF, we envision a nation where HIV/AIDS is recognized as a critical issue by all communities and policy makers, and we will continue our efforts to ensure that HIV/AIDS prevention services are accessible and serve all communities, including the increasingly impacted Asian American, Native Hawaiian and Pacific Islander communities.

For more information or to download a copy of Breaking Through The Silence, please visit: www.apiahf.org or contact Alan Yee, HIV Program Coordinator at 415.568.3308 or ayee@apiahf.org

For further reading on HIV/AIDS stigma please visit: The Banyan Tree Project www.banyantreeproject.org, a national social marketing campaign dealing with issues of stigma in the Asian American, Native Hawaiian and Pacific Islander community. (Guest Writer: Alan Yee, HIV Program Coordinator, The Asian & Pacific Islander American Health Forum -APIAHF)

 Churches Tackle AIDS Crisis
Black Churches Shun Stigma of AIDS, Take on Job of Testing

When the Rev. Bernard Smith started offering HIV screenings on church premises, the stigma of the disease followed him to his pulpit. “People would call you the AIDS preacher,” the Largo pastor said. “But I wasn’t interested, and listened to a higher power.” But after seven years and after hundreds of people entered his sanctuary to get tested for the virus, more people are listening to what Smith preaches. In fact, churches across the state are following his lead, launching a joint initiative between the state Department of Health and the African Methodist Episcopal Church to establish at least one AIDS testing site in a place of worship in every county.

In Volusia County alone, 12 churches have signed up to do testing. In Orange County, an Oakland church is hoping to become a site. In Polk County, a site in Winter Haven is set to start testing at the end of the summer. James O. Williams Sr., one of the regional leaders of the AME church, said that his community can’t hide from the disease that has affected a disproportionate number of blacks: Last year in Florida, blacks made up 54 percent of the AIDS cases reported, but just 14 percent of the population, according to the state health department. "In the past it's been standoffish as far as the churches are concerned," he said. "But these are our family members, and the church should be part of the healing process." Now, church leaders say people have to look past the stigma that links AIDS to drug use and homosexuality and understand that everyone is at risk. The disease is the top cause of death among black men and women from 25 to 44 years old, according to the state health department.

Street talk in church. And so, on Saturday, Williams found himself at a testing training session, discussing street terms for sex and drugs, along with volunteers such as Harriett Nelson, a 59-year-old church member who is more accustomed to organizing choirs and senior-citizen aerobics classes than talking about condoms. (continued on page 13)
(continued from page 12) Nelson, who said she got involved because she has family members with the disease, found herself laughing as volunteers practiced saying some less-than-polite words so they wouldn't be shocked when people said them during actual counseling sessions. "That was pretty different," she said after the training in the basement of New Bethel AME Church in Ormond Beach. "But these are the real facts. We do need to be familiar with the slang words." Nelson could begin testing at her church, Mount Zion AME in Daytona Beach, within a month.

**Reaching beyond clinics.** For years, AIDS outreach workers have tried to offer AIDS testing in environments outside of sterile and impersonal health clinics. "African-Americans were not exactly breaking down the doors of the health department to be HIV-tested," said Mellita Mills-Kendrick, a regional AIDS coordinator for the state. Polk County health workers have set up shop in laundromats, convenience stores and beauty salons, launching a campaign several years ago to train beauticians as outreach workers. The Daytona Beach-based Stewart-Marchman Foundation teams with restaurants to offer coupons for free meals to people who agree to have their cheeks swabbed for the test.

The disease’s spread has slowed, but with medical advances people are living longer. "We're dealing with three generations of people now that are impacted by HIV/AIDS," said the Rev. Ronald Weatherford, who co-authored Somebody's Knocking at Your Door: AIDS and the African-American Church. "For the mainstream churches it is just now becoming something that they are willing to do."

**A growing trend.** AIDS is becoming a part of religious life at black churches across the country. According to The Balm in Gilead, a Virginia-based group that has fought AIDS for nearly 20 years, churches that offer AIDS and HIV outreach now number in the thousands. A growing number, said the Rev. Makeba D'Abreu, director of the group's domestic program, are offering on-site testing. Recently, the Rev. Raphael Warnock, pastor at Ebenezer Baptist Church in Atlanta, where Martin Luther King Jr. once preached, took an AIDS test in front of churchgoers. Warnock has been targeting what he sees as the unholy trinity of silence, shame and stigma. "Stigma has to do with culture and values," he said. "Ministers can do more to undermine the stigma piece than anybody else."

That unholy trinity has been fading at Smith's church, Green's Chapel AME, where HIV testing continues, and where he says the congregation has "seen the light." (Rachael Jackson, Sentinel Staff Writer, OrlandoSentinel.com)

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**RESEARCH NOTES**

**FDA Warns of Possible Link Between Heart Attacks and Abacavir and ddi**

The Food and Drug Administration (FDA) has issued an early warning communication regarding the safety of Abacavir (Ziagen) and ddi (Videx). This is not a directive to discontinue use of these drugs rather it is a warning to physicians and patients to be aware of certain possible health risks and a call to consider the potential risks and benefits to each patient taking these drugs. The FDA is still reviewing the data and has not issued a statement conclusively linking either drug with any new adverse effects.

Data from a 33,347 patient observational study called The Data Collection of Adverse Events of Anti-HIV Drugs (D:A:D) from 212 clinics in North America, Europe and Australia, showed an increased risk of mitochondrial infarction (heart attack) with use of both Abacavir and ddi. The risk for heart attack increased 49% with ddi and 90% for patients taking Abacavir. The number of patients on Abacavir who experienced a heart attack was double that of normal expectations. The overall percentage of individuals within the D:A:D study who suffered heart attacks was relatively low at only 1.6%.

Researchers were reviewing the possibility of a connection between nucleoside reverse transcriptase inhibitors (nukes) and cardio vascular disease among people with HIV and AIDS. AZT and d4t were examined first and no relationship was found. There was not a large enough cohort of individuals on Tenofovir for a thorough review. Researchers then focused their attention on ddi and Abacavir. Abacavir is available in Kivexia (Abacavir and 3TC) and Trizivir (Abacavir, 3TC and AZT).

According to the studies preliminary findings, risk did not increase over time rather it remained steady during the course of treatment and reversed after the drugs were discontinued for 6 months. The study found that those at greater risk had additional risk factors for heart attacks including age, smoking, and a history of high blood pressure, high cholesterol, diabetes or heart disease.

After being made aware of the D:A:D study in late 2007, both GlaxoSmithKline (makers of Abacavir) and Bristol Myers Squibb (ddi) performed an analysis of their databases to search for data linking their drugs to heart attacks. Neither company found an increased risk although both analyses were labeled 'inconclusive'. (continued on page 14)
Through the ‘Am I Number 12?’ campaign and activities around the world on May 19, we aim to put hepatitis B and C firmly on the global healthcare agenda,” Mr. Gore said.

Mr. Gore said that, unlike other disease areas, awareness of hepatitis B and C remains inexplicably low: “We believe that, unless awareness improves, we won’t make any progress in reducing the enormous and largely preventable death toll. Hepatitis B and hepatitis C should have the same profile as HIV/AIDS, malaria and TB and should really be up there alongside those diseases in the WHO’s millennium goals.”

Did You Know?
- 500 million people worldwide are currently infected with hepatitis B or C
- Between them, hepatitis B and C kill 1.5 million people a year
- One in every three people on the planet has been exposed to either or both viruses
- Most of the 500 million infected do not know

World Hepatitis Day
World Hepatitis Day will be observed on Monday, May 19th. The day has been launched in response to the concern that chronic viral hepatitis has nowhere the level of awareness nor the political will needed to tackle it. ‘AM I Number 12?’ campaign materials are available in over 40 languages – for logo images, postcards, posters and banner ads please contact the World Hepatitis Alliance at worldhepday@fleishman.com

World Hepatitis Alliance
World Hepatitis Day is being coordinated by the World Hepatitis Alliance, a newly established Non-Governmental Organization which represents more than 200 hepatitis B and hepatitis C patient groups from around the world.

The results of this observational study are considered controversial. It is not possible to take into considerations all factors which may be relevant when conducting an observational study. For example, some of the individuals who experienced heart attacks may have been on other drugs which could contribute to their risk factor. Also inflation can increase risk of heart disease. It is not known whether those who had heart attacks had other diseases associated with inflammation or experienced hypersensitivity to Abacavir which also can cause inflammation.

Additional studies of other large databases should be reviewed to ascertain whether finds concur with the D:A:D results. Updates on this and other drug safety issues can be found at: http://www.fda.gov/cder (Guest Writer, Jeannie Gibbs)
The World Hepatitis Alliance is governed by a representative board of patient groups from seven world regions: Europe, Eastern Mediterranean, North Africa, North America, South America, Australasia & Western Pacific. The North American Steering Committee member is Chris Taylor, Viral Hepatitis Program Manager for the National Alliance of State and Territorial AIDS Directors (NASTAD).

According to Taylor, "Hepatitis advocates from around the world are planning observances on May 19, 2008. All across the United States and Canada, advocates have been planning activities to highlight the viral hepatitis epidemics in their region and throughout the world. These observances aim to raise awareness among the public who may be at risk or living with HBV or HCV, and to raise the profile of viral hepatitis on the health agendas of policymakers and government leaders."

The need to raise awareness about Hepatitis in the US is particularly important. The CDC spends a meager $17.6 million per year on HIV prevention and surveillance programs for the entire country. The AIDS Institute, along with its partners, has been working to increase that level. Additionally, we have been working to urge the Congress to pass pending Hepatitis bills that include prevention, research and care and treatment components.

The AIDS Institute has been involved in the formation of World Hepatitis Day and has called on President Bush to recognize May 19th as such. The AIDS Institute also recently signed on to a letter to Dr. Mirta Roses Periago of the Pan American Health Organization (the regional World Health Organization office) requesting official WHO endorsement of World Hepatitis Day. Global organizers are hoping that the regional offices of WHO will weigh in on the importance of increased attention to viral hepatitis at the WHO meeting in Switzerland in May.

Look out for more information about the ‘Am I Number 12?’ campaign on May 19th and in the meantime remember to sign up on its website: www.aminumber12.org. (Carl Schmid)

PEPFAR Update

On March 13, 2008, The AIDS Institute and The Whitaker Group convened a delegation of 15 African Health Ministers and other officials representing Ethiopia, Ghana, Kenya, Lesotho, Rwanda, Tanzania, Uganda, and Zambia who provided information to Congress and the Administration about the importance of the President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR is a $50 billion international aid program that targets HIV/AIDS, Tuberculosis, and Malaria prevention, care, and treatment worldwide.

The delegation’s visit came at a crucial time as Congress, specifically, the U.S. House of Representatives was deliberating reauthorization of the Tom Lantos and Henry J. Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (H.R. 5501). On April 2, 2008, the House passed its version of this landmark legislation by a vote of 308-116. The bill survived a “motion to recommit” that would have required the bill to be reported back to the House with amendments that would reduce the authorization level specified in the bill from $50 billion to $30 billion, the President’s original request. President Bush, back on May 30, 2007 had called on Congress “to demonstrate America’s continuing commitment to fighting the scourge of HIV/AIDS by reauthorizing this legislation now. I ask Congress to double our initial commitment and approve an additional $30 billion for HIV/AIDS prevention, for care, and for treatment over the next five years”. Members of the House boosted this amount to $50 billion. The four amendments to the bill that were considered and approved on the floor were: an amendment to add safe drinking water to nutrition and income security under the Referral and Coordination Section, offered by Rep. Blumenauer; an amendment by Rep. Carson that directs the Coordinator of United States Government Activities to Combat HIV/AIDS Globally and the Administrator of the United States Agency for International Development (USAID) to expand their plan for strengthening health systems of host countries by allowing for African post-secondary educational institutions to collaborate with post-secondary educational institutions and specifically historically Black colleges and universities; and amendment that ensures that audits on the Global Fund would include information on subcontractors, offered by Rep. Fortenberry; and a amendment by Rep. McCollum and Rep. Jackson that adds Malawi, Swaziland, and Lesotho to the list of focus countries. The Board and staff of the Global Program at The AIDS Institute have been working with Ambassador Ndilowe of the Malawi Embassy on securing inclusion in the program for several years.

On March 7, 2008, Senator Joseph Biden, Jr. (D-DE), Chairman of the Senate Foreign Relations Committee and Ranking Member, Richard Lugar (R-IN), in a bipartisan move, introduced the bill in the Senate (S.2731). The Senate version of the bill maintains the $50 billion funding level and includes provisions that will:

- Remove most earmarks in the original law that delineated percentages of funding devoted to treatment, to care, and to prevention that congressionally-mandated studies by the Institute of Medicine (IOM) and the Government Accountability Office (GAO) concluded; unduly limited the flexibility for those implementing the programs (one contention shared by the African Health delegation). It retains the earmark that will allocate 10% of the funds for orphans and vulnerable children with bipartisan support.

- Increase the efficiency and scope of U.S. HIV/AIDS programs by coordinating our efforts with other global health and development initiatives, such as nutrition programs.

- Promote local health capacity and pushes the U.S government to plan for a sustainable long-term effort, to help local governments take over the fight against HIV/AIDS with U.S. technical assistance. (continued on page 16)
Global Food Crisis

The developing world is on the verge on another crisis – some say a Tsunami, for hungry people around the world. Josette Sheeran, Executive Director, United Nations World Food Programme, sounded the alarm on April 18, 2008 while speaking at the Center for Strategic and International Studies (CSIS) in Washington, DC. At CSIS’ Smart Power Speaker Series, Ms. Sheeran was the first person to publicly state what we all have been hearing in the media the last few days, "More than 100 million people are being driven deeper into poverty by a "silent tsunami" of sharply rising food prices, which have sparked riots around the world and threaten U.N.-backed feeding programs for 20 million children. This is the new face of hunger -- the millions of people who were not in the urgent hunger category six months ago but now are. The world’s misery index is rising."

Soaring food prices, rising oil prices, more grain being diverted to produce bio-fuels – which in and of itself, is not an energy efficient process, more intense and more frequent weather disasters, the world consuming more food than it produces, and global grain stocks being the lowest ever for the past 30 years – all contributing to an increasing number of people at risk of hunger. The world has witnessed 15 food riots and protest since January 2007 - the most recent having occurred this month, April 2008, in Port-au-Prince, Haiti which resulted in the death of 4 people. According to the UN, 150 million people around the world live on less than fifty cents a day. According to Bread for the World Institute, a collective Christian voice urging our nation’s decision makers to end hunger at home and abroad, 854 million people across the world are hungry, up from 852 million a year ago. Every day, almost 16,000 children die from hunger-related causes – one child every five seconds. In essence, hunger is the most extreme form of poverty, where individuals or families cannot afford to meet their most basic need for food.

Where there is poverty, there is disease. The HIV/AIDS epidemic has quickly become a major obstacle in the fight against hunger and poverty in developing countries – and added cause to those already mentioned. We can look at it this way – because the majority of those falling sick with AIDS are young adults who normally plant and harvest crops, food production has dropped dramatically in countries with high HIV/AIDS burden. Infected adults also leave behind children and elderly relatives, who have little means to provide for themselves. According to the UN, in 2003, 12 million children were newly orphaned in southern Africa, a number expected to rise to 18 million by 2010.

Perhaps this is why the first Millennium Development Goal is almost always, "To eradicate extreme poverty and hunger"...the situation is likely to worsen in the coming months as food and transportation prices soar to record highs, countries hold back food from export and droughts threaten crops from Africa the situation is likely to worsen in the coming months. (James Sykes)

World Malaria Day

April 25, 2008 was “World Malaria Day” as proclaimed by the World Health Assembly. This date has been commemorated as Africa Malaria Day since 2001- a year after the historic “Abuja Declaration” was signed by 44 African Malaria-endemic countries at the African Malaria Summit in Abuja, Nigeria. In May 2007, the World Health Assembly, attended by delegations from all of World Health Organization’s 193 Member States, considered the latest malaria reports and observed that global awareness of malaria remains low despite the high death toll and cost of the disease. The Health Assembly thus resolved that World Malaria Day shall be commemorated annually to provide “education and understanding of malaria” and spread information on “year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas." (WHA 60.18)

In advance of World Malaria Day, the Global Program at The AIDS Institute held its first educational forum on Malaria on Tuesday, April 22, 2008 in Rayburn House Office Building on Capitol Hill. (continued on page 17)
In cooperation with Representative Donald Payne, Chair of the Subcommittee on Africa and Global Health, U.S. House of Representatives Foreign Affairs Committee, and his dedicated staff, specifically, Noelle LuSane, Majority Staff Director, and Antonina King, the forum was by any measure a success. Dr. Gene Copello, Executive Director, The AIDS Institute, moderated the event which featured Chris White, Advocacy and Communications Advisor, Malaria Department, Population Services International (PSI), Dr. Tonya Villafana, Director, Portfolio Management, The PATH Malaria Vaccine Initiative (MVI), and James Sykes, Global Program Coordinator, The AIDS Institute. Mr. White shared his vast experience in implementing malaria control and prevention programs in sub-Saharan Africa, Dr. Villafana, who also has extensive experience with HIV/AIDS in the same region, informed the audience about the new tools and innovations being researched and developed in the pursuit of an effective malaria vaccine, and James Sykes demonstrated the connection between malaria and HIV/AIDS. Lunch for the event was hosted by Vestergaard-Frandsen, a global partner in the fight against malaria. (James Sykes)

WEBSITE OF THE MONTH

WWW.AVAC.ORG

Founded in 1995, the non-profit AIDS Vaccine Advocacy Coalition (AVAC) seeks to create a favorable policy and social environment for accelerated ethical research and eventual global delivery of AIDS vaccines as part of a comprehensive response to the pandemic. This work is guided by the following principles:
• Translate complex scientific ideas to communities AND translate community needs and perceptions to the scientific community.
• Manage expectations.
• Hold agencies accountable for accelerating ethical research and development.
• Expand international partnerships to ensure local relevance and a global movement.
• Ensure that policy and advocacy are based on thorough research and evidence.
• Build coalitions, working groups and think tanks for specific issues.
• Develop and widely disseminate high-quality, user-friendly materials.

SOUTH CAROLINA

House to consider HIV/AIDS proposal

Bills look at requirements to tell schools of students’ infections

The symptoms pointed to a possible diagnosis of HIV/AIDS for Dr. Tracy Macpherson’s teenage patient. Prolonged fever. Unexplained rash. And acknowledgment of risky sexual activity during the past few months. Macpherson sent the teen for an HIV/AIDS test at the county health department. But a state law requiring that HIV/AIDS test results be reported to a student’s school stopped the teen in his tracks. “He wouldn’t get tested because they were going to tell his (superintendent) and school nurse the results of the test,” Macpherson said. “I couldn’t believe there was such a requirement. This law prevented a patient of mine from seeking medical care on something as critical as HIV. It’s outrageous.” That might change under a bill filed by Macpherson’s husband, Sen. Brad Hutto, D-Orangeburg. The bill, which already has passed the Senate and is scheduled for House debate this week, would eliminate the requirement that the Department of Health and Environmental Control notify a school district superintendent and school nurse if a minor tests positive for HIV/AIDS.

HIV/AIDS is the only disease the state health department is required by law to report to schools. Schools are required to report a range of infectious diseases — from tuberculosis to meningitis — to the state health department. At the end of 2006, 113 South Carolinians ages 13 to 19 were living with HIV/AIDS, according to the state health department. That is less than one half of 1 percent of the 208,000 13- to 19-years-olds in the state’s public schools.

A STIGMA

Hutto’s bill has the backing of many South Carolinians living with HIV/AIDS, including Crystal Hilton, 20. When word somehow got out that she was HIV positive, other middle school students began teasing her, Hilton said. And, she added, some teachers treated her differently. State law specifically says only the superintendent and school nurse are to be notified if a student is HIV positive. But others in the school often find out, too, says Hilton.

“Because they knew, the teachers and everyone looked at me differently and judged me,” said Hilton, who was born with HIV. (continued on page 18)
“They didn’t think other students were safe with me in the school. It’s really none of the school’s business.” School administrators are prohibited from telling others about a student’s HIV status. “It’s superfluous information that (superintendents and nurses) can’t act upon,” Hutto said. “They can’t notify another student or teacher or parent. They can’t send the student for counseling. It’s knowledge that has no purpose. So why have it at all?” But Rep. Kris Crawford, R-Florence, an emergency room doctor, says superintendents and nurses need to know because of fights, collisions on the football field and other school mishaps where multiple students bled. HIV/AIDS can be passed from one person to another through blood. In those instances, a student who may have been exposed to HIV should be rushed to the emergency room for medication, which can lessen the likelihood of transmission, Crawford said. “There are a lot of cuts, abrasions, bruises, everything on the football field,” said Rep. Jeff Duncan, R-Laurens, a former Clemson football player. “Someone at the school needs to know if a student has HIV as a precaution. Then they can direct students who may have been exposed to go to the hospital and get those drugs that reduce the chance of them getting HIV.”

Next week, Crawford, with the support of Duncan, will recommend a change to Hutto’s bill, requiring the state health department to notify superintendents and school nurses if a student tests positive for not only HIV/AIDS but also other blood-borne communicable diseases including hepatitis B and C. To satisfy Hutto’s concerns about students’ identities, the infected student’s name would not be released, under Crawford’s bill. Instead, school officials would be told an unnamed infected student attended a specific school. If there was a fight or other situation where multiple students were bloody, the school nurse would contact the state health department to determine if any of the students involved has a communicable disease.

TAKING PRECAUTIONS

But Macpherson said it should not matter whether a student has HIV, hepatitis or any other illness. Universal medical precautions require school officials to wear medical gloves when treating any student who is bloody. “You should assume that everyone is HIV positive in any kind of instance involving blood,” Macpherson said. “Otherwise, you give the school nurse a false sense of security that if someone is HIV positive, she knows about it. But that’s not true. Most kids aren’t going to get tested. She’s most likely not going to know who has it. The student is most likely not going to know either.”

The current law also raises serious privacy concerns, Hutto said. “It’s a walking HIPAA lawsuit,” Hutto said, referring to the 1996 Health Insurance Portability Accountability Act, which limits who has access to an individual’s health information. “The first time someone inadvertently reveals this information, everyone who touches it will have a problem.” The requirement the state health department notify schools if a student has HIV/AIDS was adopted in 1988, when far less was known about HIV and how it was spread, and before HIPAA. “It represents the fear and hysteria which was present at that time,” said Bambi Gaddist, executive director of the S.C. HIV/AIDS Council. “But we have come far in understanding how you get it and how you don’t. Knowing what we know now makes this law obsolete.” (Gina Smith, www.thestate.com)

MINNESOTA

Health Department reports 325 new HIV/AIDS cases in Minnesota

ST. PAUL -- The Minnesota Department of Health says there were 325 new cases of HIV infection in the state in 2007. That’s up from the 318 new cases in 2006 and the 304 new cases in 2005. The numbers are in a report released Tuesday. Health officials estimate nearly 6,000 people in Minnesota know they are living with HIV. Health officials say that in the last six years, there has been a large increase in cases of HIV among males ages 13 to 24. There were 18 new cases among that age group in 2001, compared with 38 new cases in 2007. Of the 325 new cases reported last year, 249 are males and 76 are females. More than half of the cases among males were found in men who have sex with other men.

The report shows that new infections are much more common among blacks and Latinos than whites. Health officials say that may be due to cultural and language barriers, social stigma, and a lack of access to health care. (Associated Press)

STAFF MEMBER OF THE MONTH

MICHELLE SCAVNICKY

Michelle Scavnicky is currently the Director of Education with The AIDS Institute. The AIDS Institute is a national nonprofit organization that promotes action for social change through public policy research, advocacy and community education. Michelle has over seven years experience in the HIV/AIDS arena and over twelve years in the nonprofit sector. She began her career as a prevention coordinator with a prevention and substance abuse treatment facility in Youngstown, Ohio. After moving to Florida, Michelle focused on different areas of health prevention which included diabetes prevention, health and physical wellness and HIV/AIDS. Michelle worked with a local Tampa Bay organization as a Ryan White Community Health Planner before moving into an HIV Prevention Planner position. While holding this position, Michelle assisted in writing the local HIV/AIDS Comprehensive Prevention Plan. After being appointed to the statewide writing team, she assisted the team in developing and producing the Florida HIV/AIDS Comprehensive Statewide Plan.

Michelle has over seven years experience in the HIV/AIDS arena and over twelve years in the nonprofit sector. She began her career as a prevention coordinator with a prevention and substance abuse treatment facility in Youngstown, Ohio. After moving to Florida, Michelle focused on different areas of health prevention which included diabetes prevention, health and physical wellness and HIV/AIDS. Michelle worked with a local Tampa Bay organization as a Ryan White Community Health Planner before moving into an HIV Prevention Planner position. While holding this position, Michelle assisted in writing the local HIV/AIDS Comprehensive Prevention Plan. After being appointed to the statewide writing team, she assisted the team in developing and producing the Florida HIV/AIDS Comprehensive Statewide Plan.

Michelle is a currently pursuing a Master of Science in Human Services with a specialization in Management of Non-Profit Agencies and holds a Bachelor of Arts in community health education from Youngstown State University, Youngstown, Ohio.
Selvy Hall joined The AIDS Institute Board of Directors in July of 2007. She has a long history in social services including; AIDS Partnership Michigan where she is a Prevention Specialist, she was a Pontiac Area Urban League Volunteer. Her extensive training include; Certified State of Michigan HIV/AIDS Pre-Post Test Counselor, Community Health Outreach Workers Certification, American Red Cross HIV/AIDS Training, Syphilis Elimination Training, NMAC Women of Color Leadership Training, NAPWA Leadership Training, SISTAS Intervention Training. Selvy is also an active member in; National Association of People Living with AIDS, New Mt Moriah HIV/AIDS Ministry, Michigan HIV News Publication, Michigan Positive Perspectives Speakers Bureau, Lighthouse of Oakland County Community Development, Gilead Community Speaker. She is also a former Member of Southeastern Michigan HIV/AIDS Council, Michigan PWA Task Force, PWA Liaison for Michigan Department of Corrections, AIDS Council of Oakland County, Regional Community Planning Group, and Southern Christian Leadership.

Selvy is a public speaker in various churches, substance abuse centers, corrections facilities, local television and radio stations, national conferences, newspapers, public schools and videos. She has accomplished many milestones, including; Implemented the first HIV ministry within an African American church in Oakland county, Michigan; 1st and only person living with HIV to facilitate an HIV positive support group for individuals in the Oakland County Jail, Michigan; Co-authored the first white paper on HIV in the Michigan Dept. of Corrections; 1st female living with HIV to hold the position of Liaison for incarcerated individuals living with HIV for the Michigan Department of Correction; 1st African American Female living with HIV who founded an agency in the State of Michigan whose primary focus is HIV prevention and care; 1st female living with HIV to be a recipient of the 2005 Sojourner Truth Award from the National Association of Negro Business & Professional Women’s Club, Inc. Pontiac Chapter; 1st African female co-chair elect of the Michigan PWA task force.

**Background**

In 2006, 3,579 acute clinical cases of hepatitis A were reported to the Center for Disease Control and Prevention’s surveillance system and approximately 15,000 acute clinical cases and 32,000 new infections were estimated to have occurred. During 1990--2004, overall incidence of reported acute hepatitis B declined 75%, from 8.5 to 2.1 per 100,000 population whereas the most dramatic declines occurred in the cohort of children to whom recommendations for routine infant and adolescent vaccination have applied (Morbidity and Mortality Weekly Report, 2005). According to a new study conducted by the University of California-Los Angeles and reported by Reuters (2008), deaths in the United States related to hepatitis C virus (HCV) rose 123 percent from 1995 to 2004. Although the numbers have significantly declined among hepatitis A and B over the past decade, recent statistics related to hepatitis C indicates a serious need for preventative measures.

**Hepatitis 101**

The three most common forms of acute viral hepatitis in the United States are A, B, & C. However, hepatitis D is a defective virus that needs the hepatitis B virus to exist and hepatitis E is a virus that is transmitted much the same way as hepatitis A, however does not occur often in the US.

**Hepatitis A** is a liver disease caused by the hepatitis A virus (HAV). Hepatitis A can affect anyone and can occur in situations ranging from isolated cases of disease to widespread epidemics. Hepatitis A is transmitted through oral contact with feces from an infected person. Examples include eating food prepared by an infected person who did not clean hands properly, drinking contaminated water, eating raw contaminated shellfish, close personal contact (including sex & sharing a household) and oral-anal sexual practices.

**Hepatitis B** is a serious disease caused by the hepatitis B virus which attacks the liver. Hepatitis B can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Hepatitis B is transmitted through contact with infected person’s blood or body fluids through the following: sharing injection drug or tattooing equipment, unprotected anal, vaginal or oral sex, infected mother to her infant during pregnancy, delivery or breast-feeding, household contact, and occupational exposure through needle stick. (continued on page 20)
Hepatitis C is a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have the disease. HCV is spread by contact with the blood of an infected person.

Prevention
Hepatitis A and Hepatitis B vaccine is available for all age groups to prevent infection. In addition, hepatitis A vaccination is recommended routinely for children, for persons who are at increased risk for infection, including certain persons exposed to HAV, and for any person wishing to obtain immunity. Vaccination with the full 2-dose series of hepatitis A vaccine is the best way to prevent HAV infection. Hepatitis B vaccination is the most effective measure to prevent HBV infection and its consequences.

Additional preventative measures are recommended for hepatitis A and B. Hepatitis A preventative measures include: washing your hands after using the bathroom, after changing a diaper, and before preparing or eating food; avoiding sexual practices that result in oral-anal contact; or using a latex barrier between the mouth and anus; and cooking shellfish thoroughly. Hepatitis B preventative measures include: avoid sharing needles to inject drugs, tattooing equipment, razors or toothbrushes; wearing a condom every time you have sex; encouraging pregnant women be screened for HBV and routine vaccination for all infants; and using standard precautions in occupations which involve possible exposure to blood or body fluids.

There is no vaccine for hepatitis C, however there are recommended ways to prevent the virus. Similar to HBV, preventative methods include: avoid sharing injection drug equipment, avoid sharing tattooing equipment, razors, toothbrushes, or fingernail clippers, use standard precautions in occupations which involve possible exposure to blood, and wear a condom every time you have sex.

There is a wide array of resources available to assist individuals in educating and preventing the spread of hepatitis. For example, The Hepatitis B Coalition, a program of the Immunization Action Coalition, promotes hepatitis B vaccination; HBsAg screening for all pregnant women; testing and vaccination for high-risk groups; and education and treatment for people who are chronically infected with hepatitis B. (Michelle Scavnicky)

The following is a list of additional resources to gain access to information on hepatitis and vaccination:

The Centers for Disease Control and Prevention: www.cdc.gov/hepatitis
American Liver Foundation: www.liverfoundation.org
Immunization Action Coalition: www.immunize.org
Vaccine Information: www.vaccineinformation.org
Hepatitis Foundation International: http://www.hepfi.org

World Hepatitis Day 2008 – It’s Time to Act!
The AIDS Institute is proud to support World Hepatitis Day taking place on Monday 19 May 2008. Together with over 200 patient groups from around the world we are pledging our support to the first truly global awareness event for chronic viral hepatitis B and C.

Approximately 500 million people worldwide are affected by hepatitis B or C and the majority of those infected do not know. 1.5 million people die every year from either hepatitis B or C. Hepatitis C is 10 times, and hepatitis B 100 times, more infectious than HIV. If left untreated, hepatitis B and C can lead to cirrhosis, and potentially liver cancer, liver failure and death. Together we can all make a difference and supporting World Hepatitis Day 2008 is an important first steps towards this.

The AIDS Institute’s WIN Project is planning to host a one day leadership symposium along with an advocacy day in Washington, DC on Friday, June 27, 2008. The agenda will have a domestic and international focus while addressing disconnect between the two and demonstrating that HIV/AIDS is still a crisis domestically, as well. This event is an advanced educational program targeted toward the leaders of organizations from around the country. These skilled leaders will represent organizations that deal with; HIV/AIDS Care & Services, Reproductive/Gender Health, Human Rights for Women, and Domestic Violence against Women. The symposium will have panel presentations from national WIN partner organizations as well as local and regional partners. In addition, the event will provide the most current information on crucial issues in women’s health, allow for an exchange of ideas, offer networking possibilities for the program participants and provide an opportunity to work toward solutions. Finally, the participants will engage in advocacy efforts while meeting with congressional representatives as appropriate. For more information on the WIN Project, contact Michelle Scavnicky at MScavnicky@theaidsinstitute.org or Suzanne Miller at SMiller@theaidsinstitute.org. (Michelle Scavnicky)
National Women’s Health Week: May 11-17, 2008
A Week Of Targeted Preventative Health Strategies For Women

May 11-17, 2008 marks National Women’s Health Week which provides an opportunity for women to be proactive in their preventative strategies for their individual health. The theme for the week is “It’s Your Time: Get Inspired. Get Healthy.” Among the many facets of health issues include; HIV/AIDS, heart disease, diabetes and breast cancer, for which women are encouraged to get tested or screened. In particular, The AIDS Institute (TAI) strongly encourages women to get tested for HIV/AIDS and have knowledge of their status.

The well recognized National Women’s Health Week begins on Mother’s Day each year and individuals, families, communities, and others work to help women learn how to achieve longer, healthier, and safer lives. National Women’s Health Week empowers women across the country to get healthy by taking action. The nationwide initiative, coordinated by the U.S. Department of Health and Human Services’ Office on Women’s Health (OWH), encourages women to make their health a top priority and take simple steps for a longer, healthier and happier life. During the week, families, communities, businesses, government, health organizations and other groups work together to educate women about steps they can take to improve their physical and mental health and prevent disease, such as:

Engaging in physical activity most days of the week
• Making healthy food choices
• Visiting a healthcare provider to receive regular check-ups and preventive screenings
• Avoiding risky behaviors, like smoking and not wearing a seatbelt

Another well recognized effort is National Women’s Check-Up Day. The fifth annual National Women’s Check-Up Day will be held on Monday, May 12, 2008, during National Women’s Health Week. National Women’s Check-Up Day is a nationwide effort, also coordinated by the U.S. Department of Health and Human Services’ Office on Women’s Health, to do the following:

• Encourage women to visit health care professionals to receive or schedule a check-up.
• Promote regular check-ups as vital to the early detection of heart disease, diabetes, cancer, mental health illnesses, sexually transmitted diseases, and other conditions.

It is important for women to get regular check-ups because:
• Screening tests, such as mammograms and Pap smears, can detect diseases early, when they are easier to treat. Some women need certain screening tests earlier, or more often, than others.
• Many of the leading causes of death among women can be successfully prevented or treated if the warning signs are caught early enough.

The U.S. Department of Health and Human Services’ Office of Women’s Health (OWH) also provides tools to assist in the successful planning of activities.

Below is a list of ways you can celebrate National Women’s Health Week in your community.

Plan a health event.
Individuals and groups can plan activities to promote women’s health during National Women’s Health Week or any time of year. Learn how to plan everything from a health fair to a wellness walk with these tips.

Schedule a check-up.
Exams, screenings, and vaccinations can help you stay healthy. Take the time to get a check-up, Pap test, or mammogram, and encourage a family member or friend to do the same. National Women’s Check-Up Day is the day after Mother’s Day each year.

Learn your family history, and pass it on to other family members.
Knowing your family health history can help you take steps to lower your risk for developing health problems.

Send a health-e-card to encourage healthy living.
Let your friends, family, and co-workers know you care about them and their health and safety. Choose a card for Mother’s Day, National Women’s Health Week, or other occasions throughout the year.

Join the WOMAN Challenge.
The WOMAN Challenge (Women and girls Out Moving Across the Nation) begins every year on Mother’s Day. Thousands of women across the country embark on an eight-week physical activity challenge for better health, including at least 30 minutes of moderate activity or 10,000 steps (measured by a pedometer) most days of the week.

Check for safety to prevent falls.
Each year, thousands of older Americans fall at home. Many of them are seriously injured, and some are disabled. Falls are often due to hazards that are easy to overlook but easy to fix. This checklist will help you find and fix those hazards in your home or the home of an older family member, friend, or community member.

The AIDS Institute strongly encourages you to use this time to educate your families, sisters, mothers, grandmothers, daughters, friend, and loved ones to become proactive and preventative with their individual health. For more information, you may visit www.womenshealth.gov or www.girlshealth.gov. (Michelle Scavnicky)
Appropriations committee staffers in both the House and Senate were thrilled to be hearing this important message from citizens across the country. One staffer commented “This is absolutely terrific. It is not everyday that we get these requests from someone other than silver-spooned lobbyists.” The AIDS Institute would like to thank all those who took the time to participate in the tremendously important campaign. Whether or not increased appropriations are received this year, the education and heightened awareness surrounding the importance of ADAP and the entire Ryan White program may very well prove to be a significant asset in years to come. 

From Left to Right: Jason Kennedy, State Policy Coordinator for The AIDS Institute and Fred Schaich of International Foundation for Alternative Research in AIDS in Oregon and the ADAP Saves Lives Campaign presenting ADAP Cards to Corry Claussen from Senator Harkin’s office.

The State of Florida currently epitomizes an obstacle that advocates are facing in states across the country—namely severe budgetary crisis. Florida currently is facing a project revenue shortfall of approximately 3 billion dollars. This presents significant obstacles to advocates, who are finding themselves thrown into defense-mode rather than a paradigm characterized by battles for progress.

Budgetary calamities such as this present a formidable hurdle to advocates of healthcare issues, including HIV/AIDS. As the economy begins to shrink and state revenues shrink with it, demand for social services provided by the government is likely to increase sharply. Unfortunately, the state as two primary targets for costs savings (i.e. programmatic reductions): 1) education and 2) health care and support services. Of the two, health care and support services tends to be the favored target.

One half of all people who know they are HIV positive in the United States do not have access to proper medications, a startling number considering the effectiveness of antiretroviral medication in improving disease and public health outcomes. Currently, ADAP programs are only serving 70% of the clients enrolled in the program. This statistic not only highlights the need for more funding, but also which speaks to the need for adherence outreach programs, which is something that few jurisdiction can currently offer. By fully funding the ADAP program, 17,000 additional low-income Americans (not including the 30% of those currently enrolled but not being served) would have access to treatment they need in order to be healthy and productive members of society. In addition, individuals who are healthy are less likely to transmit the disease to others.

The AIDS Institute launched a three-fold campaign over the month of April geared to slowing if not stopping several proposed cuts to the state’s HIV/AIDS care, treatment, prevention, and testing programs. Perhaps one of the most successful arguments against cutting several of these programs is that all of the funding counts towards Florida’s required matching contributions to qualify for Ryan White Program funds from the federal government.
Thus, cuts in these areas may be multiplied under the Ryan White Program.

The South Florida AIDS Network, which is a hallmark of HIV/AIDS primary care in Miami-Dade County and the surrounding area, was targeted for funding cuts of up to $750,000. Such proposals could result in 2,000 patients losing access to a wide range of comprehensive primary care and treatment services that they depend on. Thankfully, in part due to phone calls from constituents across the state in response to action alerts published by The AIDS Institute, these proposals have been removed from cost-savings discussions in both the House and Senate.

On April 10th, the Florida House voted 86 to 27 to close the doors of A.G. Holley State Hospital, which is part of the Florida Department of Health. The hospital serves all 67 counties in the state, treating patients with the most difficult, dangerous, and resistant forms of tuberculosis (TB). A specialized center dedicated to fighting TB is absolutely essential to maintaining public health, especially considering that the hospital cares for patients that no other facility in the state is equipped to treat. Furthermore, approximately 50% of patients at A.G. Holley State Hospital are co-infected with TB and HIV. To our knowledge, the Senate has yet to take up this issue. The AIDS Institute encourages any Florida resident to contact their state Senator and explain how important proper care and treatment is for the HIV/TB co-infected.

Another success story concerns two HIV prevention outreach programs in Broward County that were slated to be eliminated in the House. However, these programs, which focus on Hispanic and Haitian communities, have been saved from the “budgetary axe.”

Other cost-saving proposals include elimination of and reductions to component of Florida’s Children Medical Services (CMS) program. The Regional Perinatal Intensive Care program’s proposed 27% cut would translate into reduced perinatal care for high risk pregnancies, which is essential for preventing mother-to-child transmission of HIV and ensuring the health of newborns. These prevention measures are overwhelmingly effective, and their discontinuation may lead to an increased number of infants being born with HIV, a tragedy which is almost completely preventable.

The Pediatric AIDS Network, another component of CMS, funds primary and specialty services to HIV infected infants, children, and youth, would have been eliminated under one Senate proposal. Termination of this program would have resulted in impacted children not having access to infectious disease management, pharmaceutical management, and nutritional counseling. Thankfully, this program too has been removed from cost-saving discussions in both chambers and is likely to be funded at an equal level in this current fiscal year.

These events illustrate the importance of the broader political picture to ensuring the sustainability of programs that provide life-saving care and treatment, prevention, and support services. Thank you again to those advocates from across the state who helped secure these modest victories. We want you to know that your efforts do have an impact and help save lives.

(Jason Kennedy)
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