Is our aging population protecting themselves from HIV?
Several editions ago I wrote in ActionLink that the appropriations season was upon us. It still is, although it is now winding down for the FY 2008 budget. In that piece, I discussed how a budget is a “moral document” for a society in as much as it sets out the values and priorities of that society. A budget represents which issues are important by reflecting where a society spends its resources and, opposite, which issues are less important or not important at all. In addition, the way we address social issues is a reflection of our values. Moreover, a budget forms a framework for how society will approach its future.

Although there remains a number of policy discussions about PEPFAR and other international programs, the FY 2008 budget for global AIDS is looking impressive. See relevant articles in this edition for details. Thus far, it reflects America’s moral engagement with addressing the AIDS pandemic worldwide, especially in the poorest countries with high rates of AIDS cases. It is a clear priority of Congress and the Administration. Now is the time for advocates to thank Members of Congress and the Administration for FY 2008 global AIDS appropriations and stress the importance of ensuring that the gains made so far in the budget process remain in place through implementation.

On the other hand, the domestic AIDS budget for FY 2008 does not look as good as detailed in this edition’s Federal Update. One troubling example is the lack of funding provided for HIV prevention through the Centers for Disease Control and Prevention (CDC). Where gains were made, for example in the AIDS Drug Assistance Program (ADAP), the amount is far below the anticipated need. As a society, and, in fact, as the richest and most technologically advanced society in human history, America can and must do better. The budget needs to reflect our moral engagement in addressing the domestic AIDS epidemic as much as it reflects our engagement in the global pandemic.

In thanking Congress and the Administration for global AIDS program gains in the FY 2008 budget, advocates can also demand that our federal government more fully address the prevention, care and treatment, and research needs of America’s domestic AIDS epidemic.
The highlight of this month’s newsletter is HIV/AIDS in the Aging population. The need for targeted efforts when it comes to HIV/AIDS prevention appears to be a reoccurring theme, especially in older adults. Findings suggest that the older population do not consider themselves at risk for contracting HIV and therefore the need for enhanced communication and prevention education is critical.

Marketing is the skill to communicate effectively with stakeholders and is an important component when it comes to engaging individuals in behavioral change. There are three common types of marketing:

• Agency Marketing - engages the community through time and money.
• Program Marketing - supports programs on an ongoing basis, as well as adjusting to changes in funding.
• Social Marketing - to improve visibility in the community around the agency’s cause.

In considering the older adult population and looking into long term prevention education efforts, a social marketing approach would be suggested. Three key elements are considered for an effective Social Marketing campaign and include consumer orientation, an exchange, and a long-term planning approach. These elements are interrelated and work around each other. For example, consumer orientation is the key element of all forms of marketing. The consumer is assumed to be an active participant in the change process. Next, for an exchange to take place there must be an exchange of resources or values between two or more parties with the expectation of some benefits. For older adults, the obvious benefit would be not becoming infected with HIV. And finally, to incorporate the long-term planning approach is where it starts and finishes with research, and research is conducted throughout to inform the development of the strategy. This is necessary as it indicates the overall effectiveness of the behavioral change process. When planning to engage in social marketing efforts, be sure to include the consumer. This is a critical component whereas participation is necessary for effective outcomes in comprehensive HIV/AIDS education no matter what the target population.

(Michelle Scavnicky)
Luckily there were heroes, many unsung heroes, doctors, nurses, and especially the lesbian community that stepped up to take care of their gay brothers. In the late 1980's the pharmaceutical industry started to make incredible breakthroughs which resulted in treatments and started the community back towards stabilization, and HIV infection became a treatable disease rather than a death sentence. We still don't have a cure but people are able to live longer while adapting to incredibly complex and toxic drug regimens into their lives.

The reason I wanted to remind people who may read this is I'm often confronted now with members of the gay and lesbian community who don't want to be reminded or associated as strongly as they have been in the past with the epidemic. I'm not sure when it or even how this change in attitude happened. But I do know that this gets translated in the lack of safe sex information distributed in the bars, meeting places, in our gay youth programs, in our elder meetings as well as support of people living with the virus and agencies providing services to them. Is this resulting in the increased incidence of HIV in gay men?

I believe that we should be proud of the work we have done in fighting this epidemic. The gay community showed the people of the world how to organize to move a large industry to address the highly stigmatized issues of HIV/AIDS and what a real standard of healthcare is. We should be proud of the activist groups and all the other demonstrators that worked tirelessly towards this goal. Taking a note from the civil rights movement, we started the large scale marches and rides to raise funds for a cure that have been copied successfully by other disease states, such as breast cancer. The community itself, by building chosen, extended families, will most likely become a model for elders as they age in place. These could well be the communities of the future! (continued on page 5)

We at The National Association on HIV Over Fifty (NAHOF) wanted to take this time to talk a little about our organization, its mission and the state of the AIDS epidemic in our communities.

The National Association on HIV Over Fifty was started 10 years ago by a group of doctors, nurses, social workers and people living with HIV/AIDS who saw the aging of the AIDS community. Along with the lack of a prevention message directed towards elders. The baby boomer generation that was reaching maturity. This was the sexual revolution generation and the beginning of gay rights, reproductive rights, and a change in how we looked at ourselves as sexual beings. So NHOF was born.

The National Associations' mission is to build, among those living or concerned with HIV/AIDS or aging, understanding and support for infected or affected older people and to expand community conversations and actions so that they include older generations and more fully address the interplay of aging with various disease states.

In pursuit of this mission we use research, education, communication, personal empowerment and thoughtful challenge.

NAHOF started because few were paying attention to the needs or contributions of people over 50 in regards to their life and health. We continue in order to foster and focus such involvement.

We believe that all people are created equal and that each individual keeps certain inalienable rights, including respect, information, uncensored self-expression, social support and self-determination.

We intend to promote engagement and mutual respect among professionals in aging and HIV policy, research, advocacy and care, to champion the viewpoints and voices of those over 50 in facing the health challenges of aging, including HIV/AIDS, its risks, treatment and prevention in an increasingly complex health and social matrix, and to ask how factors of age and disease states affect HIV prevention, diagnosis and treatment and how HIV affects the experiences of aging.

The epidemic—where has it been

Many of the people reading this article can still remember the early days of the HIV epidemic, the different stages we went through, the lack of knowing how the virus was spread and most importantly watching our chosen families waste away and die by the dozens, so much so that the gay newspapers regularly had an obituary column. As we looked to doctors and nurses, some of whom refused to treat us, there were no answers, and no response from our government.
Many of our alternate family forms care now for both people living with HIV and AIDS and gay and lesbian elders as they age in place. But we need help. There are many of us-after all we are the “baby boomers”. There will be a lot more of us needing supportive care and services as we age. In order to keep a quality of life for all elders we must look at elder services across the board and build alliances with traditional aging services organizations. This means an educational campaign towards service providers, health care professionals, and government officials. We need to support and encourage any programs and laws that support alternative family forms as caregivers.

When we talk about health care professionals, we not only mean doctors and nurses, social workers but personal care attendants and home health aides that need education. As we talk about immigration legislation we have to think about who are the people that are delivering basic non-medical services. I have yet to sit at a table where LGBT issues in general are discussed with nursing home providers, let alone HIV. Although at the end of June the AARP held its first Diversity & Aging Conference. This conference addressed the challenges faced by diverse populations, E. Perci Staford, Carmelita Tursi, Gloria Cavanaugh from AAPP as well as Amber Hollinbaugh from the LGBT Task Force worked tirelessly to make sure that all were equally and honestly addressed.

When we look at the epidemic today we see gay men, men and women of color, IV drug users, both active and in recovery, and people over fifty.

The epidemic is also growing in women of all ages but especially women over the age of fifty. For older heterosexual women, whose partners are using erectile dysfunction remedies, there has been an increase in sexual intercourse in these couples that may not be aware of their being a population at risk for STDs. Health care providers continue to be uncomfortable talking to people over fifty about their possible risk factors; particularly sexual risk factors and elders are also reluctant to bring up the topic with care providers as well as with their partners. According to a recent AARP study, 30% of men between the ages of 60 and 74 have reported that they are sexually active. Now some of that could be bravado, but 24% of women between the ages of 60 and 74 reported that they are sexually active. These women are post-menopausal and consequently more at risk for acquiring HIV, secondary to physiological concerns like vaginal dryness. However their providers are generally even less likely to discuss risk with these women because of their age and perceived distance from being actively sexual. In addition to these statistics, 17% of newly diagnosed cases of HIV infection are in people over the age of 50. In some states, such as New York and Florida, possibly due to the “snow bird” phenomena, it can be as high as 23%. 16% of people infected with HIV were IV drug users, some in recovery for as much as 10 years before being tested. The final group that is overlooked most often is the people still alive and infected by blood transfusions received during surgeries from 1979-1985 (CDC).

But what I don’t see is a large coalition of people who are infected or affected working together all inclusively toward a common goal of prevention, care, and treatment. What I do see is a lot of very dedicated people working in separate communities trying to solve the issues around HIV and AIDS and other disease states.

One of the reasons for this scattered approach has been the different level of acceptance of persons living with HIV/AIDS in separate communities and their ability to live openly with their virus. If we can get to the point of eliminating stigma we should be able to get to the common goal of a comprehensive prevention plan for every community.

There is one thing I do know, we are all getting older including everyone reading this who will be part of the larger aging majority.

In my effort to share the larger and more complicated picture, I don’t want you to forget that we at the National Association on HIV over Fifty (NAHOF) suggest that everyone get tested. So get tested and know your status. Staying safe by knowing what safer sex is, knowing who you’re going to go to bed with, planning ahead and recognizing that safe sex may even mean no sex.

The National Association on HIV Over Fifty has a local chapter forming in the Boston/New England area and you may contact Jim Campbell, president of the New England Association of HIV Over Fifty, for more information, including our upcoming conference. e-mail: NAHOF@HIVOVERFIFTY.org or visit www.HIVOVERFIFTY.org

Please if you have any questions or comments contact me and don’t be shy- let us know what you would like us to discuss or suggestions for a particular column please let us know. (Guest Writer, Jim Campbell, President NAHOF)

GLOBAL ORGANIZATION OF THE MONTH

www.ajws.org

American Jewish World Service
American Jewish World Service (AJWS) is an international development organization motivated by Judaism’s imperative to pursue justice. AJWS is dedicated to alleviating poverty, hunger and disease among the people of the developing world regardless of race, religion or nationality. Through grants to grassroots organizations, volunteer service, advocacy and education, AJWS fosters civil society, sustainable development and human rights for all people, while promoting the values and responsibilities of global citizenship within the Jewish community.

HIV/AIDS Projects

The HIV/AIDS pandemic is creating global social, economic and human rights disasters that have had a particularly devastating impact throughout the developing world. AJWS supports local groups and associations of people living with HIV that are devising effective and innovative strategies to limit the spread and mitigate the effects of HIV/AIDS in their communities.
ADAP, part of the federal Ryan White Program, provides access to HIV drugs to people who are uninsured or underinsured and can’t afford to pay out of pocket. It is a true lifeline for thousands of people around the country and has helped them remain healthy and productive. However, despite the growing number of people with HIV and aggressive testing programs that are identifying newly diagnosed individuals, federal funding for ADAP has been inadequate for the past several years. Last year, ADAP received no increase at all. This has forced many states to implement cost-saving strategies, such as capping enrollment, reducing the list of available drugs, and lowering eligibility requirements.

Our elected officials need to hear that this is an unacceptable situation and that they must support full funding for ADAP. They need to hear this from their own constituents – people in their own district and state who have personal stories to tell about the importance of ADAP. Our representatives do pay attention to what their constituents have to and your calls, letters, and emails make a huge difference. This type of grassroots advocacy has been at the heart of every legislative success in the fight against HIV/AIDS and it can make the difference between the current story of ADAP waiting lists or getting the funding needed so that everyone has access to treatment.

You can be a crucial part of this effort by taking a few minutes to call or email your House Representative and two U.S. Senators and asking them to support a $232.9 million increase for the AIDS Drug Assistance Program in the Fiscal Year 2008 appropriations bill. This is the amount identified by treatment experts as needed to allow all states to provide a minimal level of service to those in need. You can find contact information for your Representative at www.house.gov and your Senators at www.senate.gov.

By taking this small action, you are speaking for those who struggle to get the treatment they need to stay alive. You are also placing responsibility where it belongs—with those who are elected to represent us and who have the power to make sure everyone in this country can access the drugs and care they need regardless of ability to pay. (Guest Writer, Ryan Clary, Associate Director, Health Care Advocacy, Project Inform)

C2EA
Grassroots Organizing Revitalized

Founded in 2005, the Campaign to End AIDS (C2EA) is thriving. C2EA seeks to channel the energy of our foremothers, fathers, sisters and brothers from the Civil Rights movement. We see ending AIDS as a matter of social justice and believe that those affected—people with HIV/AIDS and their supporters from all backgrounds—must lead the fight to get the job done. We believe in both direct action and traditional advocacy.

“What makes C2EA unique is its ability to reach across all cultural and racial divides,” says Bishop Joyce Turner-Keller, National Co-Chair of C2EA. “We have one centralized focus, yet respect other voices and embrace diversity. Our impact has been immeasurable. There are people who were silent who now speak out. Our impact has been one of mobilization.”

Through lively debate, productive confrontation and focus on a common goal, C2EA has developed a sustainable structure that allows for all voices to be heard and the development of strategic action that make a difference in our communities.

C2EA is guided by an Executive Committee whose members now come from DC, Florida, Louisiana and New York but there are active C2EAsers in all 50 states, the District of Columbia and Puerto Rico. There are fully formed affiliates in 11 states and DC, with several states in different stages of organizing. State affiliates are made up of activists and advocates led by state chairs and regional representatives.

Within C2EA there are workgroups that allows activists to exercise their community organizing muscles. The Outreach Workgroup keeps its ear to the ground to identify areas around the country where action is needed. The Issues and Actions Workgroup provides the coalition with in depth policy analysis and suggested approaches to move policy makers at the local and national level to address the legislative issues that will make the difference. The SCOUT group develops strategies to collaborate with faith communities around the country to address HIV/AIDS – particularly in communities of color for this is where, historically, major change in these communities is supported. The Youth Caucus is hosting their 3rd Annual Youth Action Institute this month in Raleigh North Carolina where we continue to train another generation of activists and there is a burgeoning Women’s Advocacy Workgroup on the horizon. And finally there is a steering committee made up of the state and workgroup chairs and the executive committee. (Guest Writer: Christine Campbell, Director, National Advocacy and Organizing, Housing Works, Inc.)

For more information:
www.C2EA.org

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The AIDS Institute Urges The Presidential Advisory Council on HIV/AIDS to Focus More on Prevention Efforts

On June 12, 2007, The AIDS Institute gave public comment at The Presidential Advisory Council of HIV/AIDS (PACHA) meeting, urging for more action and attention to HIV prevention efforts in the United States. As we anticipate CDC’s likely announcement later this summer that the annual number of new HIV infections is substantially higher than the current 40,000, we must focus our efforts on evidence based HIV prevention.

While the CDC is in the process of finalizing an addendum to the HIV Prevention Strategy, there must be a plan in place to make sure the goals contained in the strategy are met. That plan must include comprehensive educational programs, programs targeting specific populations, and other proven prevention interventions. As Suzanne Miller, Public Policy Associate for The AIDS Institute, stated in her comments, “We congratulate the CDC for adding a number of objectives that focus on such populations as MSMs, African-Americans and other groups disproportionately impacted, and for addressing the issue of co-morbidities, such as mental health and substance abuse. We also hope Black MSMs will be singled out to receive a special focus since they are so impacted by the epidemic in the U.S.”

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C2EA fights for four main goals:

1. Full funding for quality treatment and support services for all people living with HIV.
2. Ramped-up HIV prevention at home and abroad, guided by science and communities, not politics and ideology.
3. Increased money dedicated to research for a cure, effective treatments and prevention tools.
4. A fight against stigma and to protect the civil rights of all people with HIV/AIDS.

Currently one of the major projects C2EA is focusing on AIDSVote 08 (www.aidsvote.org). Our goal is to make sure that every candidate running for office pledges to commit resources (at least $7 billion domestically and $50 billion globally) to end AIDS. In addition we need our leaders to change the conversation around HIV/AIDS. It is not good enough for us to talk about how bad it is. We need to have our leaders talking about ending this pandemic and showing the political will and leadership to make all the social changes necessary to make a difference. AIDS is part of a complex web of poverty, homelessness, racism, sexism, homophobia, and leaders must be willing to confront those challenges.

He also endorsed a pastor who tried to prohibit an openly gay man from joining the church. Time magazine reported in 1991 that Dr. Holsinger quit a United Methodist Church panel on homosexuality “because he felt certain the report would follow liberal lines.” He also has written that when viewing homosexuality, “biological and anatomical incompatibility” should be considered.

The AIDS Institute has been working with a number of allied organizations to investigate Holsinger’s record and educate the Senate and the public about him. We have participated in meetings with both the majority and minority staff of the Committee on Health, Education, Labor and Pensions, which must consider the nomination. Its Chairman, Sen. Edward Kennedy (D-MA) has already questioned the nomination, as has Committee members Sens. Christopher Dodd (D-CT) and Barack Obama (D-IL).

The Institute worked with the Washington Post, which led to an editorial on June 15th. The Post paid particular attention to his 1991 paper and wrote, “Senators who will meet with Dr. Holsinger this month need to determine-at a minimum-whether his judgment of sound science and best medical practices has improved since 1991.”

Copello concluded in our press release, “It’s difficult to see how a person with these views would be able to reach out to and be accepted by the gay community as an effective health and wellness messenger, a central role of the U.S. Surgeon General.” (Carl Schmid)
Beacons of Hope: the Future of Comprehensive Health Care

On June 8, The AIDS Institute hosted a forum focusing on Universal Health Care and HIV/AIDS Care and Treatment, the first of the Public Policy Forum Series the Institute is sponsoring this year. The forum consisted of a several expert panels highlighting state and federal efforts to advance initiatives such as Massachusetts' Commonwealth Care, the American Enterprise Institute.

Jeffrey Crowley, of the Georgetown University Health Policy Institute, opened the forum by explaining the need for universal access to care and treatment for HIV+ individuals. For example, while 14% of Americans were uninsured in 2005, 29% of those living with HIV/AIDS were uninsured. Furthermore, 62% of those living with HIV/AIDS are unemployed, compared to the 5% of the general population. Crowley, recognized the importance of not only access to healthcare, but also the necessity of that care being adequate and affordable as well. He suggested that federal healthcare coverage programs are more efficient at providing such treatment than is the private insurance market. Moreover, Crowley noted that while "recent state efforts to achieve universal coverage are encouraging... [they are] likely insufficient" for people living with HIV/AIDS.

On that note, a panel of state health policy experts engaged in a discussion illustrating how states are leading the way in health policy reform. The panel consisted of Isabel Friedenzoehn of Academy Health, Dr. Kalia Ladenthon of the National Conference of State Legislatures, and Tom Miller of the American Enterprise Institute.

While discussing comprehensive healthcare coverage initiatives such as Massachusetts' Commonwealth Car, Vermont's Catamouth Health, and Maine's Dirigo Health, the panel also highlighted the fact that these complex designs make implementation expensive and difficult, especially when coordinating with the private insurance market.

Under current arrangements, the private health insurance industry is oriented to providing care the largest number of people at the minimal costs, which in effect marginalizes those persons with expensive disabling conditions, such as HIV/AIDS. Figure 1 illustrates the fiscal necessity of government compelled cost sharing as the sickest five percent of the U.S. population accounts for nearly fifty percent of healthcare costs. Such high levels of cost of care are an unbearable burden for those rejected by the private health insurance market.

All members of the State panel discussed the importance and need for advocacy by the HIV/AIDS community during the implementation phase of these state reforms in order to ensure specific access for people living with HIV/AIDS. Fredrick Isasi of Senator Bingaman's office spearheaded a discussion of federal proposals for expanding health coverage. There are several proposals pending in Congress; they vary in objectives, approaches to funding, and effects. At the moment, Congress is dealing with healthcare expansion proposals such as SCHIP, and more comprehensive reform will likely occur in a future Congress under a new President.

Senator Bingaman's (D-NM) Health Partnership Act (S. 325 / H.R. 506) is a unique experiment in federalism. It seeks to establish a "State Health Innovation Commissions," whose purpose is to accept applications from states desiring to initiate a health care expansion program and make recommendations to Congress about which programs should be federally funded. "The Commission would consider applications that include a variety of approaches, such as tax credits, expansion of Medicaid or SCHIP, single payer systems, or a health savings account."

Rep. Pete Stark's (D-CA) AmeriCare Health Care Act (H.R. 1841) takes a straightforward approach at providing universal coverage by building on what works in today's healthcare system — Medicare and employer-based coverage. AmeriCare would use Medicare's existing administrative infrastructure, but improve its benefits to provide a comprehensive prescription drug benefit, mental health parity, pediatric care and family planning, as well as pregnancy-related services. (continued on page 9)
Its net impact on health care costs would be a $60.7 billion reduction in overall spending within the American economy.

Rep. John Dingell’s (D-MI) Medicare for All Act (H.R. 2034 / S. 1218) simply extends Medicare to all Americans under the age of 65. This bill will achieve universal coverage within 5 years through a three-stage phase-in. Furthermore, it will provide benefits equivalent to those every Senator and Congressman get through their publicly subsidized insurance plan and provide a choice of enrollment in Medicare or private plans through a plan similar to the one available to federal employees. Moreover, Medicare for All establishes incentives to improve quality and bring information technology to medical care.

These comprehensive federal proposals do not stand as a lone beacon of hope to those living with HIV/AIDS who are without healthcare coverage. Christine Lubinski of the HIV Medicine Association briefed those assembled on the importance of the Early Treatment for HIV Act, which gives states the option to provide access to Medicaid funding when diagnosed with HIV, before becoming disabled with AIDS. Not only would ETHA implementation over ten years save thirty two million dollars in federal Medicaid spending, but more importantly it would reduce the death rate for persons living with HIV on Medicaid by fifty percent.

Individuals living with HIV/AIDS can also take heart in the Institute of Medicine’s report to Congress on May 13, 2004 entitled “Public Financing and the Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White.” In this report, commissioned in the context of the Ryan White Care Act’s reauthorization cycle, the IOM called for the establishment of the HIV-Comprehensive Care Program (HIV-CCP) in order to ensure that HIV-positive individuals receive early and continuous access to comprehensive care. Such a program, according to the IOM, would reduce premature deaths by fifty six percent over ten years.

Sadly, due to the political time at which the report was released, the Institute of Medicine report was dismissed as unrealistic. However, The AIDS Institute holds that hope that the objective and scientific methods that went into producing this study may be taken more seriously as conversations of comprehensive care continue to evolve. The Forum was moderated by Dr. Gene Copello and Carl Schmid. For copies of the presentations by the panelists, contact the DC office at 202-835-8373. (Jason Kennedy)

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Congress Increases Funds For Domestic HIV/AIDS Programs

The 110th Congress has begun drafting appropriation bills for FY08, and if things hold up, it looks like many domestic HIV/AIDS programs will see funding increases. In the House, the Labor, HHS, Education Appropriation Subcommittee has recommended nearly a $100 million for Ryan White Programs and another $64 million for CDC HIV prevention programs. “While the increase falls far short of what is actually needed, we are pleased to see more funding for people living with HIV/AIDS and for prevention, particularly on the domestic front, which has been seriously neglected for several years,” said Dr. Gene Copello.

“We are pleased to see the AIDS Drug Assistance Program, which provides life-saving medications, is proposed to receive an increase of $41 million,” he continued. “With over 200,000 people living with HIV/AIDS in our own country not receiving antiretroviral treatment, and given the existence of waiting lists and other cost containment measures in numerous states, the actual need for increases to ADAP is $233 million.” This year, 27 states and the District of Columbia experienced cuts to their ADAP, and with new drugs coming on the market and increased HIV testing efforts, the demand will continue to grow.

Carl Schmid, Federal Affairs Director for The AIDS Institute added, “After repeated years of inadequate funding, it is encouraging that the large urban areas most affected by HIV/AIDS and early intervention programs are being recommended for increases of $32.3 million and $23 million, respectively. The Subcommittee also is recommending $3 million to states. With growing caseloads and funding cuts in 29 cities this year, this funding will be welcomed news.” Unfortunately, the Subcommittee chose to flat fund the program that provides services to Children, Youth and Families. The AIDS Institute will work on rectifying this in coalition with other organizations, as the bill progresses through the Congress.

“After five years of funding cuts for domestic HIV/AIDS prevention programs at the CDC, we welcome the proposed $64 million increase for these important programs,” added Schmid. “Although we have not seen specifics, we understand the bulk of this will be used for HIV testing. While we are extremely supportive of increased testing programs, we hope there will be increases for prevention educational programs, as well.” He commented, “Increased funding will certainly be needed to meet the goals contained in CDC’s revised strategic plan.

The Subcommittee also blocked funding for the unnecessary Early Diagnosis Grant Program, as it did in FY 2007. Currently no state qualifies for the money and funding it would require cutting CDC’s existing funds.

“Our biggest disappointment in the bill is an increase for abstinence-only funding by $28 million,” commented Suzanne Miller, Public Policy Associate for The AIDS Institute. The AIDS Institute has been advocating an elimination of all funding for these ineffective programs, and expected the Subcommittee to at least reduce funding. Despite study after study that concludes abstinence-only programs do not work, the Subcommittee chose to actually increase funding to a record level. “We are just dumbfounded by this action and will work hard to undo it,” Miller added.

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The House of Representatives passed the FY 2008 State-Foreign Operations Appropriations Bill on June 22, 2008. The subcommittee, chaired by Congresswoman Nita Lowey (D-NY), had prioritized responding to the global HIV/AIDS pandemic. In the subcommittee mark, a total of $6.5 billion was appropriated to global health programs. Of this amount $4.150 billion is directed to the Global HIV/AIDS Initiative, which matches the President’s request and represents a $1.280 billion increase above FY 2007 enacted funding levels. This increase represents one of the largest to date for the Global HIV/AIDS Initiative. $550 million was directed to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Additionally, the Labor Health and Human Services, Education, and related Agencies subcommittee mark appropriated $300 million for the Global Fund, putting its total at $850 million for FY 2008.

In addition to funding allocations for global health programs, the FY 2008 State-Foreign Operations appropriations bill also included very important provisions regarding the expansion to contraceptives and comprehensive prevention strategies. The contraceptives provision would expand access to contraceptives in poor, impoverished nations by providing a targeted exemption from the Mexico City Policy (Global Gag Rule) solely for USAID-donated contraceptives and condoms. This provision does not provide financial assistance of any kind to family planning organizations. It simply allows organizations to receive donations of contraceptives and condoms from USAID. The abstinence-only-until-marriage provision allows for greater effectiveness and flexibility in the fight against HIV/AIDS by allowing the President to waive the restriction under the President’s Emergency Plan for AIDS Relief (PEPFAR) that mandates at least 1/3 of HIV prevention funding be limited to abstinence-only-until-marriage programs. This will allow U.S.-funded programs to better respond to the differing features of the HIV/AIDS epidemic in each country. Unsuccessful attempts were made by Representatives Chris Smith (R-NJ) and Joseph Pitts (R-PA) to withdraw these provisions on the House floor.

Other important global health programs also received increases within the FY 2008 State-Foreign Operations Appropriations bill. Those included family planning, programs combating XDR-TB, malaria, and maternal and child health. In fact, Congressman Donald Payne (D-NJ) offered an amendment requesting an additional $50 million in funding for tuberculosis. The amendment was agreed to by voice vote. The Senate is expected mark up its version of the bill during the last week of June. (Jamila Taylor)

The William J. Clinton Foundation was established by former President Bill Clinton with the stated mission to “strengthen the capacity of people throughout the world to meet the challenges of global interdependence.” Serving as a developer of new policies and programs primarily through partnerships with individuals, organizations, corporations and governments, the Foundation’s main areas of concern are health security, leadership development, economic empowerment, and citizen service; and racial, ethnic and religious reconciliation. One of the main initiatives of the foundation: The Clinton Foundation HIV/AIDS Initiative (CHAI) launched in 2002, strives to make treatment for HIV/AIDS more affordable and to implement large-scale integrated care, treatment, and prevention programs. Its activities have included HIV/AIDS care and treatment in Africa including the brokering of drug distribution agreements. 550 employees, contractors and volunteers work around the world supporting CHAI's programs.

CHAI currently is working with 25 countries to strategically address the individual challenges at hand in each country, from training health care workers to building laboratory networks and more. In the countries where it has direct involvement, the Clinton Foundation aims to get between one and two million people on treatment by the end of 2008.

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The AIDS Institute is also disappointed the Subcommittee continued the federal funding ban on syringe access programs; a proven effective method to prevent HIV/AIDS.

After years of flat funding, the Subcommittee again provided no increases for Hepatitis prevention and surveillance at the CDC, although we understand an additional $1 million will be added when the full Committee meets.

Under the bill proposed by the Subcommittee, funding for medical research at the National Institutes of Health will only increase by 2.6%.

Funding for HOPWA also is slated for an increase by another House Subcommittee, which is recommending that it receive an increase of $14.1 million, just slightly more than what the President proposed.

Due to the controversy over earmarks, the appropriations process in the House has slowed somewhat so the Labor HHS bill won’t be considered on the House floor until July. The Senate was set to begin its work in late June; differences between the two chambers will have to be decided by a conference committee.

In other good news, the House Appropriations Committee has agreed to allow the District of Columbia to spend its own local dollars on a needle exchange program. (Carl Schmid)

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For all these major reasons and more, it is clear that there are a lot of underserved populations.

Through my colleague, I began to understand how CHAI is working hard on the ground to improve the infrastructure of community health centers, and improve the management and sustainability of specialized programs whilst constantly faced with unreliable resources of the basic necessities: continuous supplies of electricity and water. Nonetheless, they are making great strides one obstacle at a time. (Nuria Siraj)

The AIDS Institute Meets with Women Activists from Sierra Leone

The AIDS Institute met with Action Aid International activists Miata Jambawai and Sylvia Goba to discuss their program initiatives in Sierra Leone, particularly those focusing on HIV/AIDS, violence against women, and the intersection between these two issues. While they do not have a specific program tackling women’s issues, their activities have very similar goals to the new TAI initiative, “Women Informing Now.”

Women, who comprise around 51% of the population, nominally dominate the population of Sierra Leone; while men dominate the social, economic, and political environment of the country. Therefore, women are left in a disadvantaged position and their lack of power manifests itself most prevalently in the violence against them. For too long, violence against women, or VAW, has saturated Sierra Leone’s society.

Action Aid International-Sierra Leone (AAI-SL) developed program initiatives by considering the media power within the country. This extensive power has a hold on the dissemination of information and awareness. The organization has involved media outlets in their campaign by broadcasting their regional and grassroots work nationally and raising awareness among Sierra Leonean women on just how much power they hold as members of society. While Action Aid works with coalitions, they began to see that the only way to achieve their goals, and in a timely manner, was to work with and form targeted task forces. This involvement included engaging women at the local level and proving their influence nationally. The organization has also seen the need to focus on local groups of women, facilitating their involvement, and letting them speak for themselves. Action Aid works with coalitions, they began to see that the only way to achieve their goals, and in a timely manner, was to work with and form targeted task forces. This involvement included engaging women at the local level and proving their influence nationally. The organization has also seen the need to focus on local groups of women, facilitating their involvement, and letting them speak for themselves. Action Aid has made attempts to incorporate more women’s issue-focused groups, ensuring the focus on the specific needs of women, rather than focusing on “people living with HIV/AIDS,”—this is due to the male dominated connotation that has surmised this phrase in Sierra Leone. However, Action Aid has found that men do need to be incorporated in their message, especially in curbing the prevalence of VAW. Therefore, once they had sufficiently established themselves with a feminist focused foundation, they began to bring men into the conversation. This integration did not happen early in the process due to fear that men would dominate the issue. (continued on page 12)
The major focus of AAI-Sierra Leone has been to investigate the ties between violence and HIV/AIDS prevalence in women, in attempts to subdue both problems. After studying this intersection, these activists realized that the two were inextricably linked. Therefore, they sought to unite HIV response organizations with women’s issue response organizations in order to start campaigning on behalf of VAW legislation instead of the two working in isolation. The Sierra Leone government, while not encouraging VAW, did not say it was unlawful. Ms. Goba cited one case in which the law states that “…it is permitted for a man to beat his wife, just as long as he does not actually break any of her bones”. The hypocrisy of the legal system fueled these women to focus on changing legislation; and through their tenacity, they have received a guarantee from the president of Sierra Leone to fast track three laws focusing on VAW and HIV/AIDS. These actions will place the laws before Parliament in consideration for implementation as constitutional laws. If these laws are approved by the Parliament, they represent a significant step forward for women in the Sierra Leonean society, granting them much more power than they previously held. (Jessica Retika)

Additional $15 Billion For PEPFAR

On May 30, President Bush announced that he will call on Congress to provide $30 billion in the fight against HIV/AIDS. This is an additional $15 billion over the original authorizing level for the President’s Emergency Plan for AIDS Relief (PEPFAR). Before President Bush announced PEPFAR in 2003, it was estimated that only 50,000 people in sub-Saharan Africa were receiving antiretroviral treatment. As of March 31, 2007, PEPFAR has supported life-saving antiretroviral treatment for approximately 1,101,000 men, women, and children throughout sub-Saharan Africa were receiving antiretroviral treatment. As of March 31, 2007, PEPFAR has supported life-saving antiretroviral treatment for approximately 1,101,000 men, women, and children throughout sub-Saharan Africa, Asia, and the Caribbean.

The President’s Emergency Plan for AIDS Relief is on track to meet its five-year goal of support for treatment for 2 million people infected with HIV. It is also well on the way to meeting and/or exceeding the goals of providing support for the prevention of 7 million new infections and support for care for 10 million people infected or affected by HIV/AIDS. As of September 2006, PEPFARsupported programs for Prevention of mother-to-child HIV transmission services for women during more than 6 million pregnancies; antiretroviral prophylaxis for women during 533,700 pregnancies; prevention of an estimated 101,500 infant infections; care for nearly 4.5 million women during 533,700 pregnancies; prevention of an estimated 101,500 infant infections; care for nearly 4.5 million women during 533,700 pregnancies; prevention of 7 million new infections and support for care for 10 million people infected or affected by HIV/AIDS.

While the global HIV/AIDS advocacy community is encouraged by this renewed commitment on behalf of the American people, we are also mindful of the fact that an estimated $45-$50 billion would be needed by 2013 to double the number of people on treatment. The leaders of the world’s 8 largest economies, the G8, in 2007 made a commitment to “scale up their efforts to contribute towards the goal of universal access to comprehensive HIV/AIDS prevention programs, treatment and care, and support by 2010”. In short, the $30 billion pales in comparison to what is really needed to meet goals outlined in the original legislation. (James Sykes)

U.S. AIDS/HIV Prevention Act of 2007: Striking the “Abstinence Only” Earmark from PEPFAR

Senator Dianne Feinstein (D-CA), along with her colleague Senator Olympia Snowe (R-ME), announced on July 6th, 2007, that they are sponsoring a bill in the Senate that would strike the “abstinence-only” earmark in PEPFAR’s reauthorization.

The bill, S. 1553, “HIV Prevention Act of 2007”, is in direct response to the Government Accountability Office report released in 2006, the Institute of Medicine review of the first 3 years of PEPFAR funding effectiveness, and the United States Agency on International Development review on HIV education. All of these reports found that the abstinence earmark restricts the ability of funding effectively to reach more of the “at-risk” population, limits individual countries from implementing comprehensive prevention programs, and stymies country teams from responding to local social norms and cultural traditions.

The “abstinence only” earmark, included in the PEPFAR legislation, is a monetary distribution requirement that states that, in countries receiving PEPFAR dollars, 33% of prevention funds must be allotted to “abstinence-until-marriage activities, sometimes at the expense of other programs.” The appropriation of the prevention funds in this way severely limits contraceptive distribution, safe sex education, as well as reducing efforts for other initiatives, such as mother-to-child prevention treatment. While the earmark is intended to influence only the prevention funds and their allotment, it also affects “services for married discordant couples, sexually active youths, and commercial sex workers, [as well as] medical and blood safety… condom procurement and condom social marketing.” These latter services were cited by the reports, as well as the country teams, as effectively contributing to prevention and treatment for at-risk and infected members of the population.

While “this bill does not prohibit the administration from funding ‘abstinence-until-marriage’ programs”, it instead “is about giving the administration and HIV/AIDS workers the flexibility to design the most effective HIV prevention program without having to worry about artificial earmarks that are based on politics, not science.” While Sen. Feinstein does believe that the abstinence programs do have merit and should be supported, the mandated earmark places undue emphasis on their importance. The report from the Institute of Medicine stated in its conclusion “there is no evidence to support a 33 percent abstinence only earmark; the 33 percent earmark does not allow country teams on the ground the flexibility they need to respond to local needs.”

S. 1553, HIV Prevention Act of 2007 is a counterpart of the House sponsored PATHWAY Act: both of which seek to strike the 33% “abstinence only” earmark from the mandated appropriation of PEPFAR funds for the 18/countries involved and dependent on those dollars. The existence of acts in both chambers of Congress will hopefully send a united message to the administration that the HIV/AIDS epidemic is in need of international assistance, not ideological indoctrination.


Senator Dianne Feinstein’s Statements on the Floor, 06/06/07 introducing the “HIV Prevention Act of 2007.”

Ibid.
I was fortunate to join two amazing individuals who are working in the field of HIV/AIDS: Dr. Maha AL-Najjar, Marie Stopes International Operations and Marketing Manager for the Social Marketing Project for Reproductive Health Services program in Yemen and Patricia Gilliam, ARNP, MEd, MSN, Adult HIV Nurse Practitioner and Clinical Consultant for the Florida/Caribbean AIDS Education and Training Center (AETC). The three of us developed a social marketing campaign to reduce HIV/AIDS stigma in Yemen as part of an introductory social marketing course held at the University of South Florida.

Yemen is located on the Arabian Peninsula in Southwest Asia and contains a population of approximately 21.5 million Yemenis (BBC, 2007). Social determinants identified as contributors to negative HIV/AIDS outcomes include “illiteracy, poverty, unemployment, a high population growth rate and widening social gaps” (Al Serouri, 2005, p. 10). The Joint United Nations Programme on HIV/AIDS states that “information points to a steadily growing epidemic since 1990, when the first AIDS case was reported” in Yemen (UNAIDS, 2007, p. 1). While HIV seroprevalence is hindered by a lack of surveillance and reporting, the official estimate provided by the World Health Organization (WHO, 2005) is 11,600. Stigma, misconceptions, and misinformation are “widely prevalent,” according to a cross sectional study conducted in 2005 to assess knowledge and attitudes among youth age 15-24 in high-risk communities (Al Serouri, 2005, p. 1).

Social marketing is the “use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole” (Kotler, Roberto, & Lee, 2002, p. 5). In addressing stigma within families in Yemen, our situation analysis included identifying fears (e.g., direct harm), myths (e.g., transmission through casual contact), and rumors (e.g., AIDS as an automatic death sentence). Positioning family member inclusion as more important and beneficial than exclusion set the tone for social marketing strategies aimed at positive behavioral changes. This ambitious project will require further research, testing, and refinement as stigma reduction efforts in Yemen move from planning to implementation and evaluation.

A further understanding of the commonalities and differences regarding stigma in Yemen and the United States will enhance The AIDS Institute’s mission to promote action for social change on both a national and global scale. (Peter Gamache)

**References**


**WEBSITE OF THE MONTH**

Alaskan AIDS Assistance Association. www.alaskanaids.org

![Four A's](https://www.alaskanaids.org)

**It’s All About Life: 20 Years and Counting**

The Four A’s is a not-for-profit AIDS service organization. We provide one-on-one case management, housing assistance and other supportive services to people living with HIV/AIDS as well as HIV prevention case management and outreach, and public HIV education.

Established in 1985 as a volunteer help-line service in Anchorage, Four A’s was the only organization in Alaska responding to the illness we now call HIV/AIDS. 2005 marks the Four A’s 20th Anniversary and as the AIDS epidemic has altered over the years, Four A’s has grown to meet the constantly changing needs of clients and has expanded its prevention activities.

Today, Four A’s has a 20 member, Board of Directors, with 20 full and part-time employees, and over 80 volunteers. Currently, Four A’s is providing direct services to over 305 persons living with HIV/AIDS and their families, and, providing prevention services to well over 30,000 persons annually.
Not only is Michael King a board member of The AIDS Institute, he is currently the Director of Prevention for the Alaskan AIDS Assistance Association. www.alaskanaids.org

His HIV career started at the Miami-Dade County Health Department, office of HIV/AIDS (2002). There he was the Community Liaison, charged with developing and improving community relations with six contracted providers in Miami.

Mr. King currently manages five HIV prevention programs with five staff members in Anchorage and the Matanuska-Susitna Valley. His undergraduate degree is a BS in Apparel and Textile Design from Michigan State University. He is currently a Graduate Student at the University of Alaska, Anchorage, working on his Masters of Science in Global Supply Chain Management and Logistics.

He is instrumental in creating the State of Alaska’s first Symposium on Crystal Methamphetamine, involving the collaborative efforts of 34 agencies and 80 volunteers. It was called “The Alaska Forum on Crystal Methamphetamine” and was a 6.5 hour event that has been broadcast numerous times on public access television. When Mr. King is not providing HIV education, his hobbies include teaching ballet at the Alaska Dance Theatre.

The AIDS Institute
In the News

* Carl Schmid provided a Federal Update at the Florida Hepatitis Educational Conference on June 29 in Orlando, Florida.

* Jamila Taylor has been invited to be a regular “Leading Voices” author for the online publication/blog RH Reality Check - Information and Analysis for Reproductive Health at: www.RHRealityCheck.org

* Jason Kennedy has been appointed as The AIDS Institute’s State Policy Coordinator.

Many patients diagnosed with HIV in the 1980s and 1990s have survived and now are entering their golden years. AIDS cases among the over-50 crowd reached 90,000 in 2003, and according to the Centers for Disease Control and Prevention, will account for half of all HIV/AIDS cases in the United States by 2015. Consequently, health care providers and social service workers are pioneering new ground to treat the growing number of HIV-positive older adults. Timothy Heckman, an Ohio University health psychologist, has been on the forefront of research involving HIV-infected older adults.

Heckman recently received a $1.5 million, four-year grant from the National Institute of Mental Health and the National Institute of Nursing Research to nationally test the effectiveness of a telephone support group for older adults with HIV. Seniors often feel embarrassment or out-of-place among what is usually a gathering of young people at traditional AIDS support groups. The seniors have different needs, which may not be met, or they may be uncomfortable talking about issues, such as sex, among younger people. "The telephone, as a tool for delivering support, is financially and psychologically easier for many older adults," said Heckman, who has spent the past eight years conducting AIDS research among the elderly and in rural populations. A project four years ago found that a telephone support program reduced depression for rural seniors. The results of that study were published in the Annals of Behavioral Medicine last year. Now Heckman plans to expand the geographical scope of the study and increase the number of participants.

“A separate study we conducted of older adults found that support groups which are designed to teach them skills to handle stress, obtain social support and cope more adaptively are more effective than brief therapy sessions initiated by the person or support groups where participants only discuss problems but do not receive what is called coping intervention treatment," Heckman said. He will further test that concept through the telephone support group study. Nearly 400 participants of the project will be divided among three therapy models, ranging from a 12-week telephone-delivered support group with sessions designed to improve the participants’ coping skills to less active therapy sessions in which participants receive individual guidance only upon request.
NEW JERSEY

Needle-Exchange Programs In Five New Jersey Cities Expected To Launch Soon, Official Says

The New Jersey Department of Health and Senior Services is reviewing criteria from five cities in the state that applied to establish needle-exchange programs, and a decision is expected soon, health department spokesperson Tom Slater said on Tuesday, the AP/Long Island Newsday reports. According to Slater, Atlantic City, Camden, Newark, Paterson and Trenton have applied to run programs. He added that the first pilot projects likely will be launched by the end of the summer (Delli Santi, AP/Long Island Newsday, 6/12).

New Jersey Gov. Jon Corzine (D) in December 2006 signed into law a bill that allows six cities to establish needle-exchange programs and provides $10 million to drug treatment programs in the state. New Jersey has the highest HIV incidence among women in the U.S. and ranks fifth in HIV prevalence in the country. In addition, it is the only state that does not allow injection drug users access to clean needles through community-based needle-exchange programs or with a prescription.

According to the New Jersey health department, 14% of new HIV/AIDS cases in the state in 2005 were attributed to injection drug use. The state health commissioner under the legislation must report to the governor and Legislature on whether the needle-exchange program is effective. In addition, people who participate in and run the programs would be required to carry identification cards that protect them from being arrested for possessing drug paraphernalia (Kaiser Daily HIV/AIDS Report, 12/21/06).

To be eligible for the program, a city much have at least 300 HIV/AIDS cases attributed to injection drug use per 100,000 residents and at least 350 confirmed HIV/AIDS cases overall. Twelve cities are eligible for the program but only five have applied, the AP/Newspad reports. According to Roseanne Scotti, director of the Drug Policy Alliance of New Jersey, Atlantic City and Camden are expected to establish the first programs. The Newark City Council recently approved a similar measure, according to the AP/Newspad (AP/Long Island Newsday, 6/12). The Patterson City Council on Tuesday approved an ordinance enabling the city to establish an exchange program, the Herald News reports (Maclinnes, Herald News, 6/14).

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If you were wondering about the theme of this year’s meeting it is One Family, One Voice, One Spirit.

If you require additional information, e-mail: conferences@nmac.org or call: (202) 483-6622

Over 3,000 workers from all fronts of the HIV/AIDS epidemic - from case managers and physicians, to public health workers and advocates - come together to build national support networks, exchange the latest information and learn cutting-edge tools to address the challenges of HIV/AIDS. www.nmac.org