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In many parts of the world, men who have sex with men (MSM) are the group most affected by HIV.



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With the dizzying array of HIV meds now available and new drugs being added every year, it may seem difficult if not impossible to make sense of all the choices. But in reality, for someone starting meds for the first time, there are only a few combinations of drugs that are recommended, and understanding the options is not as hard as it seems.

An HIV Medication Primer

by Mark Milano

In developed countries like the U.S., people with HIV have access to a range of first-line regimens and to second-line regimens if those fail. People in developing nations have fewer choices, although pills that combine certain drugs are available only outside the U.S. This article will cover all the drugs currently available, as well as the U.S. guidelines on which combinations are considered best. (For information on when to start treatment, see the "HIV Treatment Primer" in the Winter 2006 issue of ACRIA Update, available online at www.acria.org/treatment/primer.html)

WHAT'S AVAILABLE?

Six different types, or classes, of HIV meds have received approval from the U.S. Food and Drug Administration (FDA). The

best way to understand how these classes of drugs differ is to look at the life cycle of HIV and study how the drugs interfere with this process.

HIV is a virus, and viruses are very simple things. They are not even technically alive, since they are unable to reproduce on their own and consist only of a protein coat surrounding a simple piece of genetic material. The protein coat contains "spikes" that protrude and can attach to living cells. They're sort of like the burrs that you find in the woods sticking to your pants or socks. Viruses are very "sticky" since they must attach to a living cell in order to reproduce.

But each virus can attach to only a specific type of cell. Hepatitis viruses attach to liver cells, cold viruses attach to cells in the nose, and HIV attaches to any cell that has a CD4 receptor on its surface.

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ACRIA Trials In Progress

Crofelemer for Diarrhea

People 18 and older who have persistent diarrhea will first take crofelemer or placebo tablets for 6 weeks. Then everyone will take crofelemer for 5 months.

Avandia and Serostim

People with insulin resistance will take Avandia (rosiglitazone), or Serostim (growth hormone), or both for 6 months to see how they affect glucose, insulin levels and body shape.

KP-1461

People aged 18-60 who have taken an NRTI, NNRTI and PI, and have developed resistance or stopped the drugs for other reasons, will take KP-1461 (a new type of NRTI) with no other ARVs for four months.

SPRING: Aptivus in Diverse Populations

People 18 and older (half white and half non-white, half men and half women) who have taken an NRTI, NNRTI and PI (not Aptivus) and who have resistance to at least two PIs, will take a standard dose of Aptivus or

receive therapeutic drug monitoring to find the best dose for them.

IMPACT: Reyataz Resistance

People who have developed resistance to Reyataz will come in for one day of blood tests to study the I50L mutation.

Prezista Dosing

People 18 and older who have been taking HIV meds for at least 12 weeks will take Prezista with Norvir either once a day or twice a day, along with other HIV meds.

For more information on these trials, contact us at 212-924-3934 ext. 121.

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LETTERS TO THE EDITOR

To the Editor:

Thank you so much for publishing the "Special Issue on HIV and Aging" (*GMHC Treatment Issues*, April-June 2007). As a 60-year-old woman, I am glad to see people in my age group finally being included in the HIV discussion.

Twenty years ago, I watched many of my best friends die. My closest friend was diagnosed just before the first PIs came out, and he has remained in fairly good health since. Nevertheless, both of us are starting to experience some of the physical problems that come with growing older. He is positive and I am negative, but we are both facing arthritis, diabetes, and elevated cholesterol. The difference is that his condition is complicated by his HIV and the meds he is taking for that.

My friend and I have been each other's main supports over the years. I've helped him cope with bad drug side effects, while he bolstered me through my divorce. We're both looking at the future with a bit of trepidation, and we need the kind of information that was put forth in this issue.

Sincerely,
Angela Laurence

Photos used in *Achieve* imply nothing about the health status, sexual orientation, or life history of the models.

To the Editor:

Thank you for your article "Immigrant Women with HIV" by Rosa Bramble Weed (*ACRIA Update*, Winter 2008). I am one of those immigrant women who had to face many of the issues discussed. I found myself alone, without family, feeling powerless, and not having anywhere to go or anyone to speak with. Once I tested HIV positive I found myself even more desolate, not knowing about services available, or what would happen to me as an immigrant who had just tested positive.

There is such a lack of attention and services for immigrant women with HIV. There is a need for continued empowerment and programs that will allow all women to take control of their lives and make decisions about protecting themselves. More information needs to be made available. I felt the article made recommendations that are not only logical but also not so difficult that they cannot be accomplished.

Thanks,
Sandra Ramirez

Achieve would love to hear from you! Please send your comments to: Letters to the Editor, *Achieve*, 230 W. 38th St., 17th floor, New York, NY 10018 Or email them to: achieve@acria.org

An HIV Medication Primer *continued from page 1*

This includes CD4 T cells, as well as other immune cells.

In order to reproduce, HIV must complete the following steps:

1. Grabbing onto the doorknob

The process HIV uses to enter a cell can be thought of as opening a locked door. The first step is to grab onto the doorknob. HIV does this by grabbing onto the cell's CD4 receptor with one of the spikes on its surface. Drugs are being studied that may prevent this first step, but none have been approved yet. The immune system creates antibodies that fit over HIV's spikes in an attempt to prevent this step, but since HIV *mutates* (changes) so much, these antibodies are not able to stop all the HIV from attaching to CD4 cells.

2. Unlocking the door

Once HIV has grabbed onto the doorknob (the CD4 receptor), the next step is to insert its key into the lock. It does this by linking up with one of two additional receptors, known as the R5 or X4 *co-receptors*. Almost all HIV infections are caused by virus that uses the R5 co-receptor. Virus that uses the X4 co-receptor usually appears later in the course of HIV disease.

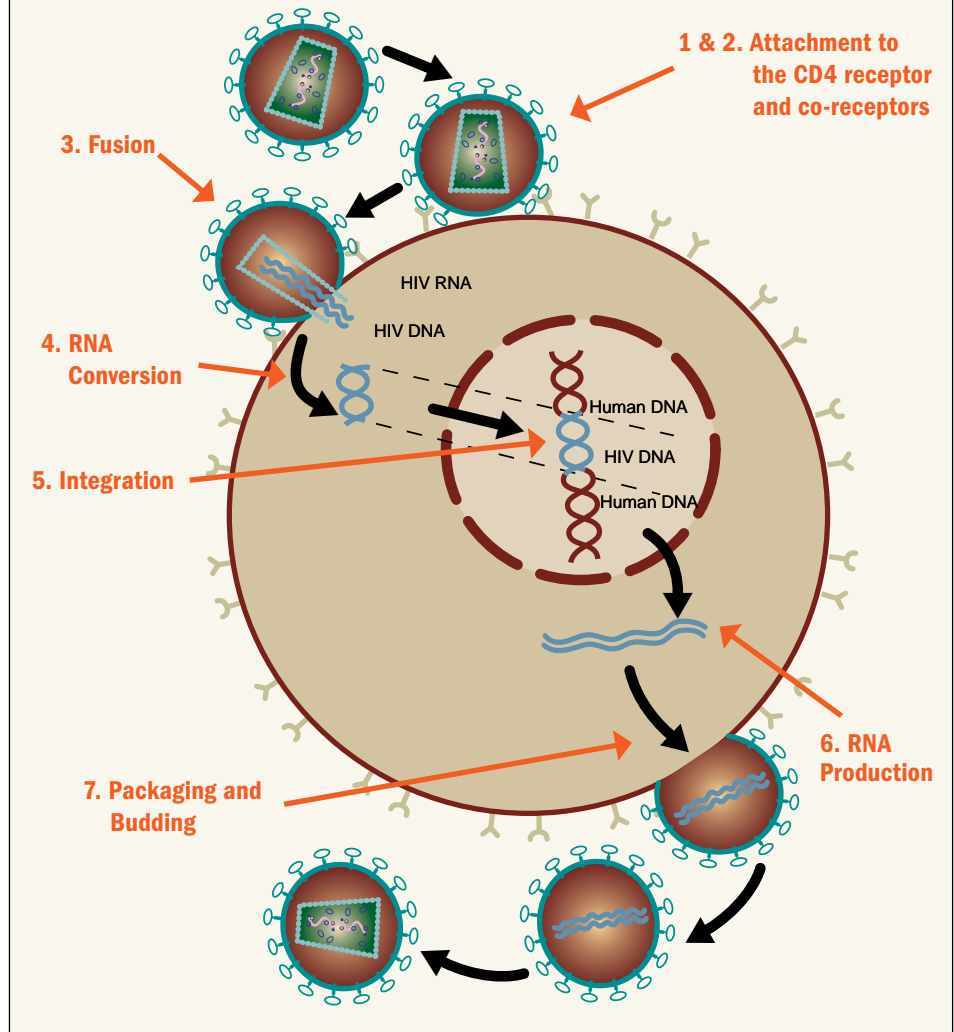
One drug has been approved that prevents HIV from attaching to the R5 co-receptor:

Selzentry (MVC)

It clogs up the co-receptor – kind of like putting glue into a lock to prevent someone from inserting a key. It was hoped that co-receptor inhibitors like Selzentry would be better than other types of HIV drugs, since they prevent HIV from even entering the cell. But Selzentry has so far been approved only as a second-line treatment, since early trials showed it didn't work as well as other meds in people who had never taken HIV drugs before. More studies are being done to see if it can be used as a first-line treatment, and other co-receptor inhibitors, like vicriviroc, are being studied in clinical trials.

Selzentry works only against virus that uses the R5 co-receptor, so it is not used in people who have any X4 virus. The FDA

The HIV Life Cycle



recommends that people get a *tropism* test before starting treatment with Selzentry. This blood test can tell if there is X4 virus in the body. If that's the case, Selzentry won't work.

3. Opening the door

If HIV is able to attach to the CD4 receptor and to one of the co-receptors, it now attempts to "open the door" by fusing, or joining, with the cell's wall. It pulls itself right up against the cell wall and shoots a spike into the cell to open it.

One drug has been approved to prevent fusion:

Fuzeon (ENF)

Fuzeon is also approved only as a second-line treatment, since it is a twice-daily injection and retails for almost \$25,000 a

year. In people who have become resistant to many HIV drugs, Fuzeon has been shown to be an important option to regain control of HIV. But it is usually used only if no other options are available.

4. Converting the RNA

Unlike most viruses, HIV contains RNA, which is the mirror-image of DNA (the strand of proteins that carries every living cell's instructions). This is why HIV is known as a *retrovirus*, and why drugs that work against it are called *antiretrovirals*.

Once HIV fuses with a CD4 cell, it inserts its RNA into the cell along with three enzymes it will use to reproduce. The first enzyme, *reverse transcriptase*, helps to convert HIV's RNA into DNA.

continued on next page

There are two classes of drugs that interfere with this process.

Nukes

The earliest types of drugs approved to fight HIV were all **nucleoside analogs**, or “nukes” for short. Here’s how they work: HIV creates new DNA using its RNA as a template – kind of like a printing press. It gathers nucleosides (simple proteins) from the cell and links them one by one into a DNA chain, using its RNA as the pattern. Nucleoside analogs are chemicals that are very similar to nucleosides, but they prevent the chain from continuing, since the next nucleoside cannot be attached to them.

Many drugs fall into this class, and they form the backbone of many first-line regimens:

Emtriva (FTC)
Epivir (3TC)
Retrovir (AZT)
Videx (ddI)
Viread (TDF)
Zerit (d4T)
Ziagen (ABC)

(Videx and Zerit are not prescribed often, because of dosing and side effect concerns.)

The nukes have also been combined into combination pills for easier dosing:

Combivir (Epivir & Retrovir)
Epzicom (Epivir & Ziagen)
Truvada (Emtriva & Viread)
Trizivir (Epivir, Retrovir & Ziagen)

Since these drugs all interfere with the reverse transcriptase enzyme, they are also known as nucleoside reverse transcriptase inhibitors, or NRTIs.

Non-Nukes

Another class of drugs – the non-nucleoside reverse transcriptase inhibitors, (NNRTIs or “non-nukes”) – also prevents HIV from completing its DNA chain. But this class interferes directly with the reverse transcriptase enzyme, which is needed to connect each nucleoside to the chain. They include:

Intelence (ETV)
Rescriptor (DLV)
Sustiva (EFV)
Viramune (NVP)

Sustiva is often used as a first-line “anchor” drug of a three-drug regimen, since it has been shown to be very effective when combined with two nukes. Intelence was just recently approved, as a second-line treatment for people who are resistant to Sustiva and Viramune. (Rescriptor is rarely used because of dosing and effectiveness concerns.)

One combo pill combines three of the most popular first-line drugs, and is taken just once a day:

Atripla (Emtriva, Sustiva & Viread)

Also, many combination pills containing generic HIV drugs are available only outside the U.S., including

(AZT & NVP) **(3TC, AZT & EFV)**
(3TC & d4T) **(3TC, AZT & NVP)**
(3TC & TDF) **(3TC, d4T & EFV)**
(TDF, FTC & EFV) **(3TC, d4T & NVP)**

5. Integrating the DNA

Once HIV has converted its RNA into DNA (known as proviral DNA), its next step is to insert this DNA into the cell’s DNA. It does this by entering the cell’s nucleus (where the DNA is stored) and using another enzyme known as **integrase**.

One drug that interferes with integrase has been approved:

Isentress (RAL)

Isentress is currently approved only as second-line treatment for those who are already resistant to other HIV drugs. Studies have shown it to be effective as a first-line treatment, but since it must be taken twice daily, it may not be as popular as once-daily regimens like Atripla.

6. Making more RNA

Once HIV has inserted its DNA into a cell’s DNA, it takes over that cell’s functions. The CD4 cell is no longer an infection-fighting cell; it is now just a factory that makes more HIV. But there is another important fact for people with HIV: The virus usually must wait until the CD4 cell becomes “activated” before it can begin making more HIV. And what activates a CD4 cell? An infection. So avoiding infections and treating infections quickly can prevent increases in the amount of HIV in

The process HIV uses to enter a cell can be thought of as opening a locked door. The first step is to grab onto the doorknob. HIV does this by grabbing onto the cell’s CD4 receptor with one of the spikes on its surface.

the body. People with HIV should not let symptoms like fevers, diarrhea, or rashes, for example, go untreated for days. Calling a doctor quickly and starting treatment sooner rather than later can help to keep HIV levels low.

If the CD4 cell is activated, the HIV DNA that has been inserted into the cell’s DNA now instructs it to start making long strands of HIV RNA, enough for multiple copies of HIV. Each of these strands must be cut into exactly the right length for each new copy of HIV. To do this, the virus uses another enzyme known as **protease**.

Protease was one of the first enzymes to be computer-imaged in three dimensions. Instead of just knowing which chemicals made up protease, scientists were able to see exactly how the enzyme was shaped. And they made an important discovery: Protease is shaped like a donut, with a hole in the middle. Using this hole, the enzyme moves along the RNA strand and snips off a piece of RNA exactly the right length for each new copy of HIV.

Protease Inhibitors

When they found out how protease worked, scientists were able to create the first “designer drugs” for HIV. Protease inhibitors are designed to fit directly into protease’s donut hole, preventing it from cutting the RNA strands to the right length.

While new HIV can still be produced, it is defective and unable to infect other cells.

So far, nine protease inhibitors have been approved:

Aptivus (TPV)
Crixivan (IDV)
Invirase (SQV)
Kaletra (LPV/RTV)
Lexiva (FPV)
Norvir (RTV)
Prezista (DRV)
Reyataz (ATV)
Viracept (NFV)

Crixivan and Viracept are not used often because of dosing and side effects concerns, and Norvir is rarely used at full dose. But it is often used to boost the amount of other protease inhibitors in the body.

Aptivus and Prezista are approved only as second-line treatments for those who are resistant to other HIV drugs.

7. Packaging and Budding

Once HIV is able to package all the pieces it needs for new copies of HIV, it “buds” from the cell, taking a piece of the cell wall and snipping it off for its own coat. Each infected CD4 cell can make hundreds of copies of HIV before it dies from the infection.

Drugs to prevent budding are currently being studied in clinical trials, but none are approved yet.

WHAT TO START WITH?

This is the decision that almost everyone with HIV will have to make at some point, since over 99% of people with HIV will eventually need meds to control their virus. But since it may be years before a person needs to go on meds, it’s smart to learn about the drugs before you need them and to decide, with your doctor, which drugs to start with.

There are U.S. guidelines, created by a panel of researchers, doctors, and consumers, on which drugs to start with. We know from long-term research that it usually takes at least three HIV meds to control HIV over the long haul. Using fewer than three usually allows HIV to mutate and become resistant to the drugs.

Current guidelines recommend start-

ing with two nukes, along with either a non-nuke or a protease inhibitor. The preferred nuke combinations are Epzicom and Truvada. (Combivir is now listed as an alternate choice.)

These should be taken with either a non-nuke or a protease inhibitor. The preferred non-nuke is Sustiva (Viramune is an alternate choice), and the preferred protease inhibitors are Lexiva, Kaletra or Reyataz (all taken with Norvir to boost their levels). (Invirase with Norvir is listed as an alternate choice.)

There is a variety of other combinations that are possible based on your particular situation. For example, people with kidney damage can’t take Truvada, Viread, or Atripla. So, people with HIV need to work with their doctor to choose the first regimen that is best for them.

WHEN TO SWITCH

When used correctly, these combinations can lower the amount of HIV in the body by over 99%. This is confirmed by an HIV viral load test about a month after starting treatment. If the test shows that HIV levels have not dropped significantly by that time, it usually means that other drugs must be tried. The goal is to get HIV levels to below 50 copies per mm³ (cubic millimeter – a few drops of blood). This is known as an “undetectable” viral load; if this can be maintained, the drugs can work for many years.

If a regimen works at first, but then stops working, it is usually due to low levels of drug in the body. This is sometimes caused by not enough drug being absorbed into the body, but the most common cause is missed doses. Missing as few as three or four doses a month can cause HIV to mutate and become resistant to the meds. If a person has an undetectable viral load, but then sees it go up and stay up, that usually means resistance has occurred and it’s time to switch to a new regimen.

WHAT TO SWITCH TO

There is now a broad choice of drugs approved for people who are resistant to HIV meds, including Aptivus, Fuzeon, Intelence, Isentress, Prezista, and Selzentry. (Older drugs may also work if

resistance has not developed to them.) A resistance test can provide good information on which drugs will no longer work for you, and will help your doctor choose a new regimen.

Many people have gone on to second and third-line regimens with success. The general recommendation is to switch as many drugs as possible, preferably all three. If only one drug is changed and HIV is resistant to the other two drugs, resistance to the new drug can occur within just a few months.

STAYING HEALTHY IN THE LONG RUN

The best option is to make your first regimen work for you. Preparing to begin taking HIV meds means talking about ways to avoid missing doses, known as **adherence**. Many adherence counselors are available

But since it may be years before a person needs to go on meds, it’s smart to learn about the drugs before you need them and to decide, with your doctor, which drugs to start with.

and have dozens of tips and tricks to help people with HIV take their meds correctly. Speaking with them *before* you start meds is the best way to achieve success.

Finally, staying healthy with HIV is not only about taking pills. Diet, exercise, rest, stress reduction, etc. all play important roles in supporting your immune system as it fights HIV. Using every tool at your disposal will not only delay the need for HIV meds, but help your body maintain health once you start them. ■

Mark Milano is an HIV Health Educator at ACRIA.

by Evelyn González-Figueroa, PhD, MPH

In many parts of the world, men who have sex with men (MSM) remain the group most affected by HIV. In 2000, about 25% of MSM in Latin America were HIV positive, up to 30% in the Caribbean, close to 10% (and climbing) in Asia, and about 7% in Eastern Europe. Even though there are few data on the number of MSM with HIV in Africa, we do know that in several African cities, 20 to 40% of MSM are HIV positive (compared with the general population rate of 0.2 to 6%).

To address HIV among MSM, we must also confront stigma, discrimination, poverty, violation of human rights, and homophobia – issues commonly found to be root causes of the epidemic. Some countries face unique problems, such as deep tensions between church and state, anti-sodomy laws, and political and economic unrest, as well as weak healthcare systems and a lack of data on the epidemic. Furthermore, while this article highlights many issues faced by developing countries, it is important to note that prevention remains a challenge even among some developed countries.

Stigma, Discrimination, and Human Rights Abuses

Even in 2008, gay men face arrest in 85 countries around the world if they openly state their sexual orientation. In some Latin-America and most Caribbean countries, laws prohibit “acts of gross indecency” (which can mean any kind of physical intimacy) between men in public or private. The penalties for expressions of same-sex affection can include imprisonment. In Central American countries, there is widespread harassment by police and healthcare providers. Gay men, MSM, and transgender people are also persecuted in India, China, and Egypt.

In many parts of Africa, laws do not need to be “interpreted” to be used against those engaged in same-sex behavior. Two-thirds of African countries ban male-to-male sex. Punishments range from imprisonment (five years in Cameroon, Senegal, and Ghana; life in Uganda) to death (Mauritania, Sudan, and parts of Nigeria). In addition to these legal chal-

lenges, current HIV prevention efforts are not effective in reaching MSM, and this affects both men and women. Limited research efforts in Kenya and Ghana have shown that MSM in Africa do not consider themselves at risk for HIV, since all prevention messages have focused on heterosexual couples. Many MSM that need to hide their true identity also have sex with women, adding to the risk women face.

Even in countries where homosexuality is not illegal, homophobia can be extremely harmful. Gay pride rallies have been attacked in Poland. In Moldova, where gay rights marches have been banned for the past three years, the prime minister linked homosexuality to disease. In May 2007, a peaceful and legal gay pride parade in Moscow was derailed after nationalist and religious protesters assaulted marchers with the help of police. Political leaders in Poland, Latvia,



Global HIV Prevention for MSM

In many parts of the world, men who have sex with men (MSM) remain the group most affected by HIV. In 2000, about 25% of MSM in Latin America were HIV positive, up to 30% in the Caribbean, close to 10% (and climbing) in Asia, and about 7% in Eastern Europe. Even though there are few data on the number of MSM with HIV in Africa, we do know that in several African cities, 20 to 40% of MSM are HIV positive (compared with the general population rate of 0.2 to 6%).

and elsewhere have spoken out against gay men and their rights as a western cultural ‘import’ alien to local values.

MSM and HIV

Because of this, gay men and MSM around the world are forced to remain silent, invisible, and hidden. Gay activists are experiencing burn-out due to governmental inaction in protecting their rights, and are increasingly going underground. For the HIV prevention community, this signals the need to become more creative in efforts to counter such harsh practices.

Many countries have only recently acknowledged the seriousness of HIV and established goals to halt its spread. Global efforts have expanded to involve organizations from various sectors, but funding must be increased, and a balance of prevention and treatment programs is necessary. Currently, evaluation of the progress on several goals is under way:

“...the spread of HIV/AIDS to have been halted, and begun to be reversed by 2015.”

The 6th Millennium Development Goal (U.N., 2000)

“To provide three million people living with HIV/AIDS in 50 low- and middle-income countries with life-prolonging antiretroviral treatment by the end of 2005.”

The World Health Organization and UNAIDS (3 x 5 Initiative, 2003)

“Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it.”

U.N. World Summit and the G8, 2005

Despite these lofty goals, prevention, care, and research related to gay men and MSM need significant improvements around the world.

Even in 2008, gay men face arrest in 85 countries around the world if they openly state their sexual orientation.

A Funding Snapshot

Commitments to fight HIV have varied widely among countries, and promises do not guarantee funding. This is especially true for countries that are recovering from civil wars, or that have inadequate systems for health care delivery, HIV prevention, and research. Certain criteria set by the World Bank that are required for countries to receive funding include the existence of a national AIDS council, development of a strategic approach to HIV/AIDS, procedures for financial management, and a commitment to transfer funds to non-governmental and community-based organizations.

International AIDS assistance is offered

mainly for HIV treatment, often leaving prevention programs underfunded. But funds have been distributed more quickly since 2005 thanks to U.S. involvement. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has contributed 70% of the funding provided by the three largest donors (the Global Fund to Fight HIV/AIDS, Malaria and TB; PEPFAR; and the World Bank). Although most PEPFAR funds are targeted toward a few core countries, a second level of funding is available to over 100 other nations. Leaders of many countries are unaware of this second level, however, and thus are unable to obtain these funds. PEPFAR is being restructured in 2008, and advocates, community leaders, and policy makers are working to ensure that it will promote prevention and care for MSM.

Overall, treatment and prevention strategies are not reaching people as planned. According to the most current report by the International Treatment Preparedness Coalition, just 28% of the 7.1 million people who need HIV treatment are receiving it in developing countries.

The Global Forum on MSM and HIV

So how do MSM around the world continue advocacy efforts around prevention, access to care, and improved research? At the 2006 International Conference on AIDS in Toronto, an international network of AIDS organizations, MSM groups, and other agencies formed the Global Forum on MSM and HIV to address this question. The Forum advocates for improved HIV programs for MSM around the world. Its objectives are: to increase research that enhances understanding of the issues faced by MSM and HIV, to secure long-term commitments to fund MSM programs from public and private donors, to create opportunities for new networks to exchange experience and ideas, and to promote collaboration between countries and regions. The Global Forum on MSM and HIV also promotes human rights concerns affecting MSM, discussing MSM issues at international meetings and encouraging MSM participation.

The Global Forum on MSM and HIV is planning an event on August 1-2, 2008, just before the International AIDS Conference in Mexico City, entitled *The Invisible Men*:

Overall, treatment and prevention strategies are not reaching people as planned... just 28% of the 7.1 million people who need HIV treatment are receiving it in developing countries.

Gay Men and other MSM in the Global HIV/AIDS Epidemic. The goals of the event are to share information, to develop strategies for expanding research and resources for HIV prevention, treatment, and care for MSM, and to foster advocacy that addresses discriminatory laws and policies. AIDS Project Los Angeles (APLA) is the Secretariat for the Global Forum on MSM and HIV. They manage all communications and work closely with the executive and planning committee-co-chairs, as well as other steering committee members in all processes,

Finally, APLA recently collaborated with the Coalition of Gay Organizations in Central America to publish *No Más en el Tintero: Hombres Gay: Nuestras Vidas y el VIH en Centro América y el Caribe* (Gay Men: Our Lives and HIV in Central America and the Caribbean). APLA is also preparing an analysis of the issues in China. These collaborations will garner support for initiatives to reduce stigma, create programs, and enhance awareness of the issues affecting MSM.

For more information about the Global Forum on MSM and HIV, visit: msmandhiv.org

For information on APLA's International Programs, visit: apla.org/programs/india.html ■

Evelyn González-Figueroa is the Associate Director of International Programs at AIDS Project Los Angeles.

The Battle for Global Treatment Access

There are 33 million people with HIV worldwide, but as of 2008 only 3 million of the 12 million who need treatment have access to it. The severity of the problem gets lost in the math and, like all social justice struggles, in the distance between “us” and “them.”



by Jennifer Flynn

In the early '90s, it was hard to surprise activists in organizations like ACT UP. Nothing seemed too strange to believe. AIDS might mean the end of civilization as we know it, or it might wipe out an entire generation of gay men, injection drug users, and poor Americans (who were predominately African American). Some even felt that the government purposefully unleashed this killer to deal with a variety of social “problems” like gays, the poor, and blacks.

But many of those same activists were truly surprised by the extent of the global AIDS pandemic. The numbers themselves are so huge that they can be difficult to comprehend. There are 33 million people with HIV worldwide, but as of 2008 only 3 million of the 12 million who need treatment have access to it. The severity of the problem gets lost in the math and, like all social justice struggles, in the distance between “us” and “them.”

But we shouldn't be surprised, because the story of this pandemic is the same story we've heard before: the most vulnerable people in the world are the most affected. Back in 1999, many people fighting AIDS had little idea of both its extent and the factors that were fueling it. It was left to a few trade and patent experts, like Rob Weissman of Essential Action and Jamie Love of Ralph Nader's Consumer Project on Technology to spread the word that millions of people around the world could not access lifesaving medications simply because the pharmaceutical industry insisted that the U.S. prioritize patent rights over drug access.

South Africa Makes the First Move

Because AIDS was a national health crisis in South Africa, its government passed the Medicines and Related Substances Control Act, which allowed it to import cheaper generic versions of lifesaving medicines from other countries. This was legal under World Trade Organization agreements but the U.S. challenged the Act and 39 drug companies sued South Africa to prevent any generic drugs from being imported.

Rob and Jamie told AIDS activists that Vice President Al Gore, who sat on the

U.S.-South Africa Binational Commission, had close ties (like many politicians) with the pharmaceutical industry. That was all a group of activists from ACT UP Philadelphia, ACT UP New York and Fed Up Queers needed to know. Al Gore wasn't simply the Vice President – he was weeks away from announcing his candidacy for the U.S. Presidency. So activists planned a carefully choreographed series of direct actions, disrupting Gore's first three announcements of his candidacy for President: in Carthage, Tennessee; Manchester, New Hampshire; and New York City. With simple banners that read "AIDS Drugs for Africa," a movement was born.

The activists' demands soon became international news and within three months, the U.S. had reversed its position and announced that "...the two governments have identified common ground with respect to South Africa's implementation of its so-called Medicines Act." This was later expanded to include all of sub-Saharan Africa when President Clinton issued an Executive Order stating that "...the United States will henceforward implement its health care and trade policies in a manner that ensures that people in the poorest countries won't have to go without medicine they so desperately need."

Durban: A Watershed

The next year, the International AIDS Conference was held in Durban, South Africa. According to Amanda Lugg of African Services Committee, "Durban blew the lid off the secret about the international AIDS crisis." By this time, reporters, politicians, and most importantly, AIDS activists all understood the complexity of global trade policy and the ways in which U. S. government complacency fueled the injustice.

Shortly before the Durban conference, the U.N. had established the "Accelerating Access Initiative" which was a collaboration between various U.N. agencies and several large pharmaceutical corporations. Countries would agree *not* to import cheaper generic medications and would be rewarded with price cuts from the manufacturers. While this would get some drugs into bodies, it also maintained the power of the pharmaceutical industry to name its price and continued to limit access to life-



One of the major steps in increasing access to treatment was the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria – a “war chest” for treatment.

saving medications.

In response, in large part, to activist pressure, AIDS was discussed by the U.N. Security Council in January of 2000. This was the first time that a disease was presented as a threat to the security of the world. In 2001, the U.N. held its first General Assembly Special Session on HIV/AIDS. At this forum, the "Declaration of Commitment to HIV/AIDS" was finalized. This document set concrete goals and commitments to provide treatment for people living with HIV in each U.N. member country. The countries had benchmarks to achieve, including ending discrimination against people with HIV and dramatically increasing access to HIV treatment. The ultimate goal was to provide treatment for 85% of those who needed it.

The Global Fund

One of the major steps in increasing access to treatment was the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria – a “war chest” for treatment. Activists from around the world got themselves invited to (or just crashed) the first meeting of the Fund and applied pressure for a fair and accountable Fund. With groups like Health GAP (Global Access Project) on the outside and the International Council of AIDS Service

Organizations on the inside, activists were able to barrage meeting attendees with ideas for funding levels, calls for distribution systems led by the communities themselves and the need for people with HIV to be on the Global Fund's board. But the U.S., which made the first contribution to the Fund, unfortunately set the bar low, committing only \$200 million. As expected, other nations followed the U.S. lead and contributed even less.

PEPFAR

By 2003, with a Republican in the White House, many had little hope that there would be any real commitment to combat HIV, yet President Bush used his State of the Union speech to announce "the opportunity to save millions of lives abroad from a terrible disease." He created the President's Emergency Plan for AIDS Relief (PEPFAR). This historic commitment provided \$15 billion over five years to fight HIV in the poorest countries in the world – the largest single commitment by one nation. Congress authorized support to provide treatment for two million people with HIV in 15 "focus countries" by 2008 and to prevent seven million new infections. In fact, this year Congress approved spending nearly \$6 billion on global AIDS

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The Battle for Global Treatment Access

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programs alone, \$600 million more than the President initially requested.

Current Battles

Fast forward to 2008. The Global Fund is deciding how to distribute its eighth round of funding, and PEPFAR is up for renewal. On May 30, 2007, in a speech in the Rose Garden, President Bush dramatically undercut his own program by proposing to “double” PEPFAR to \$30 billion over 5 years – \$6 billion per year. But the U.S. was already planning to spend about \$6 billion in 2008, so what the President announced was not a doubling, but in fact a flat-funding of a program that should be accelerating toward universal access.

This backsliding of PEPFAR II was most apparent in the targets for the number of people treated. In the first five years of PEPFAR, the U.S. aimed at treating 2 million people. But, by the end of the second five years (2013), President Bush proposed to only treat 2.5 million, or an additional ½ million over five whole years. Because the U.S. controls a third of the world’s economy, activists feel it should fund a third of the response to the global AIDS crisis, or \$59 billion during the next five years.

If we commit to the U.N. goal of providing treatment to 85% of those who need it, 19.2 million people would be on treatment at the end of 2013. But under the Bush scenario, there will be only 7.5 million on treatment by that date. When you subtract 7.5 million from 19.2 million,

you are left with 11.7 million extra people dying for lack of treatment.

According to Health GAP’s Brook Baker, “The AIDS pandemic continues to kill at an alarming rate – 3 million people are newly in need of treatment each year. Although new infections are finally falling, orphans and vulnerable children continue to overwhelm social support systems. Weak health systems are pushed to the breaking point. In this environment, President Bush’s treatment, prevention, and care goals in PEPFAR II all decrease dramatically – the only thing that doubles is deaths.”

'08 Stop AIDS

Given this information, Health GAP joined with other AIDS advocacy groups such as Housing Works, Global AIDS Alliance, Results, and the Student Global AIDS Campaign to create the '08 Stop AIDS Campaign. Activists used the tactic of “Birddogging” at each Presidential campaign stop to win real commitments from the candidates and to shift the public debate. Birddogging is a tactic that allows activists to directly confront key decision makers like Presidential candidates. Over 400 students, religious leaders, and people living with HIV have been trained to show up and ask detailed questions about the U.S. commitment to fight global AIDS.

In the months leading up to the first Democratic Presidential debate, AIDS activists urged each candidate to sign a commitment to fund PEPFAR II at the amount needed to truly reverse the AIDS pandemic: \$50 billion. In addition, ACT UP Philadelphia organized one of the most photogenic demonstrations the U.S. has seen in years, using vivid torches and red flares to make their point. By the time of the debate, each Democratic candidate had caved into the pressure and the threat of the demonstrations, and committed to the \$50 billion. The public debate had been altered and the President’s meager commitment of \$30 billion became obsolete and widely accepted as being too low.

However, the battle to ensure that PEPFAR II is effective is still being waged. Both the House and Senate Committees on Foreign Affairs authorized \$50 billion for PEPFAR II. But with the addition of tuberculosis and malaria, and a very detailed list



Family planning services need to be a part of a comprehensive plan to end the global AIDS pandemic. By increasing access to contraceptives and reducing unwanted pregnancies, not only do you advance women’s health, you also reduce the number of children born with HIV.

of lifesaving activities, the bill now needs to be funded at \$59 billion.

The Global Gag Rule

Just before the House Committee on Foreign Affairs was about to mark up the PEPFAR II bill, Congressman Tom Lantos, a hero to the global AIDS community, passed away. Immediately following his death, the new Chair, Congressman Berman, met with the President's staff, and created a compromise bill. Months of work on the bill, which would have created a truly comprehensive and effective proposal to fight AIDS, tuberculosis and malaria was flushed down the toilet by compromises that were made that night behind closed doors.

One of the worst additions was confusing and ultimately dangerous language about family planning programs. The new bill suggests that only family planning programs that agree to the "Global Gag Rule" will be eligible for funds to provide HIV education, counseling and testing. (The Gag Rule prevents organizations that get U.S. funds from taking funding from any source to perform abortions or to provide referrals for abortion.) AIDS activists have repeatedly told legislators that the Gag Rule should be repealed. Family planning services need to be a part of a comprehensive plan to end the global AIDS pandemic. By increasing access to contraceptives and reducing unwanted pregnancies, not only do you advance women's health, you also reduce the number of children born with HIV.

Health Care Workers

Activists are also fighting to strengthen health systems in the developing world. In the early days of global AIDS activism, the pharmaceutical industry and naysayer politicians liked to point out that health care barely existed in many countries throughout the world. While they pointed this out to explain why it would be impossible to actually provide lifesaving medications in those countries, activists responded by saying we should fix the problem. Hence the campaign for healthcare workers was formed.

AIDS is taking a major toll on the health workforce, from the illness and death of the health workers themselves to the enormous

stress AIDS is placing on health systems. In addition, the U.S. and other Western countries have long engaged in the practice of taking the best and brightest people from other countries and bringing them here to treat our sick. How quickly are health workers leaving? As of 2001, only 360 of the 1,200 physicians trained in Zimbabwe during the '90s were still practicing in the country. In 2002, more than 3,000 nurses who trained in Africa moved to the United Kingdom. Ethiopia is losing about 9.6% of their public doctors every year, primarily to other countries and the private sector.

We know that funding is needed to support 140,000 new doctors and nurses. The U.S. needs to contribute its fair share of funding for these workers, but also must ensure that it doesn't lure health care workers away from developing countries. It must support in-country training and retention of foreign health care professionals. And the campaign to win more funding for healthcare workers goes beyond AIDS. Funding will strengthen public health systems throughout the world and provide medical professionals to treat malaria and tuberculosis and to advance maternal and child health.

The Senate version of PEPFAR II only mentions 140,000 new "healthcare professionals and paraprofessionals." That vague language is no mistake. It could provide wiggle room that would allow the U.S. to focus on training poorly-paid community health workers and not the more highly-

trained doctors, nurses, and pharmacists needed to provide the U.S.'s one-third fair share. Of course we need community health workers to bring treatment and care to rural communities, but those local efforts can only succeed along with strong training, supervision, and referral systems. If we are not serious about strengthening health infrastructures throughout the world now, the crisis will just get worse.

Just ten years ago, we thought that universal access to HIV treatment was a utopian dream, but now it is a real possibility. The one very real barrier to maintaining HIV medication regimens is the number of doctors, nurses, and other health workers needed in developing nations to distribute them.

Conclusion

We shouldn't be surprised by these new life-and-death battles in the struggle for PEPFAR reauthorization. It is the same story: family planning gets left out because the groups that engage in this lifesaving work get painted as abortion providers. Funding is provided for only a fraction of those who need treatment. Women, girls, and sex workers get left out simply because "they" think they can get away with it. Let's take the next couple of months and prove to them that they can't. ■

Jennifer Flynn is the Managing Director of Health GAP (Global Access Project).



The one very real barrier to maintaining HIV medication regimens is the number of doctors, nurses, and other health workers needed in developing nations to distribute them.

Fighting for Treatment in Thailand

I was sitting in my doctor's office back in June of 1995, waiting for my test results. The doctor walked in and said, "So what disease do you think you have? Syphilis, herpes, hepatitis, or HIV?" as if it was a game show. I guessed herpes. "No! You have HIV!"

by Kamon Uppakaew

I felt nothing. I had no information about HIV and no idea about how it would affect me. I was 19 years old, and as I walked down the hospital hall to tell my dad, I felt more stressed out with each step; all of the messages floating around society at that time, such as "AIDS = death" and the scariness of AIDS, starting popping up in my head.

There went my chance to work in Taiwan, since getting a blood test was a requirement for working overseas. I told my father and my family that I wouldn't be able to take that job, even though I had passed every other test. My father was silent. My family was generally supportive, but like me, they had little information. I did think about killing myself when I was alone and my parents were out in the fields, but it was my love for them and thinking of how they had raised me that kept me from doing it.

When I went for another HIV test to see if it was true, I was introduced to a group of people living with HIV at my hospital in Khon Kaen, and it was good to see other people in a similar situation. There were no medications available at that time, so we mostly talked about what we were eating and what herbs we were using. Some of us tried macrobiotic eating: nuts, sprouts, red rice, pumpkin, and I would boil a special mushroom that my grandparents suggested. If we had fevers we would take Tylenol. Someone said a guy had a headache and then just died – we didn't know then that it was probably cryptococcal meningitis. We didn't even know about

generic Bactrim to prevent PCP, which cost one baht (three cents) a day.

Our group became the "Khon Kaen Friends Group," and that was the start of my involvement with AIDS work. We mainly acted as buddies, doing home visits and just talking. Many in the group were happy because they had no one to talk to; they were isolated from their families. Some were forced to live alone on their family's land, outside the family house. It was good to have their family members see that they could have friends help them bathe, to be with them and not ostracize them. In some cases, their children moved back in with them.

I was one of the only people in my area to start saying I was HIV-positive. I was nervous, because at that time no one talked about it. That annoyed me. People asked why I didn't go to Taiwan but when I told the truth, no one believed me!

One friend came to our group with these huge pills: AZT and ddI. We had no idea what they were. He took them in the morning and evening. He was in a study, but the doctor gave him no other information about the meds. He was okay for a while, but then he died. I guess he developed resistance. These were the only drugs available at the time, and only to people in special studies.

I was lucky enough to be invited to a meeting on Samet Island, with a group from the Bangkok Wednesday Friend's Club, an HIV support group at the Thai Red Cross. It was great to meet people who were doing more than just providing moral support ("gamlang jai") – they had information

Many said that we shouldn't even be talking about AIDS treatment, that it was too expensive for Thailand and we were living in a dream.

about treatment from a professor at the Red Cross who conducted trials to help people access medications. And they were all drinking and smoking! This surprised me, because I liked to drink and smoke, but in Khon Kaen we were shamed for this bad behavior. But I saw that the Bangkok crowd did what they wanted, regardless of what anyone thought. They were also doing real community mobilization.

When I went back to the northeast, we started creating support groups there. We didn't have cell phones, but my new Bangkok friends would call and keep in touch. They had to call the village phone, and someone would come running to my house to tell me that I had a call. I ended up going to a pivotal meeting in Chiang Mai, which led to the founding of the national PLWHA network, and it was there that I

heard people with HIV talking about treatment information, having sex as a positive person, living as a couple, etc. At that time, having a sexual partner was taboo for people with HIV.

In fact, when I decided to get married, the organization that housed Khon Kaen gave me an ultimatum: lose my job if I got married, or keep working and get a raise. They thought people with HIV shouldn't marry or have children. I chose to get married, and went back to my village. But then a grant that I had written was accepted, and they told me the CDC wouldn't fund it unless I was part of it. I went back, but I insisted that the small group of people who supported me become independent. So we moved into our own space and did a lot of good work at that time.

I started hearing that other countries had HIV treatment called "ARVs." But we were dying of TB, PCP,

Medecins Sans Frontieres (Doctors Without Borders) had a chapter in Bangkok and they were a key partner for us.

When I was at the beach with friends and couldn't ignore the rash anymore, I finally got a CD4 count, and it was 66.

and crypto. We fought with the HIV organizations here because many said that we shouldn't even be talking about AIDS treatment, that it was too expensive for Thailand and we were living in a dream. But we had to know what this was and why we couldn't have it.

Medecins Sans Frontieres (MSF, Doctors Without Borders) had a chapter in Bangkok and they were a key partner for us. They helped us set up an activist fund for ARVs for people in our network who really needed treatment. We also focused on a campaign to get generic Bactrim for everyone who needed it, since it was affordable. We had to force our doctors to give it to us! They didn't have the knowledge to prescribe it when needed.

Unfortunately, I wasn't facing my own health issues. I had a rash on my arms and legs, but acted uncon-

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Fighting for Treatment in Thailand

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cerned. I just wore long sleeves. Though I knew it was a choice between dying or taking care of myself, I kept hoping I could wait until there was a cure for HIV. But my body was getting weaker. When I was at the beach with friends and couldn't ignore the rash anymore, I finally got a CD4 count, and it was 66.

I had a chance to start treatment through the government's "Access to Care" program, which had meds for only 1,600 people. And once you were on a regimen you could only take that one. Even if you failed on it or developed an allergy or whatever, you could not switch to another regimen. You simply had to stop. But

If you were very poor you had to be selected by your village headman, who could buy healthcare for 500 baht. But this option was limited to a certain number of families around the country.

since I was part of a PLWHA network, I was able to get generic meds from India (illegally), and did that instead of taking one of those precious slots.

I really didn't want to start HIV treatment because it was a change I was not ready for, including having to stop drinking and smoking. Also, I thought that once I started I would be on it for the rest of my life. And if I developed resistance, there were few options available (which is still true today).

I started with vitamins, which is how they test us to see if we can be adherent. I then got nevirapine for two weeks, and finally they added the 3TC and d4T. I soon developed neuropathy, but stuck it out and luckily it never went further up than my legs. My flip-flops were constantly slipping off. To this day I still experience the numbness, but it's not a big deal.

About three months after starting ARV, I got sick with TB. My doctor told me to stop taking my HIV meds while I was on the TB medicine, because of drug interactions. But because of my involvement with MSF, I knew that I could switch to efavirenz to avoid the rifampin interaction. I fought with the doctor, and ended up having to hide the fact that I was continuing to take my HIV meds.

The only time I missed my treatment was for a few hours when I was detained with 1,400 other interna-

tional activists during the WTO demonstrations in Hong Kong. We were attacked with tear gas and pepper spray. They arrested many people, including about 98 Thai protestors, but they released most of us. I finally managed to have my ARVs returned to me after they let me go to the hospital where a doctor confirmed I should take them, but my wrists were still handcuffed and my legs were in chains.

At that time, there were different healthcare plans for different people. If you were very poor you had to be selected by your village headman, who could buy healthcare for 500 baht. But this option was limited to a certain number of families around the country. There were other healthcare plans for civil servants and laborers, but we felt that everyone in Thailand should have access to healthcare. As people living with HIV, most of us very poor, we were concerned that there was no coverage for us.

We needed 50,000 signatures to propose a parliamentary bill, so people with HIV across Thailand mobilized and got at least 30,000 of those. Then the country's Prime Minister stole our idea and transformed it into his campaign platform, the "30-baht Plan," where in principle any healthcare cost 30 baht. Of course in reality it didn't work that way, and the system had many limitations and strict eligibility criteria. Today, the system has been improved, recognizing that the care should be free, but there are still many issues to work out. We also illegally imported Triomune, a generic HIV med from India, before Thailand began making its own version of this combination of 3TC, d4T, and nevirapine, called GPO-vir.

My wife (who has HIV but still does not need meds) and I decided to try to have a child, one of our dreams. I saw that dreams could come true – I could have HIV and not die right away, and I could get treatment. We did a lot of research about our options and about the potential of her developing resistance to nevirapine. But we decided to go ahead, and I will never forget the phone call I got after we tested our new daughter for HIV, when I learned that she was not positive. I was so nervous I almost didn't answer the phone!

I feel like all the activism my friends and I did was beneficial for me, too. Those nights sleeping in front of the Ministry of Public Health during protests, illegally importing our first generic meds from India – these actions had meaning not just for the movement for overall health rights, but for the lives of my friends, and for me. I truly believe that the problems that we face are best solved by us, with our voice. We are so clear about what we need. ■

Kamon Uppakaew is a former chairman of the Thai Network of People Living with HIV/AIDS (TNP+) and currently manages the PLWHA community development program at Thai AIDS Treatment Action Group (TTAG) in Bangkok.

Microbicides

LOOKING BACK WHILE MOVING FORWARD

Seventeen years ago, a Ugandan woman stood up at a conference and asked, “If they can put a man on the moon, why can’t they make something we can use to protect ourselves from HIV?” Since then, researchers and advocates have tried to answer her call. In a world where a young African girl is much more likely to get HIV than an African boy, finding the answer has never been more urgent.

by Katie West

One of the answers may be microbicides. Microbicides are products that can prevent HIV infection, and possibly other sexually transmitted infections. Some are designed for vaginal use and some for rectal use. They may take the form of gels, creams, suppositories, films, lubricants, or even a sponge or a vaginal ring.

Over 1,200 people gathered in New Delhi, India, last February at the Microbicides 2008 Conference (M2008) to discuss recent developments and next steps. Researchers shared the results of the first microbicide trials and presented updates on antiretroviral-based microbicides. Advocates spoke about ethical issues and the need to include more voices, especially those of women with HIV.

The Challenges of Clinical Trials

Carraguard

Although two microbicide trials ended prematurely during 2007, a large trial of a microbicide candidate called Carraguard recently finished on schedule. This was a milestone in itself because microbicide trials are very difficult to conduct. People in the trials may not use the product correctly, so researchers need a large group. In the Carraguard study, there were over 6,200 women who were followed for up to two years. The trial found that Carraguard was safe and acceptable, but that it did not prevent HIV. This was of course disappointing to everyone who had been watch-

ing this microbicide for over ten years.

These trials also provided information on how to adapt research so that it responds better to some of the challenges that arise. For example, people in the Carraguard trial had a hard time sharing information about their sex lives and how they used microbicides during sex. But without this information, studies can't tell if a microbicide fails because of a problem with the product itself or because it wasn't used consistently or correctly.

As every doctor knows, most people don't tell the truth about sex. They also have different ideas of what sex is. And most people tell researchers what they think they want to hear. There are various ways to deal with these problems. Some trials use computers for the interviews, since people may be more honest with a machine than with a person. In addition to asking people whether they used the microbicide, one trial tested the microbicide applicators to see if they had been used. Another trial let people answer the questions on a portable keypad device.

Community members and women's groups can provide valuable insights into how various factors and research decisions can affect adherence (consistent use of study products) and retention rates

(the ability to keep participants enrolled in trials). By involving the community, researchers can ensure that their desire to obtain accurate trial results does not unnecessarily burden or stigmatize the women volunteering for the trial.

ARV-Based Microbicides

Microbicides that would prevent HIV infection by using some of the same antiretroviral drugs (ARVs) that people with HIV use are also being studied. The first trial of an ARV-based microbicide began in 2007 by the Centre for the AIDS Programme of Research in South Africa (CAPRISA). Almost 1,000 women are testing a gel that is applied in the vagina before and after sex. Other ARV-based microbicides are also being studied.

While the potential of these new microbicides is exciting, concerns about the potential for drug resistance are being raised. What happens if a woman becomes infected while using an ARV-based microbicide, either because the microbicide did



not work or because it was not used every time she had sex? What if she knows she is HIV-positive but uses the microbicide to try to protect her partner? The HIV in her body could become resistant to the ARV in the microbicide, limiting her future treatment options. The chance of this happening depends on how much of the ARV in the microbicide is absorbed into the bloodstream. Researchers are now studying this.

Another important question about microbicide testing is whether or not the

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women in the trials will be able to get treatment if they become HIV-positive during the study. Much more discussion is needed around this issue.

Women with HIV at the M2008 conference raised concerns about resistance to ARV-based microbicides. Researcher Jeanne Marrazzo noted that resistance is on everyone's mind and that researchers will do everything possible to prevent it. People will be given monthly HIV tests and receive only a month's supply of the microbicide, to reduce the chance they will use it for too long while HIV-positive.

HIV-positive women also expressed concern that microbicides were only being developed for HIV-negative women. Louise



Binder, a well-known Canadian activist, warned researchers not to “make the same mistake that was made with treatment fifteen years ago – failing to take us up on our offer to get involved with shaping trials.” She urged researchers to involve women with HIV when planning and running studies.

Microbicides are products that can prevent HIV infection, and possibly other sexually transmitted infections. Some are designed for vaginal use and some for rectal use. They may take the form of gels, creams, suppositories, films, lubricants, or even a sponge or a vaginal ring.

Ethics of Clinical Trial Research

Another topic that received considerable attention at the M2008 Conference was the healthcare offered to women who become HIV-positive during the study and the ethical obligations of researchers to provide them with care.

Women who became HIV-positive during the Carraguard trial and those who tested positive at the start were referred to medical, psychological, and supportive services in their communities. Some of the trial sites offered additional services, such as CD4 T-cell counts, nutritional counseling, medical check-ups, and support groups. They were also invited to come back to the study clinic after the trial was over for follow-up visits. At these visits, they were offered CD4 counts, Pap smears, testing and treatment for sexually transmitted infections, counseling, and referrals to government HIV medication programs.

But how do trials meet the needs of those who stay HIV-negative during the trial and their partners? At M2008, The Global Campaign for Microbicides presented findings from a 2006–2007 study of the healthcare and prevention services provided in trials. This survey looked at how healthcare deci-

sions are made at trial sites. It also assessed how much progress is being made toward achieving the ethical goals laid out in key guidance documents. It offered recommendations to strengthen the ability to respond to health care-related challenges in future trials.

The Role of Civil Society

Civil society includes people who are involved, often through nongovernmental organizations, in trying to influence government policy or business practices. At M2008, one thing was clear: Civil society's role in microbicides research is expanding, and is increasingly important to donors, researchers, and research institutions. The impact of civil society was the topic of a day-long event at the conference attended by almost 200 advocates. The first-ever “Advocate's Corner,” a collaboration between seven civil society groups, offered advocates a way to share their work and materials, network with each other, and participate in skills-building workshops, including question-and-answer sessions with researchers.

Specific groups such as rectal microbicide advocates, sex workers, and women with HIV were also more visible and vocal than ever before. But more collaboration between civil society and researchers is still needed. We must ensure that these voices are not only heard, but are equal participants in the search for an effective microbicide. For more information about the Global Campaign for Microbicides and how to get involved in microbicide advocacy, visit www.global-campaign.org. ■

Katie West is a Program Associate at the Global Campaign for Microbicides.

Rectal Microbicides

WE NEED LESS SILENCE AND MORE SCIENCE

by Jim Pickett

At the opening session of the Microbicides 2008 Conference in New Delhi, India's Minister of Health and Family Welfare spoke about the importance of finding a safe and effective rectal microbicide (RM). Just hearing a public official talk about RMs was a significant victory for everyone fighting for them.

Rectal microbicides are products that could be available in the form of lubricants, creams, gels, douches, or enemas, and could be used to protect against HIV transmission when used during anal intercourse (AI). They do not exist yet, but researchers and scientists are working on them.

Around the world, almost all AI is unprotected. Compared to unprotected vaginal intercourse, unprotected AI is 10 to 100 times more likely to transmit HIV. Why? The lining of the rectum is more fragile than that of the vagina, and the cells that are open to infection are closer to the surface. During AI, this lining may rupture, allowing HIV to break through and infect these cells.

Unfortunately, our knowledge of who is having anal sex, with whom, and in what context is not clear. We do know that significant numbers of heterosexuals, gay men, and men who have sex with men (MSM) in developed and developing countries are acquiring HIV by engaging in this behavior.

However, by focusing almost exclusively on gay men, MSM, and the Western world (the Americas, Europe, and Australia) when thinking about the role of AI in the HIV epidemic, we fail to see

that this is a behavior that also happens between women and men and could be playing an important role in the heterosexual epidemic.

Meanwhile, our policies tend to ignore the very existence of gay men and other MSM in Asia, Africa, and other parts of the developing world. This neglect costs lives. In its ground-breaking report *Off the Map*,

the International Gay and Lesbian Human Rights Commission decried the wall of silence that surrounds AIDS and same-sex practices in Africa. The situation in developing countries outside of Africa is often much the same, with denial of male homosexuality and anal sex between women and men.

Very little research has examined the role of AI in the epidemic in developing countries. Studies in Senegal, Ghana, Kenya and Sudan, however, indicate that HIV rates among MSM are significantly higher than in the general population. This has also been demonstrated in most countries of Latin America, and in several countries and cities in Asia.

Many countries make anal sex a criminal act, and there is strong stigma, taboo, and homophobia associated with it. At the same time, there is a lack of clarity in the language we use to describe populations and the behaviors that put them at risk, so we do

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Around the world, almost all anal intercourse (AI) is unprotected. Compared to unprotected vaginal intercourse, unprotected AI is 10 to 100 times more likely to transmit HIV.



not fully understand the role of AI in the general epidemic. We tend to use sex acts as a way to identify populations – equating gay men with anal sex, for instance. Phrases like “heterosexual transmission” assume we are talking about vaginal intercourse, and actually hide the fact that women and men who identify as heterosexual engage in anal sex. This lack of clarity and honesty in discussing how HIV is transmitted between all types of human beings is troubling. It means that a significant portion of the pandemic often described as “driven by heterosexual HIV infection” could actually be caused by unprotected AI.

Language matters. Inaccurate, overgeneralized descriptions of the epidemic affect how we design HIV/AIDS programs, whom we design them for, and the kind of research we do. Ignoring populations and behaviors means important voices are silenced, and it also means these vulnerable groups are not served by prevention programs.



These dangerous silences – the denial of anal sex, and the denial of the existence of MSM – among communities, funders, policymakers, and even key players in the microbicide community – help to create the unfortunate circumstances we are in, namely, that the necessary resources have not been allocated to the research and development of safe, effective, and acceptable rectal microbicides. Funding for rectal microbicide research is a trickle compared to that for vaginal microbicide research.

So, when the top health official in India

“There is an ethical obligation here to advance the research and development of rectal microbicides, with good science and community awareness.”

simply mentions the words “rectal microbicides,” it really *is* a big deal. Ending the silence is the first step to getting the amount of funding we need to push the science forward. In addition, we need to push for more research into human sexual behaviors so that we have a better understanding of the epidemic, whom it affects, and how the virus is passed from person to person.

International Rectal Microbicide Advocates (IRMA), a network with over 600 members from 46 countries, released *Less Silence, More Science: Advocacy to Make Rectal Microbicides a Reality* at the Microbicides 2008 conference in India. This report, which can be found on IRMA’s website (www.rectalmicrobicides.org) calls for a Global Rectal Microbicide Development Plan. It describes the global challenges to their development, lists key goals and strategies, and serves as a reference on rectal microbicide science.

“Rectal microbicides are an essential technology that could allow men and women to protect themselves, without fear, without shame, without taboo,” says Ghana’s Manju Chatani, Coordinator of the African Microbicides Advocacy Group and a member of the IRMA Steering Committee. IRMA calls for at least a five-fold increase in funding for rectal microbicide research by 2010 – from \$7 million a year to \$35 million – and states that governments and foundations from Europe, Canada, Australia, and the U.S. must invest in this critical, desperately needed prevention technology.

“This work is so incredibly important. Every day we don’t move forward, thousands more get infected,” said Dr. Peter Anton from UCLA, principal investigator for the world’s first safety study of a rectal microbicide. “There is an ethical obligation here to advance the research and development of rectal microbicides, with good science and community awareness.”

Anton presented several times at the Microbicides 2008 conference, sharing some interesting early data from his study of a gel called UC-781, which contains a non-nucleoside reverse transcriptase inhibitor (NNRTI). The study was small and was designed to look at the gel’s safety. While all the data are still not fully analyzed, Anton noted that there were possible signs of efficacy – meaning that the product is not only safe, but actually may work to protect against HIV infection. We should know more in the next several months. Anton’s slide presentations from the conference are all available on the IRMA site, and Gus Cairns provides a nice, concise summary of this study at www.aidsmap.com (search for UC-781 to find it.)

“It is imperative that morality not get in the way of protecting human beings and life; people of every sexual orientation have practiced anal sex since the beginning of time,” according to Rick Jones of Amsterdam, representative from the Global Network of People Living with HIV/AIDS and a member of IRMA’s Steering Committee. “The time for bigotry is over. We need to help those who are not infected stay that way.”

Rectal microbicide advocacy includes you. If you only have a few minutes, you can be part of the solution. Visit the IRMA site and read a fact sheet, peruse a news item, or flip through a presentation to learn more. Sign up for IRMA’s active email list to stay in the loop. And share the love! Pass along the IRMA web address to another advocate, researcher, policy maker, or potential funder. You too can help end the silence! ■

Jim Pickett, who chairs the International Rectal Microbicide Advocates and is Advocacy Director of the AIDS Foundation of Chicago, has been living with HIV for 13 years.

Give Us Our Daily Meds

by Jorge T. Salinas

In Peru in the 1980s we first began to hear of gay men – friends – dying almost every day, one after another, while the government said nothing about HIV. The only news we heard came from friends in the U.S. At first we joked when someone would suddenly disappear – we’d simply say “murió” (he died). We didn’t know that these friends were actually dying of AIDS, and there was always silence around their deaths. Usually we would find out weeks or months after they passed.

As HIV became more visible, we organized to take care of those who were dying. I had a friend, Pepe, who became terribly ill in 1989. No one had any HIV medications, unless you had a relative wealthy enough to get drugs sent from the U.S. But Pepe had been abandoned by his family and had no one to take care of him. By the time he died in December of 1989, he had been diagnosed with CMV, crypto, toxo, shigella, salmonella, KS, typhoid, thrush, and more.

A group of friends organized to make sure that nothing like this happened to anyone else. We took care of those within our circle, but heard of many more who died in the same condition as Pepe or who chose to commit suicide to avoid the pain for themselves and their families.

I found out I was HIV positive in 1996, when I was given an HIV test without even being asked. I received a diagnosis of PCP, and my T-cells were at 160. Although I had been taking care of friends with AIDS, and had friends who would be understanding, I denied that I had been diagnosed with AIDS when my friends stopped by to visit – they didn’t even ask me, as if they all knew my fate.

I was told that there weren’t any HIV medications available, but that soon the health system would be set up so that I could be begin to receive them. I prayed that my fate would not be like that of so many friends. I did get better, but mainly because I began to take care of myself. I ate better, took all of the PCP treatments, and followed up with my doctor as much as I could – at the first symptom of anything I would be at the doctor’s office.

In 1999, I traveled to New York City and was able to get in contact with an agency there that could provide me with HIV medications. I didn’t think I would need them, since my health was better and I hadn’t gotten sick since I was first diagnosed. My friends suggested that I try to stay in the U.S, but I decided to go back to Peru.

In 2001, I became ill and felt as though my legs were becoming weaker, but my doctors could not figure it out. When I was sent back to New York for a training, I was pushed by friends to get a second opinion. I had dozens of blood tests along with multiple scans, but there was no clear diagnosis.

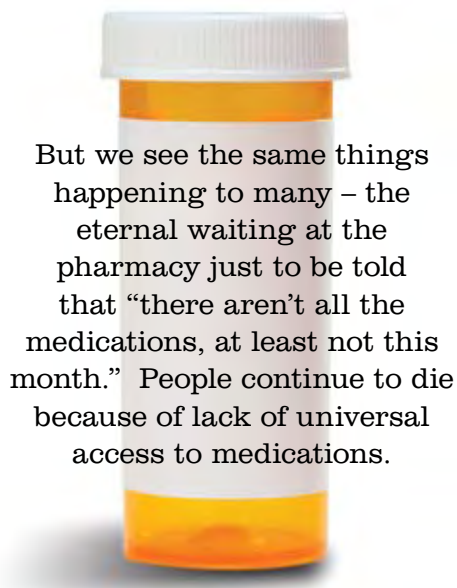
I returned to Peru, and a couple of weeks later my legs were so weak that I was unable to walk. I have never walked again, and use a wheelchair to this day. Once again, I was told that there weren’t any HIV medications, but that soon the health system would be set up to provide medications for everyone. But I couldn’t wait. My friends mobilized quickly and I began to receive HIV medications from the organization in New York City.

Finally, in 2004, I was told that I would have access to HIV medications through Peru’s social security health system. I decided to try this, but kept my access to treatment through the New York organization. I’m glad I did, because I would see my doctor and he would write my prescriptions, but sometimes after waiting for hours I would be given only some of my medications. I decided not even to attempt to get my medications through the social security system.

In 2006, the government finally announced it would provide universal access to HIV medications. Things have improved for some – for those better informed, for those with more education, for those who were lucky enough to be insured. But we see the same things happening to many – the eternal waiting at the pharmacy just to be told that “there aren’t all the medications, at least not this month.” People continue to die because of lack of universal access to medications.

It’s been twelve years since I was told that the system would soon be set up so that everyone could have access to HIV medications. Is it only the government’s fault? I don’t think so. While the government has attempted to increase the health budget, there isn’t enough money to cover universal access to HIV medications. There is much more that could be done, starting with HIV prevention, fighting discrimination against people with HIV, fighting ignorance, improving medical providers’ knowledge, etc. However, there needs to be open discussion with local and international pharmaceutical companies and global health organizations to allow universal access to medications.

While I still have a voice, I won’t be silent – there has been too much silence. I remember seeing the phrase “Silence = Death.” At first, I wasn’t sure what it meant, until I finally saw that my own silence was killing me. Silence will not become my death. ■



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PEOPLE WITH HIV NOT WELCOME HERE

by Nathan Schaefer, Felix Lopez, Vishal Trevedi, and Joshua Volle

The U.S. remains one of only 13 countries in the world to bar even short-term visitors from entering simply because they are HIV-positive. (The other 12 countries are Iraq, China, Saudi Arabia, Libya, Sudan, Qatar, Brunei, Oman, Moldova, Russia, Armenia, and South Korea.) This policy violates the

SINCE 1987, U.S. POLICY HAS BANNED HIV-POSITIVE NONCITIZENS FROM ENTERING AND BARRED THOSE ALREADY LIVING HERE FROM ATTAINING MOST TYPES OF LEGAL STATUS.

human rights of immigrants and travelers and contributes to stigma and discrimination. Highly skilled workers who have full health insurance cannot seek legal permanent residence in the U.S. if they have HIV, unless they have an opposite-sex spouse or

child who is an American citizen or lawful permanent resident. This discriminates against gay men and lesbians. Further, the ban undermines the global fight against HIV/AIDS by blocking access to treatment and returning people to countries where HIV care is limited or unavailable.

Since 1987, U.S. policy has banned HIV-positive noncitizens from entering and barred those already living here from attaining most types of legal status. Language in the U.S. Immigration and Nationality Act includes “infection with the etiologic agent for acquired immune deficiency syndrome” as grounds for inadmissibility. (Etiology refers to the cause of a disease, in this case HIV.) The result has been AIDS-related deaths abroad, as people are denied access to life-saving medications or are targeted for violence based on HIV status and real or presumed sexual orientation. The ban also undermines public health within the U.S., as immigrants avoid seeking healthcare and treatment out of fear of being deported.

UNAIDS Executive Director Dr Peter Piot said recently, “Travel restrictions based on HIV status again highlight the exceptionality of AIDS, especially short-term restrictions...No other condition prevents

people from entering countries for business, tourism, or to attend meetings. No other condition has people afraid of having their baggage searched for medication at the border, with the result that they are denied entry or worse, detained and then deported back to their country.”

Impact on Public Health

U.S. law bars aliens with HIV from entering the country even for a stopover. It also bars HIV-infected aliens *living* in the U.S. from qualifying for lawful permanent residence (getting a “green card”) except in the most limited circumstances. Many noncitizens first learn that they have HIV or AIDS while they are in the U.S. Some learn only when they receive the results of their Immigration Service medical exams.

Individuals denied green cards because of their HIV status confront a dilemma: Return to the country they came from, where they will often not have access to HIV treatment, or violate American law by remaining here, where HIV treatment can extend their life. At one time the lack of access to HIV meds outside of the U.S. was not a great cause for concern, as the earliest treatments were relatively ineffective. But antiretrovirals have greatly improved the length and quality of the lives of many people with HIV. Intended to protect the public health, the HIV travel and immigration ban has in fact not prevented HIV from increasing dramatically since the 1980s.

Aliens who want to become legal permanent residents must be tested for HIV. Those who test positive are subject to deportation. To avoid this, many “go underground” or hide from the Immigration Service. Many others, out of fear of being deported, may never get tested and ultimately may pose a greater threat to the U.S. healthcare system. In seeking to avoid detection, they may lose contact with health and social service agencies dedicated to helping those with HIV. Aliens who shun social service agencies do not receive the counseling and education they need to prevent the spread of HIV, which can lead to an increase – however inadvertently – in the cost of treating HIV.

The HIV ban was enacted in 1987, when homosexuality was still grounds for barring entry to the U.S. Hostility toward gay men was clearly at play in the development

of the policy. As it stands, the policy holds uniquely dire consequences for lesbian, gay, bisexual, and transgender people and those perceived to be. If they are deported, their positive status may “out” them in their countries of origin where HIV is equated with homosexuality, which in turn marks them for violence. Furthermore, people with HIV who manage to get a waiver for short-term travel to the U.S. have their passports stamped with an indicator that they have HIV and are thus branded at every port of entry on the globe.

Human Rights and Economic Costs

The U.S. was a prime mover behind the Universal Declaration of Human Rights, which was adopted by the U.N. in 1948. As

INDIVIDUALS DENIED GREEN CARDS BECAUSE OF THEIR HIV STATUS CONFRONT A DILEMMA: RETURN TO THE COUNTRY THEY CAME FROM, WHERE THEY WILL OFTEN NOT HAVE ACCESS TO HIV TREATMENT, OR VIOLATE AMERICAN LAW BY REMAINING HERE, WHERE HIV TREATMENT CAN EXTEND THEIR LIFE.

Eleanor Roosevelt said, “[The Declaration is] a global testament of humanity, a standard by which any humble person on Earth can stand in judgment of any government on Earth.” The Declaration states that “All human beings are born free and equal in dignity and rights.” The travel and immigration ban, and compulsory HIV testing for certain visa and all lawful permanent residence applicants, is an affront to human dignity, and violates the rights of equal protection, nondiscrimination, privacy and freedom of movement – rights that the U.S. has long defended in the international arena.

The U.N. International Guidelines on HIV/AIDS and Human Rights state that “any restriction on liberty of movement or choice of residence based on suspected

or real HIV status alone, including HIV screening of international travelers, is discriminatory. HIV-related travel restrictions raise fundamental issues regarding the human rights of non-discrimination and freedom of movement of people living with HIV in today’s highly mobile world.”

People with HIV have full human rights, including the right to privacy, confidentiality, and protection from stigma and discrimination. HIV travel restrictions infringe upon these and other human rights in multiple ways. The U.S. Citizenship and Immigration Service currently conducts the largest mandatory HIV testing program in the world. Every applicant for permanent residence over the age of 15 is required to undergo HIV testing. In many instances the test is done without pre- and post-test counseling or safeguards that the result will be kept confidential.

HIV testing should be done voluntarily, with informed consent. People applying for nonimmigrant entry are questioned on their HIV status, and if they admit to being positive, can be refused admission. If the government suspects them of HIV infection, it can require an HIV test. People entering the U.S. with HIV medications in their luggage can be questioned or expelled. This causes many people with HIV to lie when entering the U.S. and to leave their medications at home, clearly not in the best interest of their health. Nonimmigrants with HIV can request (and can be denied) a waiver for short trips under limited conditions. U.S. policy on HIV and travel has been called “one of the most unenlightened in the world.”

The personal impact of HIV-related travel restrictions can be devastating for those seeking to immigrate, gain asylum, visit family, attend meetings, study, or do business. Travelers may learn that they are infected with HIV, they are not allowed to travel, and their HIV test result may become known to government officials, family, community, or employer, exposing them to serious discrimination and stigma.

Furthermore, HIV-positive persons from wealthy countries that have visa waiver relationships with the U.S. are not subject to review when traveling to the U.S. In contrast, people with HIV from African, Asian, or Latin-America/Caribbean coun-

tries must declare their HIV status as part of visa application procedures.

While long-term visitors and immigrants who have HIV may indeed require public healthcare services, and therefore add to the public health budget, such a financial argument to justify the entry exclusion is discriminatory as there are no entry exclusions for people with other high-cost diseases such as cancer. Such arguments also ignore the fact that the current system has other health costs. If people don’t get tested and into treatment early, they may show up at emergency rooms with an AIDS diagnosis, costing the health system much more than if they received care earlier.

THERE IS NO EVIDENCE TO SUPPORT ARGUMENTS THAT ADMITTING PEOPLE WITH HIV IS COSTLY FOR THE HOST GOVERNMENT. IN FACT, THE EVIDENCE FROM OTHER COUNTRIES INDICATES JUST THE OPPOSITE.

There is no evidence to support arguments that admitting people with HIV is costly for the host government. In fact, the evidence from other countries indicates just the opposite. Brazil began providing free universal access to HIV meds in 1996, far earlier than most developing countries. Despite a nonrestrictive travel policy, the country did not see an influx of HIV-positive immigrants seeking treatment. A representative of the French government, describing studies showing that only a small number of people immigrated to France for health-related reasons, reported that France, with an open borders policy similar to Brazil, “has not been burdened by an excessive number of HIV-positive immigrants seeking treatment.”

The HIV entry ban costs the U.S. economy untold millions each year. First, the inability of the U.S. to host the biennial International Conference on AIDS, and the inability of HIV-positive AIDS workers from around the world to travel to the

continued on next page

PEOPLE WITH HIV NOT WANTED HERE

continued from page 21

U.S. for trainings, costs millions. Second, worker productivity is undermined by the perverse health effects of the ban described above. Third, thousands or even millions of people with HIV might travel to the U.S. as tourists each year but many avoid it, costing the tourist economy millions of dollars annually.

Detainees

One of the greatest human rights violations has to do with migrants who are held in a U.S. detainee facility. Reports from these centers have shown that the U.S. does not provide adequate care, treatment, or support to detainees with HIV. The 2007 Human Rights Watch report, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, documents cases where HIV treatment was denied, delayed, or interrupted, resulting in serious risk and often damage to their health. The investigation provided evidence that:

Detention facilities which housed immigrants with HIV infection failed to consistently deliver anti-retroviral medications, conduct necessary laboratory tests, ensure continuity of care, and ensure confidentiality or protection from discrimination.

Contrary to international human rights obligations, constitutional protections, and best practice advisories, the Department of Homeland Security's detention guidelines for HIV/AIDS care fail to meet both national and international standards for appropriate care, and the agency does little to enforce their own minimal standards. Those immigrants who end up, for any reason, being detained by the US in a detention facility receive dangerously inadequate health care services. This creates a system in the US where we have established a health system for HIV positive people that is based on an inherent double standard; with policies and laws seeking to protect [our] own citizens from HIV and from HIV-related discrimination [we are] ignoring the equally valid needs and rights of non-nationals.

One of the most egregious abuses was the death in U.S. custody of Victoria Arellano, a 23-year-old HIV-positive

THE CONCERN THAT HIV-POSITIVE MIGRANTS WILL PLACE AN UNDUE DRAIN ON HEALTH RESOURCES HAS BEEN SHOWN TO BE UNTRUE, THROUGH THE EXAMPLE OF OTHER COUNTRIES THAT DO NOT HAVE THESE RESTRICTIVE TRAVEL BANS.

transgender detainee who died in July 2007 after eight weeks in an immigration detention facility in San Pedro, California. Arellano was reportedly denied treatment and became gravely ill. Detainees in her housing unit repeatedly told guards that she needed medical care, but she was left suffering in her bunk as her condition worsened. Finally taken to the facility clinic, she was taunted and ridiculed by staff. She told her cellmates before she died, "It was a nightmare."

Human Rights Watch documented the following deficiencies in the healthcare of migrant detainees:

- 1) Failure to consistently deliver HIV medications
- 2) Failure to conduct necessary laboratory tests in a timely manner, including CD4 and viral load testing as well as resistance testing
- 3) Failure to prevent opportunistic infections
- 4) Failure to ensure continuity of care, including access to necessary specialty care

In addition to being based on an ungrounded public health basis, the travel restrictions lack an economic justification. People living with HIV can now lead long and productive working lives. When these restrictions were first developed this was not the case. The epidemic has changed and we must change our approach to it. The concern that HIV-positive migrants will place an undue drain on health resources has been shown to be untrue, through the example of other countries that do not have these restrictive travel bans. We must

weigh people's potential contributions to the U.S. with the small potential drain on the healthcare system.

Legislative response in the 110th Congress

On a more optimistic note, as *Achieve* went to press the 110th Congress was taking action to rectify this unjust and counterproductive policy. Representative Barbara Lee (D-CA) first introduced a bill in August 2007 that would reverse the immigration and travel ban. In December 2007, Senators John Kerry (D-MA) and Gordon Smith (R-OR) introduced a similar bill in the Senate. In March 2008, the Senate Foreign Relations Committee approved a five-year reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR). A repeal of the HIV immigration ban was included. If passed, the determination of whether HIV is a necessary cause for denial of entry will be left to the discretion of the Department of Health and Human Services.

The legislation still requires approval by the full Senate and must be reconciled with the House version. At the time of this publication, advocates are optimistic that the ban may be overturned. If so, this will be the first significant overhaul of the policy in over 15 years.

International AIDS Conference

The International AIDS Society (IAS) hosts a biannual international AIDS conference, the largest professional conference on HIV/AIDS in the world. Because of the U.S. policy on immigration, the IAS has declined to host the conference here. GMHC and other members of the Coalition to Lift the Bar will host a satellite meeting before the next conference in Mexico City to provide an update on the immigration policy and to identify next steps in either overturning the ban or, if it has already been reversed, properly implementing the new, more inclusive immigration policy.

For more on the immigration and travel ban: gmhc.org/policy/federal/immigration_travel.html. ■

The first three authors work on immigration and other issues for Gay Men's Health Crisis. Joshua Volle is an independent consultant.

Abstinence-only Education: Counterproductive and Harmful

Abstinence-only-until-marriage programs are not only a monumental waste of \$300 million a year in taxpayer dollars, they are actually counterproductive and harmful to young people in the U.S.

While most parents want their children to delay sexual activity, the reality is that 47% of high-schoolers are sexually active. Four million young people in the U.S. contract sexually transmitted diseases (STDs) each year. Teen pregnancy rose in 2006 by 3%, the first increase since the early 1990s. Clearly we are failing to promote sexual health among young people.

Research has found that young people taking “virginity pledges” were one-third less likely to use contraception when they did become sexually active than those who had not pledged. Research has also found that in communities with more virginity pledgers, overall STD rates were significantly higher than in other settings.

In addition, abstinence-only curricula promote outdated and sexist gender stereotypes, antigay bias, and ignorance about HIV. Here are some examples:

“Women gauge their happiness and judge their success by their relationships. Men’s happiness and success hinge on their accomplishments.” (*Why kNOw*)

“A guy who wants to respect girls is distracted by sexy clothes and remembers her for one thing. Is it fair that guys are turned on by their senses and women by their hearts?” (*Sex Respect*)

“At the least, the chances of getting pregnant with a condom are 1 out of 6.” (*Me, My World, My Future*) (In fact, used correctly, condoms are 98% effective in contraception.)

“AIDS can be transmitted by skin-to-skin contact.” (*Reasonable Reasons to Wait*) (In fact, HIV is transmitted only by blood, semen, vaginal fluids, and breast milk.)

“Many homosexual activists are frustrated and desperate over their own situation and those of loved ones....some people with AIDS are now suffering because of the choices they made.” (*Facing Reality*)

Under the federal definition of abstinence-only programs, students must be taught that “*a mutually faithful monogamous relationship in the context of marriage is the expected standard of all human sexual activity.*” Programs accepting these funds are prohibited from discussing contraceptives, except in the context of failure rates. Usually the only time homosexuality is discussed is in the context of HIV risk.

With over \$1 billion spent, there remains not a single peer-reviewed study in a respectable scientific journal showing that abstinence-only programs work to help young people make good and healthy decisions about sex. In April 2007, an evaluation of abstinence-only programs commissioned by the U.S. Department of Health and Human Services found them to be ineffective in increasing teen rates of abstinence.

Comprehensive programs about sexuality that include information about both abstinence *and* contraception have been found to be effective in delaying the onset of sexual intercourse, reducing the number of partners, and increasing contraception and condom use among teens. No such findings exist for abstinence-only programs.

But President Bush is seeking a \$28 million increase in abstinence-only education. At a recent hearing on

the subject at which experts testified to the harmful effects of these programs, Rep. John Duncan of Tennessee said, “It seems rather elitist to me for people who maybe have degrees in this field to feel that because they’ve studied it somehow they know better than the parents what is best for [their children].”

It is not elitist for young people to get the information they need to maintain their health. It is not elitist to demand that young women not learn sexist stereotypes, or that the homophobic bullying of the playground not be reinforced in class. It’s time we ended taxpayer funding for this counterproductive and wasteful program. Call your U.S. Representative and Senators (202-224-3121) and ask them to support science over a failed conservative ideology. If you’re not sure who your Congresspeople are, go to votesmart.org to find out. ■



ACRIA Drop-In Support Groups

The popular groups formerly offered by Body Positive have found a new home. These peer-led drop-in support groups are held every Thursday and Friday from 6:30 to 8:00 p.m. at the LGBT Community Center, 208 West 13th St., NYC. For more information, call Gustavo Otto at 212-924-3934 x129.

Satellite Session at the International AIDS Conference in Mexico City

In August 2008 Gay Men's Health Crisis will host a satellite session at the International AIDS Conference in Mexico City on the U.S. travel and immigration ban. The session will be Sunday, August 3 from 11:15 – 13:15. For more information and details on the event, please visit gmhc.org or email Nathans@gmhc.org.

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