Federal AIDS Funding Decreased as Need Continues to Grow

by Rob Nixon, Communications Manager

On March 1, the U.S. Department of Health and Human Services (HHS) announced the FY 2004 Ryan White CARE Act Title I awards. Forty major metropolitan areas, including some of the most AIDS-impacted urban areas in the country, received significant decreases in federal funding.

The Atlanta Eligible Metropolitan Area (EMA) award for the upcoming fiscal year is $18,339,732—a decrease of $441,446 from the funds available in FY 2003. The EMA application to HHS requested $21,000,000 to address the need in the metro area. As of December 31, 2002, there were an estimated 21,484 people living with HIV or AIDS in the EMA.

The Atlanta EMA covers the 20 counties that currently make up the metro Atlanta area as defined by the census bureau. The number of counties in this EMA is expected to expand in the next year or two due to changes in the census bureau definition.

Compounding the funding crisis, U.S. Senate and House leaders unveiled budget resolutions recently that would cap or cut funding for domestic HIV/AIDS and other social programs and even cap spending for Medicaid, the nation’s largest single source of funding for HIV/AIDS care.

“If these budget resolutions do pass, it will only cause further strain on our system,” notes Jeff Graham, Executive Director of AIDS Survival Project. “This Congressional action will force even deeper cuts to medical care and essential support services, such as nutrition, health education and transportation.”

In addition to Atlanta, 39 of the 51 Title I cities received funding cuts. Among the hardest hit were San Francisco (a metro area with one of the highest AIDS caseloads in the country), Los Angeles, St. Louis, Denver and Newark, New Jersey.

“Our Congressional leaders can do better; our president can do better,” remarked Patricia Bass, Chair of the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition, a national group that advocates for Ryan White CARE Act funding. “In the past year, the number of people living with AIDS increased by nearly 8%, but overall federal AIDS funding to the nation’s hardest-hit cities decreased by nearly $4 million. The Administration and Congress have made significant increases in global HIV/AIDS funding. It is frustrating and unacceptable that our nation’s leaders continue to neglect the domestic HIV epidemic to the point where the situation could deteriorate to that of a third-world country.”

AIDS Survival Project is one of the Atlanta agencies in the CAEAR Coalition, which represents more than 300 grantees under Title I and Title III of the Ryan White CARE Act, including the 51 major metropolitan areas most adversely affected by the HIV/AIDS epidemic.

Title I provides emergency assistance to these hardest-hit areas and supports comprehensive HIV health care and treatment for increasing numbers of uninsured and underinsured persons. Title I programs fund desperately needed services for persons living with HIV/AIDS, such as outpatient health care, case management, home health and hospice care, housing, nutrition services and transportation. Title I is the major safety net for thousands of low-income Americans living with HIV/AIDS who are ineligible for entitlement programs, inadequately insured and would otherwise not have access to HIV/AIDS treatment and care.

The Ryan White CARE Act and other key AIDS programs would see further cuts under the budget resolutions proposed by Congress, which are expected to be even larger than those included in President Bush’s budget proposal. Defense and antiterrorism spending not included in the Bush budget (e.g., all spending in Iraq and Afghanistan) will force additional cuts in domestic programs later this year and in coming years. Health care spending would be cut by 11% or more under the new rules, according to the Center on Budget and Policy Priorities.

“We’re calling on people to urge their senators and representatives to oppose these budget resolutions and block efforts to cap needed domestic and entitlement spending,” Graham says. “More than half the Georgia congressional delegation represents the people living with HIV and AIDS in the Atlanta EMA. Therefore, it’s important that all our elected officials in Congress get the message that as the epidemic moves deeper into more vulnerable populations, including women and communities of color, the increased need for funding for care and support services is growing.”

AT A GLANCE

Atlanta EMA request for FY 2004 funding .............. $21,000,000

Atlanta EMA funding awarded for FY 2004 .......... $18,339,732

Decrease in Atlanta EMA funding from 2003 .......... $411,446

Estimated number of people with HIV or AIDS in Atlanta EMA (December 2002) .......... 21,484

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Chuck Foster was one of my three best friends during my senior year in high school. A New York native, his family moved to my school district in Irmo, South Carolina, the preceding summer. With long, jet black hair and an olive complexion, his Greek ancestry and urban savvy gave him an exotic look and an enigmatic demeanor that was unique to that Southern suburban school in the late 1970s. Introduced through our common love of song and dance in the school’s Concert Choir, we became cohorts and comrades, kindred spirits and social outcasts. We both had wicked senses of humor that played well off each other; we often gave the appearance of being mischievous when in fact we were just having some honest fun. Chuck was the first friend I’d ever had who came from anywhere else outside my own little local neighborhood; I lived vicariously through his past. Conversely, I was Chuck’s first real friend in the Deep South—his social bridge from who and what he’d left behind to where he’d found himself at that point.

I met Steve Foster in a bar in 1981 when I was only 19, back in the day when the legal drinking age was only 18. My first two years out of the closet had involved little else besides casual and/or anonymous sex in bars, parks, rest areas and other notoriety-laden cruisy places, so when I took Steve home on the night we met, I really didn’t expect anything more than sweaty teenaged sex. But something magical happened that night, and Steve and I became very close very fast. Less than three months after our first encounter, we set up house together and quickly became domesticated. I was the breadwinner while he took care of the house. I was warmly welcomed into Steve’s family as his partner, his lover, his spouse with a level of acceptance and equality that he unfortunately never received from my parents. Accordingly, my new “in-laws” became my new family, and for the next three years, although we struggled to survive in the economic recession of the very early ‘80s, we found happiness and security in our love, our relationship and our home.

I met Al Kaps in 1989, about a year after I moved to Atlanta, in a bar called Buddies off Cheshire Bridge Road. Al had been a longtime customer of that well-known watering hole and it quickly became one of my own favorite after-work hangouts. Al had a razor-sharp sense of humor and was a master of the emasculating one-liner comeback. He lived by the famous old quote, “If you can’t say something nice about somebody... come sit next to me,” and no matter how tired or stressed out I might have been after work, a few friendly verbal barbs with Al at the bar would have me cracking up. Over time, I learned that behind the Julia Sugarbaker zingers was a heart of gold, and a friendship that began as drinking buddies eventually became best friends and then, ultimately, roommates. At that time, I was struggling with both a full-time job and a full-time college workload, and on many occasions when I was just too damned exhausted to finish my homework and I wanted to give up, Al gave me the encouragement I needed to make it through the night. I wouldn’t have finished college without his support.

I met Jeff Boyd in a bar in 1991, not long after finishing college the first time around. A handsome man with brown hair and brown eyes, he was a history buff, a devout Episcopalian and could speak Portuguese—yes, Portuguese! He read the newspaper almost every day and could speak convincingly on most any political subject. Jeff worked his entire life in retail sales, with an especially long tenure at the men’s fragrances counter in Macy’s at Northlake Mall. In a classic case of when opposites attract—I took five years of French, prefer science fiction over history and don’t participate in organized religion—we found ourselves living together in a committed relationship after only a few months. Although we loved each other, our relationship started to run into serious trouble after only a few months. Jeff wasn’t just an alcoholic; he was an obnoxious drunk. His family begged me to try to make him stop drinking, and I naively believed my love was stronger than his addiction. I was wrong. After almost two years, we parted ways, still in love but unable to love.

Ron Day was the most musically talented man I have ever known. We met in 1993 when I first joined the Atlanta Gay Men’s Chorus, but we didn’t become friends until I moved from the baritone to the bass section in 1994. Ron also had a quick wit and his infamous “Look out, he’s backing up!” quip when my beeper went off at a critical musical pause at rehearsal one night is legend among oldtime chorus members. Aside from having a wonderful singing voice, he was also the most gifted arranger of four-part choral music I’ve ever known, and his arrangements continue to be performed by the AGMC until this day. I’ll never forget the night we went to a karaoke bar together and as I was stumbling through some favorite old showtune on the microphone, Ron was standing next to his bar stool, gesturing at me with conductor’s cues, trying to help me improve my performance as if I were at some concert hall. I always admired Ron’s enormous talents and abilities, and he always tried to help me reach my own greatest potential while never making me feel inferior.

Charles Glenn Foster, Jr., died of AIDS in 1984. He was the first official AIDS casualty documented in South Carolina.

CONTINUED ON PAGE 20
Fighting AIDS in Our Own Back Yard

For the first time in years, metro Atlanta has received a significant decrease in our federal AIDS funding. The story is disturbing enough. Unfortunately, it is only part of the full picture of the challenges facing people with HIV and their advocates here in the South. A loss of funding of under half a million dollars may not seem significant at first, but when combined with the already weak infrastructure of services available throughout the region, the ripple effect of decreased funding can be profound.

Every day, we live with the reality of HIV in the South and know first-hand the struggles that lie ahead. To get the full picture, it’s important to look at the broad range of issues that complicate our ability to adequately address the epidemic in our own back yard.

Funding

- Southern states have historically received less federal funding for HIV/AIDS care: $5,184 per AIDS case averaged across the Southern states, compared to $5,625 per case for the U.S. as a whole (2001).
- Southern states have received fewer federal dollars for HIV/AIDS prevention: an average of $1,579 per AIDS case in the South against $1,766 per case for the U.S. as a whole.
- When these differences of a few hundred dollars per person are multiplied by the tens of thousands of people being served through our local agencies and health departments, the disparity in funding becomes enormous. It has been estimated that a special appropriation of nearly $122 million would be needed just to offset this disparity, should other funding levels remain the same.

Rapid increase in reported AIDS cases

- By 2001, 46% of newly diagnosed cases of AIDS were located in the South. In other parts of the country, the numbers of new AIDS cases are either dropping or remaining the same.
- More people have AIDS in the South than in any other U.S. region, according to the Henry J. Kaiser Family Foundation.

Poor health infrastructure

- In some states, due to limited resources and access to health services, persons with HIV become considerably ill before obtaining access to necessary care.
- Predominantly rural states are generally poorer, have higher unemployment rates and are less educated than their counterparts with predominately urban populations.

Lack of health insurance

- The South is home to the greatest number of uninsured people—an estimated 17 million.
- Latinos and African-Americans are most at risk for being uninsured. Nearly one-half (46%) of working-age Latinos lacked insurance for all or part of 2001, as did one-third of African-Americans.
- Lack of health insurance is linked to less access to care and more negative experiences seeking care.

Changing demographics

- The face of AIDS is increasingly becoming rural, female, black and heterosexual.
- Seven of the 10 states with the highest AIDS case rates in the nation are located in the South.
- The South represents little more than one-third of the U.S. population (38%), but accounts for 40% of people estimated to be living with AIDS and 46% of the estimated number of new AIDS cases.
- Among the 25 metropolitan areas (pop. 500,000+) with AIDS case rates above the 2001 national average for this size, 18 are in the South. In addition, six of the metro areas with the 10 highest case rates in the nation are in the South.

Racial disparity

- Almost 38% of the cumulative cases and an average of 49% of newly reported cases in 2000 and 2001 were in the African-American community.
- The South includes almost 19 million African-Americans, almost 19% of the region’s population. The region with the next highest number of African-Americans is the Midwest, with almost 6.5 million (about 10% of the population).

Lack of affordable housing

- HIV disease is disproportionately represented in communities where stable housing environments are sorely lacking.
- Homelessness promotes continuation of risky behaviors for survival on the streets, where sex is traded for food and shelter.
- Without stable housing, those already infected with HIV are not able to comply with dosage and timing requirements for maximum efficacy of their medications.

Socioeconomic factors

- Eight of the 10 states with the highest percentage of population living below the Federal Poverty Level are located in the South, ranging from 15% to 19.1% living in poverty (compared to the 12.1% national average).
- Nine of the top ten states with the lowest percentage of high school graduates are in the South.
- Seven of the 15 states with the highest rate of unemployment (2002) were Southern states.

These statistics can be found in the Southern States AIDS Manifesto, available online through the Southern States AIDS Coalition (www.southernaidscoalition.org).

Taking action

You can take action on this issue today by supporting efforts to secure a special appropriation. Information can be found on the AIDS Survival Project web site about the letter-writing campaign urging Georgia Representative Sanford Bishop to introduce this legislation in the 2005 federal budget. You can also take action by recognizing the need to fully support efforts to secure additional funding for our state AIDS Drug Assistance Program, Grady Health System and local programs such as the Fulton County Human Services Department. Finally, and perhaps most importantly, you must realize the crucial role that talking about these issues has. If our churches, community groups, friends and family do not know the challenges we face, we will never be able to build the support necessary to fully fight the impact of the disease spreading like kudzu through everyone’s back yard.
There has been a growing discussion recently about coverage of HIV/AIDS by the U.S. news media. Because journalists have reported increasing difficulty in getting their media organizations to run HIV/AIDS stories, questions naturally arise about whether news outlets are expressing some sort of “AIDS fatigue.” Coverage of the issue—or the lack of it—can be seen as a key indication of how prominent HIV/AIDS is in the realm of public information and opinion.

The Kaiser Family Foundation, in conjunction with Princeton Survey Research Associates, recently conducted an analysis of HIV/AIDS media coverage over the 22-year period from 1981 through 2002. Their survey sampled more than 9,000 news stories from major U.S. print and broadcast sources, including national publications and TV networks, as well as major regional papers in areas particularly hard-hit by the epidemic (Los Angeles, San Francisco and Miami). The Kaiser report also referenced polls that asked people to name the most urgent health problems to the U.S. did not receive the coverage equal to the high impact of AIDS on their lives, according to the study. In the 22-year period, only 3% of stories were about minorities, 3% about teenagers and young adults, and 2% about women. In the study’s analysis of the “face of AIDS” as seen on television news, the most frequently portrayed population was healthcare professionals (20% of stories). Gay men appeared in 3% of the stories, teens and young adults in 3%, communities of color in 1% and women in 1%.

The Kaiser Foundation concluded that the most disturbing trend is the decrease in stories with an educational component, particularly in light of the fact that as recently as 2000, four in ten Americans still thought HIV could be transmitted through kissing, one in five believed it could be transmitted through sharing a drinking glass and one in six thought it was possible to be infected by coming into contact with a toilet seat.

Note that in October 2003, 73% of the U.S. public said most of the information they get about HIV and AIDS comes from the media.

The following are major highlights of the Kaiser study:

**Decreased coverage**

Coverage of AIDS peaked in 1987 with over 5,000 stories in the media and declined steadily to 1,000 stories in 2002. The decline began six years before the decrease in the number of new diagnoses of AIDS in the 1990s and continued even as the cumulative number of AIDS cases in the U.S. rose above half a million. Beginning in the late 1990s, there was a large increase in coverage of global AIDS issues as domestic coverage declined. By 2001 and 2002, more than one in five HIV/AIDS news stories were from outside the U.S and more than 40% presented at least some global perspective.

Populations most affected by the epidemic in the U.S. did not receive the coverage equal to the high impact of AIDS on their lives, according to the study. In the 22-year period, only 3% of stories were about minorities, 3% about teenagers and young adults, and 2% about women. In the study’s analysis of the “face of AIDS” as seen on television news, the most frequently portrayed population was healthcare professionals (20% of stories). Gay men appeared in 3% of the stories, teens and young adults in 3%, communities of color in 1% and women in 1%.

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**Be a Media Activist**

Such statistics, however, are merely grim facts without some plan of action. What can we do to affect the way the media covers this still very crucial story? Media outlets, of course, depend on consumers just like any other business. As a reader of publications, a TV viewer and a radio listener, you can make it clear to the organizations that depend on your support and attention that you want to see more stories about HIV/AIDS in the U.S. today. Here are some things you can do:

- Monitor your local media. Keep track of how many AIDS stories they run, what their focus is and what prominence they get in overall coverage.
- Send letters and emails to representatives of the media and let them know what kind of coverage they need to provide. Most publications and broadcast media have web sites listing staff contacts. Don’t just go for the editor-in-chief; you’re more likely to get attention from individual department editors (news, health, etc.) and from reporters whose “beat” includes AIDS-related issues. Don’t make angry demands—offer suggestions and information as a consumer.
- Write letters to the editor expressing opinions about important issues and about the angle of coverage they receive. Avoid emotional rants. Present information the public should have; this may catch the eye of an editor or reporter and lead to a featured story.
- Know your stuff. Gather your own statistics from public health resources about the number of AIDS cases in your area and the populations most affected by the epidemic, and use them to convince the media that AIDS has a far greater impact on their readership or audience than they may realize.
- Urge others to do the same. Individual messages are necessary, but there’s strength in numbers. The more they hear from the public, the greater attention they’ll have to pay.

And keep at it, even if you don’t get a response right away. Recently, we received a request from the Oprah Winfrey show to find people willing to appear on an episode about the state of HIV/AIDS in the U.S. today. When I spoke to a prominent HIV+ activist about this, she was delighted. She said she and many others had been working on producers for a long time to get them to do a show specifically about domestic HIV/AIDS. With the right approach and persistence, it works.
Understanding Hepatitis

In the United States, over four million people are infected with hepatitis and of those, approximately 300,000 have a coinfection with HIV. The term hepatitis is actually a general term used to refer to an inflammation or swelling of the liver. A number of factors influence the development of hepatitis. Excessive use of alcohol and drugs, exposure to poisonous toxins and certain infections, such as Mycobacterium Avium Complex (MAC) or Cytomegalovirus (CV), can produce an autoimmune response, causing the body to attack the liver, leading to inflammation and swelling, known as hepatitis. However, viral hepatitis is the most common cause of this condition. There are seven known viruses which can cause hepatitis, but over 90% of cases are mainly caused by hepatitis A, B and C. Of these, hepatitis C (HCV) is the most common to individuals living with HIV. Hepatitis C is a very common disease, yet extremely complex. Unfortunately, many people do not know of their infection and those who do are unsure of the standard of care or the complexities that surround living with both HIV and hepatitis.

What is hepatitis C?

Hepatitis C is a virus that causes direct damage to the liver. Signs and symptoms of HCV are jaundice, fatigue, dark urine, abdominal pain, loss of appetite and nausea. Chronic infection can result in cirrhosis or scarring of the liver, liver cancer and liver failure, which can potentially result in death. Modes of transmission are similar to that of HIV and HBV. HCV can spread more easily than HIV through contact with infected blood. Infection occurs when blood or bodily fluids from an infected person enters the body of a person who is not infected. HCV is most commonly spread through the sharing of needles when engaging in intravenous drug activity. Over 80% of injection drug users have HCV. However, there is also a transmission risk with HCV through sexual activity. Unfortunately, there is no vaccination for HCV to help prevent infection.

How is it diagnosed?

Since HCV directly affects the liver, one of the first steps to a diagnosis is to perform a liver enzyme test. Often, individuals with HCV have abnormal liver enzymes, which are often elevated, potentially revealing liver disease or damage. However, there are two problems with liver enzyme tests. First, abnormal liver enzymes signify liver damage, but it doesn’t necessarily confirm HCV because of several external factors that may cause liver damage. The second problem is HCV can cause liver damage that might not be reflected in the liver enzymes. An individual could potentially have HCV and produce a normal liver enzyme test. To account for these uncertainties with liver enzyme tests, there are blood tests for HCV which include an antibody test and a viral load test. These tests are similar to the antibody tests and viral load tests performed for HIV. These tests can be much more accurate in diagnosing HCV; however, the best way to know if your liver has been damaged is through a biopsy. In a biopsy, doctors collect liver cells by using a thin needle, then study the collected cells under a microscope to determine whether the liver has been damaged.

What is the standard of care?

There are six different types of HCV, called genotypes. Most people in the United States infected with HCV have genotype 1. Unfortunately, genotype 1 is often much harder to treat than genotypes 2 or 3. Because of this, an important first step in treatment is to find out your genotype. Typically, the treatment for HCV is a combination of the drugs interferon and ribavirin. Pegylated interferon alfa is a drug that is injected under the skin once a week and ribavirin is a pill that is taken every other day. Both of these medications can create serious side effects, including depression, anemia and neutropenia. It is most important to know and understand there are potentially dangerous drug interactions between ribavirin and other nucleoside analogues—ddI (Videx) and d4T (Zerit). Ribavirin can increase the levels of these drugs in your blood, causing toxic effects on the body, which may be fatal.

Treatment for HCV usually lasts six to twelve months and can be a long, difficult process. There are two goals for treatment. The primary goal is to sustain the virus in an undetectable state, and the secondary goal is to bring liver enzymes to a normal level with the desired outcome of reducing inflammation of the liver. Unfortunately, only half of the individuals experience a successful treatment. Various uncontrollable factors influence treatment outcome: HCV genotype, HIV status, race, age and body weight. Two factors play a role in the success rate of treatment: early detection of HCV infection and refraining from substances that also damage the liver, such as drugs and alcohol.

Coinfection: hepatitis C and HIV

Because of the similarities in transmission between HCV and HIV, many people are infected with both viruses and are described as having a coinfection. When two viruses are impacting your body, there are complications that may occur because of the relationship between them. You must be aware of these factors to understand the changes your body may face, as well as issues that may arise during treatment. HCV can make the impacts of HIV on your body worse. HCV is directly damaging your liver, while HIV medications may be stressing your liver even further, often creating an environment for liver damage to become more severe with the potential to progress more rapidly than a person only infected with HIV or HCV. Also, individuals who are coinfected often experience more severe side effects and repercussions during HCV treatment. The HCV medications’ side effects can compound the effects of HIV as well as the side effects of HIV medications, often making treatment unbearable, directly impacting adherence. The other difficulty with HCV and HIV coinfection is the limited amount of research to support a definite standard of care. Most often, if someone meets the criteria to start treatment for HIV and their case of HCV is mild, treatment for hepatitis is placed on hold until their HIV treatments are started and stabilized. However, if a person doesn’t need to immediately start HIV treatment and is infected with HCV, then the consensus is to begin HCV treatment first because the earlier you start treatment, the easier it is to control the HCV infection.

Decisions involving treatment of both HIV and HCV can be extremely complicated. It is important that you have a physician that you can work with and who is knowledgeable about both diseases to help you decide on the best time for treatment.

HCV is a very serious health problem in the United States. Unfortunately, many affected by this disease are unaware of the infection. Early detection can often mean a more successful chance at treatment if the situation is right for one to begin the complex drug regimen. However, for those individuals who have a coinfection, the outcomes from treatment are still not as effective as one should expect them to be. That is why it is important for us, as health advocates, to concentrate our efforts toward HCV drug development.

May/June 2004
Most women know that the familiar line found in some clothing labels—“one size fits all”—is a rather hopeful myth. Our bodies are just not that easy to categorize. This message was brought home to me in a different venue when AIDS Survival Project (ASP) sponsored the forum “For Women, By Women” this March.

The workshop was facilitated by Tonia Poteat, an experienced yet humble medical provider from the women’s clinic at the Grady Infectious Disease Program. For two hours, Tonia answered questions, facilitated discussion and provided both basic and advanced education for twenty-five women. While commonality between the women was acknowledged, the unique nature of each woman’s experience was impressive. The women’s knowledge of health issues and their experiences related to their physical being were diverse. It was clear from the lively workshop that for women living with HIV, there may be a lot more questions than there are answers—even if you are a medical provider. The interaction of hormones, HIV and medications are complex and unique, compounded by our natural aging process, birth control needs, pregnancy and stress. The mystery of how these elements affect health, metabolism, physical appearance, mood and sexual desire remains largely unsolved.

If you are an HIV+ woman reading this, please be aware that research on women-specific HIV issues has been slow to develop, so there may not be answers to all your questions. However, there will be information about your questions. As a team, you and your medical provider can consider this information in evaluating your situation and treatment plan. Education and sensitivity to physical and psychological changes are essential.

Women are often described as being relationship-oriented. This can be a valuable quality for an HIV+ person if she uses her medical provider, friends, partner and support group peers as sources of information and experience. Robin Lenon-Deering found in her study of HIV+ women in all-female support groups that “individuals can go to a support group for support and come away with more healthful behavior.” Her research found that within the population she studied, 66% of group members had reduced their risk behaviors, 49% had improved adherence with their medications and 69% felt less ashamed about having HIV. The sharing of factual education can empower women to grasp increasingly complex medical issues, which allows for better self-management.

Although specific answers about how HIV affects women may be hard to come by, information is available in many settings. In addition to support groups, many AIDS service organizations offer free treatment forums, publications, retreats and peer counselors for women. Peer counselors are usually available by phone, so any woman with access to a phone can obtain information while maintaining confidentiality.

Some excellent publications for HIV+ women are listed in a sidebar to this article. Among the many articles and booklets about HIV in women,

**ORGANIZATIONS FOR HIV+ WOMEN**

**Women Alive**

Los Angeles CA ................................. (323) 965-1564 Hotline ........................................ (800) 554-4876 www.women-alive.org

Treatment information, supportive services and lots of links.

**WORLD: Women Organized to Respond to Life-Threatening Diseases**

Oakland CA ................................. (Bilingual) (510) 986-0340 www.womenhiv.org

Treatment information (particularly about pregnancy), advocacy, news and HIV University.

**NJWAN: New Jersey Women and AIDS Network**

“Sister Connect” Hotline ........................ (800) 747-1108 www.njwan.org

**NEWSLETTERS FOR POSITIVE WOMEN**

**BABES—Newsletter from Babes Network; English & Spanish** ................................. (206) 720-5566 ext. 12 1001 Broadway, Suite 100, Seattle, WA 98122 www.babesnetwork.org/newsletter.html

**Wise Words—Newsletter from Project Inform** ......................................................... (800) 822-7422 www.projectinform.org/pub/ww_index.html

**Women Alive—Newsletter** ................................. (323) 965-1564

**WORLD—Newsletter by and for HIV+ women and their loved ones** ........................ (510) 986-0340

**FREE PUBLICATIONS**

**A Guide to the Clinical Care of Women with HIV/AIDS** ................................. (888) 275-4772 hab.hrsa.gov/womencare.htm

**Knowledge, Action, Health: A Woman’s Guide to HIV Treatments**

Call Women Alive ................................. (323) 965-1564 Hotline ................................. (800) 554-4876 www.women-alive.org

**Positive? How Are You Feeling?** brochure for women ................................. (800) 822-7422

**Understanding Your Lab Results, Managing Drug Side Effects & Clinical Trials Explained** (English and Spanish)

ACRIA publications .............................. (212) 924-3934 ext. 121

One which I have found outstanding and accessible is *Treatment Issues for Women*, published by ACRIA [AIDS Community Research Initiative of America at (212) 924-3934]. It can be downloaded at no charge from their web site at www.acria.org.

Women with access to the Internet will find a host of valuable web sites. Some of them are listed in a spanbroad for this article.

**ONLINE SOURCES OF TREATMENT INFORMATION**

**AIDS Nutrition Services Alliance (ANS)**

Fact sheets on nutrition and HIV; links to nutritionists and other nutrition sites.

www.aidsnutrition.org

**AIDSmends.com**

Treatment information, question & answer forums and treatment news.

www.aidsmends.com

**The Body**

Comprehensive site offering treatment materials from a variety of sources. Check out the women’s section (profiles, articles & question & answer forum).

www.thebody.com

www.thebody.com/features/women

**HCV Advocate.......... Hepatitis C Support Project**

Information and support for people with hepatitis C/HIV coinfection.

www.hcvadvocate.org

**HIV/AIDS Treatment Information Service (ATIS)**

Guidelines for the use of antiretroviral agents.

www.aidsinfo.nih.gov

**National Center for Complementary and Alternative Medicine (NCCAM)**

Not HIV-specific; info about complementary and alternative therapies and clinical trials studying these therapies. ................................. (888) 644-6226

www.nccam.nih.gov

**New Mexico AIDS InfoNet**

Fact sheets in English and Spanish and lots of links.

www.aidsinfonet.org

**The Well Project**

Specific to women with HIV

www.thewellproject.org

**Women’s Interagency HIV Study (WHIS)**

Treatment information, plus updates on the study.

www.lawihs.com

This list reprinted with permission from the AIDS Community Research Initiative of America (ACRIA). (212) 924-3934; www.acria.org.
The fifth annual African-American Outreach Initiative (AAOI) conference, held in Atlanta March 12-14, was undoubtedly the best one yet! Having outgrown the previous hotel venue, the conference was based in a new location at the Renaissance Hotel, near the Hartsfield-Jackson Airport. Shuttle buses were provided to bring participants from the MARTA train station starting at 7:00 a.m., and at 7:15 on Saturday morning when I arrived, people were already making their way to the breakfast buffet lines.

The overall mission and goal is to target those African-Americans who are HIV+ and not yet in treatment. This is a conference that simply cannot be beat! Two full days, including breakfast and lunch, free transportation (via MARTA tokens), lots of good information and an opportunity to network and meet new friends, health care providers and agency representatives from around the area. This year, there were 33 exhibitors who provided information on everything from pharmaceuticals to life insurance. Participants are encouraged to access holistic treatment services in order to increase utilization of health care and promote medical adherence by providing information on available services, programs and other resources.

The conference provided some 29 different plenary sessions, panels and workshops. Topics were as diverse as “Disclosure” to “Using (Qi Gong) Chinese Breathing to Promote Healing.” There were also separate seminars for Men Who Love Men, Men Who Love Women, For Women Only, Sexually Alive and HIV+, and Can I Get an Amen (spirituality and HIV). The lunchtime plenary session on the first day was a research panel with representatives from the AIDS Research Consortium of Atlanta (ARCA), the Emory Clinic, Emory Vaccine Center and SisterLove, Inc. Plenary topics included “African-Americans and Clinical Trials,” “HIV Vaccine Research and Development” and “Microbicides.”

The second day, there was a panel discussion with representatives from diverse sexual orientations discussing living positively. The discussion brought together all of the workshop topics from the perspective of people living with HIV and AIDS. The African-American Outreach Initiative has always been a volunteer effort. The planning committee is composed of some individuals who have been involved since the beginning and others who have joined along the way. Some of the committee members have become involved after attending the Initiative. The planning committee meets over a nine-month period to plan each year’s activities. Additional volunteers attend the Initiative annually to perform a variety of tasks. All of the speakers, workshop presenters, panelists and group facilitators volunteer their time and services. The primary goal of the Initiative is to continue to bring information on taking care of one’s body, mind and soul to African-Americans positively living positive.

This year, the entire conference was dedicated to the work of Faye Brown-Sperling. Faye was a pioneer in the field of substance abuse and its connection and interaction with HIV and AIDS. Among the many hats she wore so competently, Faye was the co-founder of the African-American Outreach Initiative and the first chairperson of the AAOI budget committee, as well as the co-founder of our Common Welfare (OCW), the first licensed, specialized drug treatment facility for persons with HIV/AIDS in Georgia.

OCW runs a Substance Abuse Day Program (SADP). Operational since 1995, SADP offers a licensed, 45-day intensive outpatient program, delivering a full drug treatment curriculum supported by HIV/AIDS education and prevention services to persons with HIV/AIDS. Services include intake and assessment, individual and group therapy counseling sessions and a continuing care program for continued support in recovery. OCW has short and long-term housing available for substance abusers with HIV in DeKalb County. Housing and support programs (HSP) accommodate persons who are homeless and have low or no income. The goal for the HSP is independent living and assisting residents to achieve positions of productivity and usefulness in society. OCW also offers financial assistance to persons living with HIV/AIDS. An application and proof of need is required.

The Partner and Significant Other Notification and Education program (PSONE) is available to assist HIV+ persons become educated and notify sex and/or needle-sharing partners or family and friends about their HIV status. PSONE (pronounced “P-S-One”) offers individual and group sessions. Education, Support and Prevention (ESP) is a course designed to provide a safe environment for participants to explore the sensitive issues that inhibit behavior change. ESP supports the drug treatment messages and provides an introduction to the foundation steps of 12-step programs. Registration for this program is required. Finally, OCW conducts HIV counseling, testing and referral services. The organization was the 2001 National Life Award recipient for their efforts in community HIV antibody testing. In 2001, they tested more than 1,900 persons, with 87% returning to receive their results.

Our Common Welfare is located at 4319 Memorial Drive in Decatur, Georgia. Their hours are Monday to Friday from 8:30 a.m. to 5:00 p.m. (Hours for different programs vary. Call the main office for more information.) Their phone number is (404) 297-9588 and their web site is www.ourcommonwelfare.com. 🌟
I am so grateful to POZ magazine for a recent article published by its founder, Sean Strub, in the February/March 2004 issue. In his article, Sean outlines his three-month experience with Sustiva (efavirenz), which led him into a spiraling depression. As I read about his experience, I had one of those “ah ha” moments that cause me to take notice. Unlike Sean, I had been “successfully” taking Sustiva for about four years. “Successfully” because it was keeping my viral load below 50 copies and my CD4 count in the 300s. Both indicated that the drug was working and I should (there is that dreaded word again) just deal with the side effects.

Clinical study data show that about 53% of patients taking Sustiva have some kind of central nervous system (CNS) symptoms, as opposed to about one-quarter of those in control groups. For 33% of patients, the symptoms were mild. Another 17% experienced symptoms described as moderate, and 2% had severe symptoms. By my fourth year of taking Sustiva, I found myself in the 2% category that suffered from “severe” symptoms.

My first year on this medication went without incident. There was the three to four-week adjustment period, after which I was able to tolerate the side effects. In fact, I began to enjoy the vivid dreams, complete with Dolby sound and Technicolor visuals. I thought to myself that this isn’t too bad.

The second year brought with it more depression. I had been taking Zoloft 50 mg for about four years prior to starting Sustiva. Perhaps this helped me during that first year. However, I found myself depressed more and after consulting my physician, we increased the dosage of Zoloft to 100 mg and 150 mg if necessary. This helped some with the depression. I was also taking Xanax .025 mg PRN for anxiety and for sleep since I was, by this point, waking four and five times per night. Most weekends were spent in bed, sleeping ten to fifteen hours per day just to be able to function on any level the other four days.

By the third year of “successfully” taking Sustiva, I went to my physician in tears wanting to know if I was losing my mind! He added Wellbutrin XL 150 mg daily to Zoloft 100 mg daily. This helped for about four months, if for no other reason than I was numb. Amazingly, in spite of major depression and anxiety, I did quit smoking! So, the addition of Wellbutrin was not a total waste. How I managed to pull this off in the midst of utter desperation, I will always wonder.

However, within four months, the depression began to rear its ugly head again and by this time, I thought I was condemned to spending the rest of my life hopelessly depressed and despondent. I couldn’t remember a time when I did not feel sad and I began to question why I was still alive. Every social commitment became a burden. I even avoided my family during the holidays. I found that the only time I was not unhappy was when I was asleep and having those vivid dreams. Not much of a life, even with 300+ T cells!

Most of my waking hours were spent avoiding contact with anyone because of my shaky emotional state. I would cry at the drop of a hat and could not bear to spend time with those whom I most loved. Somehow, their presence made me even more vulnerable to an emotional meltdown. What is most disturbing as I look back is that I was unable to reach out to any of these folks for help. I was ashamed of my inability to cope and didn’t want to be a burden on them.

Each of the symptoms I experienced became worse gradually—almost insidiously so—until I saw that article in POZ. Something clicked in my mind and I realized that the story I was reading about was not unlike my own. I must give Sean credit, for whatever reason, to rob you of the life you deserve. Depression is one of those demons that has a way of perpetuating itself. It seemed to me that depression took on a life of its own and would not let go until I found its source. Luckily, my depression—for the most part—was induced or exacerbated by a medication. By withdrawing the offending prescription, I was able to deal with it.

Depression is not a condition to be ignored or dismissed. It is serious and can be fatal if not dealt with properly. Understand that many of those suffering from depression feel hopeless and as if nothing can be done. This is typical. There are several self-assessment tests on the Internet. One in particular I found useful was at www.intelhealth.com, which included a Center for Epidemiologic Studies Depression Scale (CESD). Upon completion and if your score indicates clinical depression, there is a report you can print out to take to your health care provider. One other recommendation is to always promise yourself at least one call to 911 should your depression become overwhelming and you feel suicidal. Also, there is an agency in our building, Positive Impact, whose mission is to provide mental health counseling for those living with HIV. Their number is (404) 589-9040.

I am fortunate my solution was as simple as it was. And at this time, I feel whole again, and I am grateful that there is life after Sustiva—and not a bad one, I might add. -toolbar
When I arrived at my doctor’s appointment in March, I was greeted with some great news: my CD4 count was going up and my viral load was undetectable. The bad news was mentioning starting hepatitis C treatment, which stopped me in my tracks. The fear of starting this treatment consumed me. As a treatment educator at AIDS Survival Project, I know this can be a challenge—both emotionally and physically. After feeling good for so long, the thought of “getting sick to get better” is a hard pill to swallow in addition to a weekly injection.

When I returned to ASP, still processing this new information, the regrets of my past lifestyle stayed in my head. After being an intravenous drug user (IVDU) for 26 years, I’m grateful to say I’m coming up on eight years clean! Among HIV-infected people, 30% are coinfected with hepatitis C (HCV). In those infected with HIV by IVDU, the rate of coinfection increases to 60-90%, totaling about 300,000 coinfected people in the U.S. Before I go any further, it is suggested that all HIV-infected persons be screened for HCV. HCV and concurrent HIV infection may quicken the progression of HCV. Liver damage rarely gets better unless something is done to stop or slow the progression.

The following are some of the things that can be done:

- HCV drug therapy
- Lifestyle changes, such as avoiding alcohol and street drugs, good nutrition, relaxation, stress reduction and moderate exercise
- Complementary therapies, such as acupuncture and herbs
- Vaccinations against hepatitis A and B

As I refocused on my “to do” list on my desk, my first priority was to complete a curriculum I was writing on “Knowing Your Treatment Options” as it applies to HIV therapy.

Some of the things I had listed are:

- Are you ready for treatment?
- What is your objective?
- Learn the basics about HIV medicines and how they work
- Get involved in decision-making options with your doctor
- Create a network for information and support
- Get ready emotionally and physically

We have a saying in recovery: “Keep it simple.” In a moment of clarity (which doesn’t come to me often), I realized I could utilize this list as I prepared myself for HCV therapy. This is where the term “self-management” comes into play. Self-management means just what it sounds like—teaching people to manage their own health and to make informed choices, taking charge of their own destiny.

The treatment I will be doing is Pegasys interferon, which is injected under the skin once a week in combination with Ribuvirin, which is taken orally three times weekly. Although I’m ready physically for HCV treatment, I’m not completely ready emotionally. Knowing the list of side effects does not help. They include flu-like symptoms, depression, possible anemia, a low platelet count and injection-site reactions. A large percentage of coinfected people are African-American and studies find that more than 90% of them have genotype 1. There are six known varieties of HCV, called genotypes. People with genotype 1 have a lower rate of response to HCV therapy. I have genotype 1. Additionally, people with a history of drug use may have issues with depression, which sounds like me. Seven years ago, I made a decision to do whatever was necessary to stay healthy and fit. Having said that, I’m ready to begin this treatment.

One of my objectives is to decrease the viral load of HCV to below detection. The second is to normalize my liver enzyme levels, improving the condition of my liver. However, my main objective is to enjoy my life and my children one day at a time.

My doctor and I are a team and we will always be so because we make decisions together. My support system includes my family, my colleagues and my doctor, as well as the people in my recovery network—especially my fiancée, Gwen, and our dog China.

My colleague, Sarah Biel-Cunningham, has written an article about HCV on page 5 in this issue of Survival News. She discusses the medical and technical side of HCV. Very seldom do we as staff writers do personal articles, but I was encouraged to do so with the support of the staff. I plan to report back in about six months. I hope this will allow our readers to catch a glimpse of my experience with this treatment. As we say in recovery, “I hope this helps somebody, because it helped me.” My fear has turned to faith. Keep safe!
Exercise and HIV/AIDS

By Ellen Steinberg, MS, RD, LD

Spring is here and summer approaches! Go outside and garden, walk a dog, wash your car or ride a bike. There are many ways to include physical activity in your day and you don’t have to run marathons to reap the health benefits of exercise. In fact, even moderate physical activity can stimulate immune function, delay or prevent wasting, increase strength and endurance, and help you feel better.

For those individuals needing inspiration or affirmation that exercise should be a part of their daily routine, consider these additional health benefits:

- Increased muscle mass that can boost the total amount of energy your body produces. In turn, elevated energy levels can enhance the immune system even more
- Reduced cholesterol and triglyceride levels. Some HIV medications increase the amount of fat in your blood, but exercise can help protect you against the associated risk of heart disease
- Decreased fatigue
- Regulated bowel function
- Improved mental outlook
- Increased bone density—protection against osteoporosis
- Improved circulation, heart capacity and lung function

This type of exercise is probably the most important for people with HIV because more muscle = better immune function. Resistance training may include push-ups, pull-ups and deep knee bends, but is even more effective when weights are used. If you don’t have access to a gym, be creative! Instead of weights, simply use common household items such as soup cans, books or milk jugs filled with water or sand.

Aerobic (cardiovascular) training involves exercises that increase your heart rate. These include walking, running, swimming or bicycling. Aerobic activity is not only great for the immune system, but it also decreases your risk for developing heart disease and helps with weight management. While aerobic training is not advised for individuals experiencing wasting or unintentional weight loss, these individuals can benefit greatly from resistance training.

In general, try doing some form of physical activity at least every other day. If you like to exercise daily, you might consider alternating the days on which you train aerobically or with weights. No matter what the activity, always warm up with stretching and aim for 30-40 minutes of exercise. If you are not already active, consult your doctor before beginning any exercise program. Start slowly and gradually increase the time and intensity of your workouts as they become easier.

Whoever you are—the athlete, weekend park-goer, weight-loss seeker or the person who has yet to become physically active—never underestimate your potential! The health rewards of physical activity are within your reach.

For more information, contact AIDS Treatment Initiatives (ATI) at (404) 659-2437. ATI has the resources to help you optimize your health through diet, exercise and nutritional supplementation.

Along with this article, of special note among these is a website developed by Dawn Averitt, a former staff person at ASP. Dawn’s most recent creative contribution to empowering HIV+ women is the website www.thewellproject.org. It is dedicated solely to issues of concern to HIV+ women.

Unfortunately, too many women miss out on resources available on the Internet. In fact, Lennon-Deering found that although 52% of the women in her study had access to a computer with an Internet connection, only 4% identified that they utilized this resource. Here at the ASP office, the staff and volunteers in our Treatment Resource Center (TRC) will happily—and patiently—assist people in seeking HIV-related information on the computers in the TRC. The TRC library also has a sizeable section devoted to women and HIV. These services are available at no cost. The TRC staff is available by telephone to assist women (as well as men) in gathering and understanding information about HIV-related concerns. They thrive on new questions, so come on, women, and bring them a challenge!

Here are some guidelines for HIV+ women looking to maximize their health:

- Become a team player with your medical provider. If you work on this and are still unsatisfied with the quality of your relationship, seek another provider.
- Do your homework — learn all that you can about your concerns before your medical appointment.
- Write down any symptoms and questions you have and take the list with you to your medical visits. Pay attention to what’s normal for you and keep track of changes so your provider can assess their significance.
- Take a family member or friend with you to your appointments to act as your advocate. If you feel confused, vulnerable or anxious your advocate can help make sure you have your concerns addressed.
- Have medical people write down any terms they use with which you are not familiar. This includes diagnoses, medications, suggested tests and treatments.

- Become a good researcher. This includes developing a working understanding of your reproductive system (also known as “down there!”). With cervical cancer and menstrual irregularities more common in HIV+ women it’s critical that you know all you can about gynecological care. According to The Well Project, HIV+ women are 10 times more likely to have abnormal Pap smears than HIV—women are.
- Participate in a women’s support group.
- Find a mentor and work her into your life regularly.
- Explore clinical trials.
- Be aware that medical knowledge about HIV/AIDS is always changing so the approach you and your provider take needs to remain flexible.
- VOTE! Funding for HIV/AIDS care, insurance regulations, confidentiality, family planning and medical research are all influenced by government funding and policies. Make sure your needs and perspective are represented.
A warm ASP welcome goes out to:

• Ellen Steinberg, the new nutritionist at AIDS Treatment Initiatives. Ellen has already shared her wealth of knowledge with us both at a recent Healthy Choices = Healthy Lives and at the March THRIVE! Weekend. We look forward to working with you more in the future!

• Our newest volunteers: Menika, Maddalena, Thea, Thomas, Jason, Trevor, Joe, Alex, Wanda, Joyce, Pamela and William. Thanks for all your hard work and welcome to the team!

A big thank you to all the ASP volunteers and staff who helped with:

• The March THRIVE! Weekend
• The March and April Healthy Choices = Healthy Lives
• Counseling Skills-Building Training
• The 2004 African-American Outreach Initiative
• All our lobbying efforts during the 2004 Georgia legislative session
• The Art of Dinning
• The April Treatment Forums

Your continued devotion to helping us educate and empower those living with HIV/AIDS is truly inspiring. We couldn’t do it without you!

Congratulations to volunteers and staff members who will be celebrating birthdays:

In May:

Gloria B.  Victorine M.  Steven G.
Sonny M.  Marily H.  Jimmie S.
Carolyn J.  Trevor T.

In June:

Michael A.  David S.  Joan C.
Eric T.  Kirkland C.  Jason V.
Bob D.  Jim W.  Teresa H.

We are now hosting several community activities in the Bruce Almond Community Room. Please show up for any of these events if you are interested in becoming involved with these groups. Please contact the hosting organization listed below for more information.

• Monthly HRC meetings are held on the third Thursday of the month at 6:00 p.m.
• Ryan White Consumer Caucus meetings are held on the third Wednesday of each month at 12:00 noon
• Every Saturday, the “Can’t Do It Alone” group of Narcotics Anonymous meets from 7:00 p.m. to 8:30 p.m.
• ZAMI’s women’s yoga classes have been can-
Chronicles

from the Centers for Disease Control & Prevention’s National Prevention Information Network for HIV/AIDS, STDs and TB

Clinton, UN Offer Cheaper AIDS Drugs. The William J. Clinton Foundation announced Tuesday, April 6, that the special drug prices it has negotiated for HIV/AIDS patients in 16 countries in Africa and the Caribbean will now be available to all developing nations supported by UNICEF, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. “With these agreements, we are one step closer to making sure future generations can live without the scourge of AIDS,” the former president said in a statement released by his U.S.-based foundation. Other than Brazil, which provides free drugs to all HIV/AIDS patients, fewer than 200,000 people out of the estimated six million patients in the developing world needing the basic antiretroviral treatments recommended by the World Health Organization actually receive it. “We are hopeful that developing countries and those who support them in the fight against AIDS will take full advantage of this agreement and act quickly to do all they can to help in this fight,” said Clinton. Under the Clinton Foundation agreement, five generic drug makers—Indian manufacturers Cipla, Ranbaxy Laboratories, Hetero Drugs and Matrix Laboratories, and South African maker PharmaCare Holdings—will provide antiretroviral treatment for one-third to one-half the lowest price available elsewhere—as little as $140 per patient per year. Five different companies will supply diagnostic testing assistance, including machines, training, maintenance and chemicals at a price that is up to 80% cheaper than the normal market price. Interested developing country governments and aid agencies can contact the Clinton Foundation directly. They must provide guarantees of payment and ensure drug distribution security to prevent the drugs from being smuggled back to rich nations to be sold for huge profits. Stephen Lewis, the UN’s special envoy for HIV/AIDS in Africa, welcomed the use of generics. “Clearly, when you have the power, the imprimatur and the dollars of the Clinton Foundation, World Bank, UNICEF and Global Fund weighing in behind generics, the debate is over,” said Lewis.

Health Officials Fail to Agree on Guidelines for Use of Low-Cost Generic Medicines. On Tuesday, March 30, in Botswana, international health officials failed to reach agreement on guidelines for low-cost generic AIDS drugs after U.S. officials raised concerns about their use. Fixed-dose combination (FDC) drugs that combine three medicines in one pill are a key part of the World Health Organization’s plan to treat three million people in poor countries by 2005, and generic FDCs are considerably cheaper than their patented equivalents. Several have already been certified safe by WHO but not by the U.S. Food and Drug Administration. U.S. officials questioned whether WHO’s screening process was stringent enough, and they worried that widespread, inappropriate distribution of the drugs could contribute to viral resistance. Critics of the U.S. position fear that a parallel review system could slow attempts to get the drugs to people in Africa. Although he said that “conceptually, FDCs are an urgent good,” Dr. Mark Dybul, deputy chief medical officer of the U.S. Global AIDS Coordinator’s office, added it was “important to have an agreed set of principles so we can use money to buy drugs that the U.S. FDA has not approved.” U.S. officials deny the charge, leveled by Medecins Sans Frontieres, that the United States is seeking to protect the interests of the drug-makers who hold the individual patents. “This will kill the low-cost AIDS program for Africa,” said William Haddad, chair of Gileadsciences, a U.S.-based generic AIDS drug manufacturer. Conference organizers plan to publish their deliberations for comment by April 19. The meeting was called by the U.S. Department of Health and Human Services, WHO, UNAIDS and the Southern Africa Development Council.

Anti-AIDS Coalition Scolds U.S. On Wednesday, March 31, in Washington, former UN Ambassador Richard Holbrooke said the White House’s denial of cheap generic AIDS drugs for Africa is undermining the efforts of U.S. nonprofits to fight the epidemic. According to the World Health Organization, generic antiretrovirals—such as those produced in India, Brazil and elsewhere—could provide AIDS treatment for as little as $140 annually per patient. Although WHO has screened the generics, the United States will not approve of their purchase with U.S. funds until they meet Food and Drug Administration standards. U.S. officials outlined their objections to the drugs at a conference this week in Botswana. Holbrooke leads the Global Business Coalition on HIV/AIDS, a group of 140 multinational companies. At a discussion sponsored by the Council of Foreign Relations, he lectured John Lange, deputy coordinator of the Bush administration’s global AIDS initiative. “It’s a big issue, and it’s tearing apart all the good work that people are doing because there is a feeling that the United States is protecting big [pharmaceutical companies].” He added that Rep. Henry Waxman (D-CA) has written the president, “blasting the administration on this issue.” Lange, however, said the United States was only concerned that the drugs be as safe and effective as FDA-approved drugs. Dispensing ineffective drugs could lead to drug resistance, causing more harm than good, he said, adding that by the fall, information will likely be available on whether to approve U.S. funding of generics. Columbia University infectious disease specialist Dr. Scott Hammer, who chaired the WHO committee that recommended using the generic combinations, said that WHO’s screening of generics produced by two Indian firms established that “the pills contain the correct drugs in the correct amounts.”

Johnson & Johnson to Give Away New AIDS Drug. On Monday, March 29, at the Microbicides Conference 2004 in London, the International Partnership for Microbicides (IPM) planned to announce it had reached a royalty-free agreement with Tibotec Pharmaceuticals Ltd., a Belgian subsidiary of Johnson & Johnson, to develop an HIV drug, TMC-120, for use in developing nations. The drug is the first vaginal preventative gel to interfere with HIV’s ability to infect cells. Trials are underway to test TMC-120 for safety in humans, and IPM estimates it will cost $50-$100 million to fully develop the compound in five to ten years. Vaginal microbicides are increasingly being touted as an important HIV preventative weapon for women, who may be exposed to the virus by infected partners who do not use condoms. “Having products in microbicides will be very important in reducing HIV for women,” said Helene Gayle, director of HIV/ TB and reproductive health for the Bill and Melinda Gates Foundation, which issued a $60 million grant for IPM to develop TMC-120, and which has donated about $113 million to nonprofit organizations and academic institutions for microbiode research. Johnson & Johnson’s decision reflects a growing interest in finding new ways to get potentially expensive drugs to poorer nations. Researchers plan to conduct larger clinical trials this year involving more human subjects. If the trials are successful, scientists say the first anti-HIV microbicide could be available by 2010.

Experts Say HIV, AIDS Booming in South. According to a report presented Sunday, March 28, at the National HIV/AIDS Update Conference in Miami, the South accounted for only 38% of the U.S. population but 40% of its AIDS cases in 2002, as well as 46% of new AIDS cases from 2000-2002. The report, prepared by Michelle Scavnicky, community relations director for the AIDS Institute, and Kim Williams, CDC researcher, examined 17 Southern states and Washington, DC. It said a growing number of people living in rural areas are being diagnosed with HIV, and there are more new infections among Blacks and Hispanics. Blacks comprised 19% of the region’s population but accounted for 53% of its AIDS cases, the report said. In many small towns, Scavnicky said, a reluctance to discuss sex, drug use and sexual orientation is making prevention difficult. In addition, access to health care is problematic: 17 million Southerners have no health insurance and many Southern states offer limited Medicare coverage. Scavnicky

CONTINUED ON NEXT PAGE
AIDS Rate Rising Among Americans Older than 50. "Older people are probably the least-educated group about AIDS," Dr. Nathan Link, professor of social work at the University of Illinois-Chicago, told the National HIV/AIDS Update Conference in Miami on Monday, March 29. Although new infections among those over 50 are not higher than among younger people, HIV is growing faster in this population than among other age groups, according to James Campbell, president of the National Association on HIV over Fifty (NAHOF). Link cited CDC figures indicating that people 50 and older made up 15% of HIV/AIDS cases before 2002, but 21% of cases since 2002. He said the infection rate could explode as the Baby Boom generation ages. In Florida, people over 50 made up 13% of new AIDS cases in 1992 and 19.2% in 2002. The state had 12,314 AIDS cases over age 50 in 2002. White non-Hispanics comprised 34%, Blacks 50% and Hispanics 16%. "Do people over 50 have sex? Yes," said NAHOF Treasurer Tom Sentell, who said he is 68, gay and has AIDS. "Some of them may even do drugs." But he said many health providers do not prescribe testing for this population. Jane Fowler, 68 and HIV+ since 1985 when she said her husband gave her the virus, talks to groups of young medical students. "I tell them that, whether they know it or not, Grandma and Grandpa may be out there [having sex] and shooting up." Speakers before 1993, people over 60 were not included in AIDS studies because researchers feared other ailments, such as congestive heart failure, which mimics AIDS-related pneumonia, or Alzheimer’s disease, which resembles AIDS-induced dementia, could confound results. "They’re not included in the studies and they’re not included in the outreach programs," Sentell said.

Group: 25 Million to Lose Parents to AIDS. On Wednesday, April 7, in Washington, Sens. Mike DeWine (R-OH) and Hillary Rodham Clinton (D-NY) joined two AIDS groups in releasing a report forecasting that the worldwide number of AIDS orphans will reach 25 million by the end of the decade. Children orphaned by AIDS, like those who are HIV-infected, "experience high levels of psychological distress... social isolation, stigma and discrimination," said the report, which was funded by the International AIDS Trust and the Children Affected by AIDS Foundation. In addition, orphans are at increased risk of "physical and sexual abuse, as well as child labor exploitation;" the report said. Some 13.4 million children have lost one or both parents to AIDS, a number the report said is expected to nearly double by the end of the decade. Of the estimated 40 million people with HIV worldwide, more than 2.5 million are under 15, and 11.8 million are ages 15-24. These numbers are personalized in the report through the narratives of individual children’s lives. “We talk a lot now about getting treatment to people living with AIDS, but we also have to look at the social impact that this epidemic is having on families and communities, particularly in the hardest-hit regions,” said Sandy Thurman, president and CEO of the Washington-based International AIDS Trust. DeWine said the report underscores the need for Congress to approve the funds that improve public health systems in poor countries. So far, only $350 million of the $15 billion President Bush pledged to fight AIDS internationally has been released. “This isn’t just about AIDS. Most of the childhood deaths are avoidable and preventable. We can do simple things to save millions of children’s lives,” said DeWine.

Fast Saliva Test for HIV Gains Federal Approval. On Friday, March 27, Secretary of Health and Human Services Tommy Thompson announced Food and Drug Administration approval of the first HIV test that uses saliva rather than blood and delivers results in 20 minutes. Health officials hope the new test will encourage wider and more frequent testing. CDC estimates that 25% of Americans with HIV do not know their serostatus. Globally, according to the World Health Organization, that figure may be as high as 95%. According to Michael Gausling, president of Bethlehem, PA-based OraSure Technologies, the OraQuick HIV-1/2 Test is more than 99% accurate. Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, said the test is “a very good thing. It’s extraordinary how many people don’t come back for follow-up when they have to wait two weeks.” Typical HIV tests require a vial of blood, and a lab returns results in 2-14 days. Two years ago, FDA approved an OraSure test that uses blood from a finger prick and took only 20 minutes to give results. Since then, the company has sold more than 500,000 of the tests. Gausling said. The new test delivers results as quickly but uses saliva, which is hundreds of times less infectious than blood and therefore less dangerous to the tester. The test uses a plastic stick with a pad rubbed against the gums. The saliva sample is put in a vial of reagent solution. Within 20 minutes, two reddish-purple lines appear if the result is positive. OraSure expects to charge $8-$20 per test, and for now, the test can be used only in certified laboratories. But Dr. Lester Crawford, the acting commissioner of food and drugs, “strongly urged” the company to apply for a waiver to let the test be used in simpler settings such as neighborhood clinics. Fauci said he thought it was “almost certain” a waiver would be granted. The company said the test is for preliminary screening and must be confirmed with a more sophisticated test before treatment is begun.

Circumcision Seen as Method to Block HIV Infection. A recent study shows that circumcised men are less likely to contract HIV for biological, not behavioral, reasons. Previous studies have shown that men whose foreskin was removed are six to eight times less likely to become HIV+, but scientists debated about the reason. Researchers at Johns Hopkins University Medical School-Baltimore found circumcision has a protective effect against HIV, but not against other STDs such as syphilis and gonorrhea. “The specificity of this relation suggests a biological rather than behavioral explanation for the protective effect of male circumcision against HIV,” Dr. Robert Bollinger wrote in the Lancet. Bollinger and coauthors studied men in India, where circumcision is not common, between 1993 and 2000. All of the 2,298 study participants were attending one of three STD clinics and were HIV– at the study’s start. Researchers assessed the men’s HIV status and risk behavior regularly. Because circumcision did not prevent the men from contracting other STDs, Bol linger believes the study supports the hypothesis that HIV protection derives from the removal of the foreskin, which contains cells with HIV receptors that scientists suspect are the primary entry point for HIV into the penis. “Our results suggest that the foreskin has an important role in the biology of sexual transmission of HIV,” Bollinger said. Bollinger and his team have called for clinical trials where circumcision is culturally acceptable to assess the safety and effectiveness of the practice as a tool against HIV/AIDS. They also stressed the need for new compounds to block the virus’ entry into the cell. The study, “Male Circumcision and Risk of HIV-1 and Other Sexually Transmitted Infections in India,” appeared in the Lancet (2004;363(9414):1039-1040).

Study: Nearly Half of People Don't Have Protected Sex. A new online study of 1,155 people ages 18-35 indicated about 84% believed they adequately protected themselves against STDs, but nearly half engage in unprotected sex. Approximately 47% of the respondents never used protection for vaginal sex, 82% never used protection for oral sex and 64% never used protection for anal sex, according to the study conducted by the American Social Health Association (ASHA). The survey—which has a margin of error of plus or minus 3%—showed that about 93% believed their current or most recent partner did not have an STD, yet around one of three people have never discussed STDs with their partner. More than two-thirds of respondents, or 68%, worried little about contracting an STD. “What surprised us and distressed us is the fact that so many young adults believe that they are not at risk of a sexually transmitted disease and they don’t believe that their
sexual partner is at risk," noted Dr. James Allen, ASHA president and a former assistant U.S. surgeon general. "They don't talk with their partner about whether they may or may not be at risk. So they're simply making assumptions." The study also found that more than half of the people interviewed were unsure of their vaccination status or said they had not been vaccinated against hepatitis A and hepatitis B. "Those are the only two STDs—hepatitis A and hepatitis B—that are vaccine-preventable and they need to talk to their doctor about that if they're at risk," said Allen. Around half of the respondents said they did not know those forms of hepatitis could be sexually transmitted. ASHA said more than 1.25 million Americans have hepatitis B.

Condom Label Changes Spark Debate. The request by President Bush to have the Food and Drug Administration modify current warnings on condom packaging to include information about human papillomavirus—also called HPV or genital warts—has set off a fierce debate. On one side are scientists who say that condoms should be promoted as a critical line of defense against STDs. On the other are groups that advocate abstinence before marriage and see the dangers of HPV as a justification for their cause. Linda Klepacki, manager of the abstinence policy department at Colorado-based Focus on the Family, said research demonstrates that condoms do not necessarily prevent the spread of HPV because the virus may be found on parts of the body they do not cover. "The lack of information getting to the American public regarding this disease is beyond comprehension," said Klepacki. She argues that abstinence is the best way to prevent HPV. Adding the information to condom labels would be "truth in advertising," according to Libby Gray, director of Project Reality, an Illinois-based organization that promotes abstinence in public schools. Gray noted that most students she deals with have no idea what HPV is. But abstinence groups may be overlooking important medical information to promote their own values, some scientists say. Tom Broker, professor of biochemistry and molecular genetics at University of Alabama-Birmingham and president of the International Papillomavirus Society, a coalition of health organizations, said that receiving the results of the first studies. Now, activists are calling for health agencies to stop doing business with companies that produce N-9 condoms. The three major manufacturers still making N-9 condoms are Amkel (maker of Trojans), Ansell (maker of LifeStyles) and Okamoto Industries (maker of Beyond Seven). Goshi said the LA Gay and Lesbian Center would stop doing business with any manufacturer that continues to make N-9 products. Chris Owen, associate program director of the Stop AIDS Project, said his organization would take the same step. Klausner said he would ask that his department's condom supplier no longer furnish condoms made by companies that produce an N-9 variety. The activists were critical of FDA, which they said has allowed N-9 condoms to be sold without any evidence of safety or effectiveness. According to agency spokesperson Mary Ellen Taylor, FDA is addressing those concerns with a proposal that calls for new labeling requirements.

Anti-HIV Cream for Women Gets Support. At the Microbicides Conference 2004 in London in late March, Lori Heise, director of the Global Campaign for Microbicides, said that more than $80 million in grants from the Bill and Melinda Gates Foundation has helped make the quest for a microbicide for women in developing nations a promising area of research. About 1,000 people attended the conference. The goal is to find a cream or gel women can apply intravaginally to prevent sexual transmission of HIV by physically blocking or chemically disabling the virus. The Gates Foundation's first microbicide research grant was given to the New York-based Population Council, which will begin trials this year on Carraguard—a brand of seaweed extract often used as a food additive. A Gates-funded trial in India is evaluating an antifungal vaginal cream as a possible HIV microbicide. There is also a large-scale trial in Africa of antibacterial and antimicrobial ointments funded by $13.5 million from the European Union and conducted by the United Kingdom's Medical Research Council. On Monday, March 29, Johnson & Johnson announced that its Belgian subsidiary Tibotec had donated patent rights for an experimental gel to the International Partnership for Microbicides, a nonprofit that received a $60 million Gates Foundation grant last year. The Rockefeller Foundation and the governments of Britain, the Netherlands, Norway, Ireland and Denmark have also donated to the partnership. Experts say married women in developing countries—who are typically expected to bear children and are in no position to ask their husbands to use condoms—are now the most at-risk for HIV. A microbicide would give these women protection they could control themselves. About 14,000 new infections every day occur among women. Researchers at the London School of Hygiene and Tropical Medicine estimated that an effective anti-HIV microbicide could prevent 2.5 million infections worldwide over three years, even if such a cream were only 60% effective against HIV and only 20% of women used it half the time they did not use condoms. Heise said science is still several years away from developing an effective microbicide.

Women's Health: Rape Exploits Women's Increased Vulnerability to HIV Infection. Worldwide, between one-fifth and one-half of all girls and young women report their first sexual encounter was forced. Women are more vulnerable to HIV than men because many are unable to refuse sex or insist on a condom due to a lack of social and economic power, according to the film Women Are, which premiered in Geneva on March 8 to mark International Women's Day. "The call to empower women is not new, but AIDS makes it more urgent," said Musimbi Kanyoro, general secretary of the World Young Women's Christian Association (YWCA), which coproduced the film with UNAIDS. Peter Piot, UNAIDS executive director, said women account for half of the 40 million people with HIV/AIDS globally. In addition to lacking adequate HIV/AIDS knowledge and female-controlled HIV prevention methods such as microbicides, women are biologically more vulnerable to HIV/AIDS, said Piot. Male-to-female transmission is twice as likely as female-to-male transmission. Piot said men should declare zero tolerance on violence toward women, be committed to their daughters' education and help alleviate the burden of care placed on women. Organizations are addressing inequalities by supporting a global push to achieve education for all and the World Health Organization/UNAIDS' cam-

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HIV/AIDS Women’s Health: Oral Lesions in HIV+ Women Reduced in HAART Therapy. Recent research reveals that highly active antiretroviral therapy (HAART) helps prevent the development of Candida-induced oral lesions in female HIV patients. D. Greenspan and coauthors at the University of California-San Francisco “investigated such changes among 503 HIV+ women over six years in the Women’s Interagency HIV Study,” they wrote. “The incidence of erythematous candidiasis (EC), pseudomembranous candidiasis (PC), hairy leukoplakia (HL) and warts was computed over follow-up visits after HAART initiation compared with before-HAART initiation. Analysis of our data demonstrates a strong decrease in candidiasis after HAART initiation,” the study said. “The incidence of EC fell to 2.99% from 5.48% (RR 0.545); PC fell to 2.85% from 6.70% (RR 0.425); and EC or PC fell to 3.43% from 7.35% (RR 0.466).” “No changes were seen in HL or warts,” Greenspan and colleagues wrote. “Higher HIV-RNA was associated with greater incidence of candidiasis and HL, but not warts. Analysis of these data indicates that recurrence and incidence of candidiasis are reduced by HAART, and that recurrence is reduced independently of CD4 and HIV-RNA,” the scientists concluded. The study, “Incidence of Oral Lesions in HIV-1-Infected Women: Reduction with HAART,” was published in The Journal of Dental Research (2004;83(2):145-150).

AIDS Fears Grow for Black Women. Once, concern about Black women and HIV/AIDS focused on those who had used drugs or had sex with drug injectors. But increasingly, HIV/AIDS transmission through heterosexual sex is a danger for African-American females. In government studies of 29 states, a Black woman was 23 times more likely to be infected with HIV than a White woman. In 2001, according to the Kaiser Family Foundation, an estimated 67% of Black women with AIDS contracted the virus through heterosexual sex, compared to 58% four years earlier. CDC said Black women accounted for half of all HIV infections in men or women acquired through heterosexual sex from 1999 to 2002. Recent studies suggest that 30% of all Black bisexual men may have HIV, and as many as 90% do not know they are infected. CDC researchers call such men “bridge” to infection from gay men to heterosexual women. However, Dr. Robert S. Janssen, director of CDC’s Division of HIV/AIDS Prevention, warned that evidence was lacking about what drives infection among Black women. “Yes, the risk of contracting HIV is highest in the African-American community and there’s no question Black women are at higher risk compared to other women, but there’s still a lot we don’t understand,” he said. Janssen added that CDC is concerned enough to tell women of all socioeconmic groups to ask partners about their serostatus and if they are having sex with men. The shortage of Black men as potential partners, experts say, may lead some Black women to make unsafe sexual decisions. “Large numbers of Black men are in prison, or unemployed, or dead, so there is simply a smaller pool of available partners to choose from,” said Dr. Gail E. Wyatt, a psychiatry professor and associate director of the University of California-Los Angeles AIDS Institute. “When marriage rates are low, there is a higher likelihood of concurrence—the pattern of having more than one partner at the same time,” said Dr. Edward O. Laumann, professor of sociology at the University of Chicago. Such “fragile relationships” can facilitate the spread of sexually transmitted diseases,” the professor said.

Health Workers Say AIDS Rate in Baton Rouge Area Cause for Concern. State and local health officials expressed surprise over a recently released CDC report showing the Baton Rouge, LA area tied with Miami for second place in new AIDS cases per capita: 49.5 per 100,000 for 2002. “We’re tied for No. 2. You immediately want to say things are getting worse,” said Beth Scalco, administrative director of the HIV/AIDS program for the Louisiana Office of Public Health. Scalco said that states use different ways to count new HIV/AIDS cases, making comparisons difficult. Louisiana’s system includes laboratory results that indicate HIV/AIDS diagnosis in addition to physician reporting, she noted. Nevertheless, Scalco concedes the numbers are a problem. “People are still not testing until too late in the disease,” she said. In 2002, there were 1,200 new cases of HIV reported in the state, and a year later, 37% of those people had an AIDS diagnosis. Shirley Lolis, director of the Metro Health Education office in Baton Rouge, said people with HIV can stay in good health for a significant period of time, and when they do get sick, they mistake it for something else. “If you don’t feel you’re at risk, then you’re not going to get tested,” Lolis added. Jackie Shellington, director of the immunological support program at Baton Rouge’s Our Lady of the Lake Regional Medical Center, said the city’s ranking may prove to be a good thing. “Honestly, I think it’s a call to arms for the community that we can no longer keep this well-hidden secret.”

Canadian Researchers Start New Trials for Anti-AIDS Vaccine. On Tuesday, March 30, Canadian researchers announced the beginning of clinical trials for a new HIV/AIDS vaccine aimed at replacing antiretroviral drug cocktails. The government-backed trials are being run by the Canadian Network for Vaccines and Immunotherapeutics, in cooperation with the Strasbourg, France-based Aventis Pasteur and the Immune Response Corporation, a U.S. company cofounded by polio vaccine discoverer Jonas Salk. The trials will begin in April and run for 18 months, involving 60 patients from Ottawa and Montreal. Canadian Industry Minister Lucienne Robillard said the 60 patients “have been on effective therapy and have had no detectable HIV in their blood for at least two years.”

Montreal Hospital Says No HIV Cases Yet from HIV+ Doc. Ste-Justine Hospital said Monday, March 29, that no affected patients have tested positive for HIV in tests conducted after the hospital learned a surgeon who operated on 2,600 children there from 1990 to 2003 was HIV-infected. The surgeon died in August. Blood samples from 2,175 patients were tested at the hospital or at private laboratories. Hospital officials said Ste-Justine reached 85% of the surgeon’s patients by registered mail or telephone after it discovered her HIV status in January. Although the risk of infection was very low, according to a hospital statement, “the hospital wanted to be sure, beyond any doubt, and to reassure the parents and children that no patient had been infected.” Dr. Lucie Poitras, director of professional services, said the remaining 15% of patients fell into one of two main categories: people who did not want to be tested and people with whom the hospital had lost touch. She added that an 85% response rate is “quite exceptional.” In its statement, the hospital apologized to the families and patients who had been upset by the discovery of the surgeon’s condition. More than 13,000 calls deluged the hospital’s two call centers when the story went public in mid-January. Hospital administrators insist they did not know of the surgeon’s infection until this year, although her supervisor and a committee of doctors knew about her serostatus in 1991. The Quebec Medical Association has since adopted a policy requiring doctors to disclose their HIV+ status to employers while protecting the physician’s confidentiality.

AIDS Fighters Hear Good News from Haiti. Though AIDS still kills 30,000 Haitians a year, innovative treatment and prevention programs have cut Haiti’s HIV rate by 50% since 1993, Dr. Jean Pape, of the Cornell Well Medical College and director of Les Centres Gheskio in Haiti, said Sunday, March 28, at the National HIV/AIDS Update Conference in Miami. With funding from the U.S. government and from the private group Project MediShare, Haitian clinics over the past ten years
have slashed mother-to-child transmission rates from 22% to 4%, increased HIV screening sevenfold and increased condom use from nearly zero to 15 million in 2003, Pape told attendees. Harvard University medical anthropologist Dr. Paul Farmer, cofounder of Clinique Bon Sauvage in the rural village of Thomonde, said the world must view AIDS prevention and treatment as a human right, rather than a tool delivered or withheld based on cost-effectiveness. He criticized articles featured in the medical journal Lancet and elsewhere, arguing that prevention is more cost-effective than providing antiretroviral drugs to patients. “We don’t know how much it costs us as human beings not to have equity, to have a situation in which some people have access to drugs and others do not. We know we’re not going to meet the goal, but it doesn’t mean we should stop trying,” said Farmer.

In Brazil, a similar human rights approach to HIV/AIDS has cut AIDS deaths by 50% to 90,000 a year since 1996, said Dr. Roberto Brant Campos, deputy director of HIV/AIDS programs at Brazil’s Ministry of Health. In 1988, the Brazilian Constitution declared health care to be every person’s right and the government’s obligation, he noted. Brazil then followed up with massive HIV/AIDS outreach campaigns to sex workers, army inductees and prisoners, Campos added.

Brazilian Scientists Find Something in Rainforest to Help Cut Condom Costs. In a bid to cut the rising costs of importing condoms, the Brazilian government has given scientists there the go-ahead on a prototype condom made from natural latex found in an Amazon rainforest reserve. A study by the National Institute of Technology and the University of Rio de Janeiro led to the development of an environmentally friendly prototype condom that easily passed certain quality control tests. The São Paulo state research group noted the condoms were made with native rubber extracted from the Chico Mendes reserve. Brazil’s Health Ministry and local authorities plan to support the construction of a new plant to manufacture the condoms in the municipality of Xapuri, where many people earn a living by extracting rubber. The government hopes that the new condoms will lower the health costs associated with the distribution of some 600 million condoms each year in Brazil. The new factory should turn out 100 million condoms in 2005, with production doubling in 2006.

AIDS Cases Rising in Germany. A recent study by the Robert Koch Institute for Infectious Diseases showed that German HIV/AIDS cases are rising due to unprotected sex. New HIV diagnoses numbered 1,958 in 2003, up from 1,716 in 2002 and 1,470 in 2001. Gay men represented 41% of the new cases; women accounted for 22%. At the end of 2003, roughly 43,000 people had HIV and approximately 5,000 had AIDS. Some 600 people in Germany died of AIDS last year. The institute said 73% of study participants under age 45 said they used a condom at the beginning of a new relationship, down 5 percentage points from 2000. Condom sales were down to 189 million last year, versus 207 million in 2002.

Bushmeat Sparks Fears of New AIDS-Type Virus. New research shows that people in central Africa who hunt monkeys and apes for food and trade are being infected with viruses from the animals, sparking fears of a future epidemic like AIDS. Researchers from the Johns Hopkins Bloomberg School of Public Health-Baltimore, the Cameroon Ministry of Health, CDC and other institutions traced the transmission of the infection, simian foamy virus (SFV). The scientists called for measures to end hunting wild primate populations to lessen the potential for new infections among humans. “It is in all our interests to put into place economic alternatives to help people move away from hunting and eating these animals,” said Dr. Nathan Wolfe of Johns Hopkins. “In addition to preserving endangered species, such development efforts will reduce the ongoing cross-species transmission of retroviruses and other pathogens that could spark future epidemics similar to HIV.”

HIV, SARS, Ebola and bird flu are among diseases that have been spread from animals to humans. Like HIV, SFV is a retrovirus that can integrate its genetic material into human hosts’ genomes. The scientists found SFV antibodies in 1% of 1,099 people from nine Cameroon rural villages who had been exposed to nonhuman primate blood. The villagers had multiple forms of SFV from distinct primate species. Infections from several different areas suggest that cross-species transmission of the viruses is widespread. But limiting primate hunting could be a challenge because bushmeat is a multimillion dollar industry and a key source of food and work for the poor. Dr. Martine Peeters, of the Institute for Research and Development-Montpellier, France, said infections from animals are among the most important public health threats facing humanity. “The risk of acquiring such infections is expected to be highest in individuals who are regularly in contact with primates, by hunting or preparing primates for food or by keeping primates as pets,” Peeters said. The report, “Naturally Acquired Simian Retrovirus Infections in Central African Hunters,” appeared in the Lancet (2004;363(9413):932-37).

Ten Percent of South African Youth Have HIV, Survey Shows. One in ten South African youths have HIV, according to a survey of 12,000 young people ages 15-25 released on Wednesday, April 7, by Witswatersrand University in Johannesburg. Helen Reese, executive director of Witswatersrand’s reproduction health research unit, which conducted the interviews, said that by age 19, 2.6% of males and 13.8% of females have HIV. By age 24, that number jumps to 11% of males and 26.8% of females. Many women, Reese said, were forced into having unwanted sex or they “succumbed to subtle forms of coercion or presents, money or food.” Reese did note that there were signs of “cautious optimism,” including an indication that the HIV infection rate in the 15-19 age group appeared to be leveling off in comparison to other recent surveys. Condom use is now reported by one-third of those surveyed, compared to 8% cited in a 1998 health survey. But Reese stressed there is no “cause for celebration.” “The rate of infection among South African youth, particularly young girls, is among the highest in the world. There are persistent behavioral trends, such as multiple sex partners, that exacerbate the problem.” Around 10% of those surveyed reported substance use—with alcohol abuse being the most common, and 10% said they had used drugs and 3% intravenous drugs. “If this is a trend that is beginning to creep in...it’s clearly something else that we need to be very mindful of and to be watching for,” Reese said. The survey showed that eastern KwaZulu-Natal had the highest HIV prevalence rate, at 14%. The northern Limpopo province, a relatively poor and rural area, had the lowest, at 4.8%.

Virginia Doctor to Help Open African AIDS Clinic. An international coalition of physicians, including the University of Virginia’s Dr. Michael Scheld and Dr. Nelson Mandela Sewankambo of Uganda, will open an AIDS clinic in Uganda’s capital city of Kampala by May 1. The Pfizer Foundation funded the new $6 million, 25,000-square-foot clinic, which will provide antiretroviral drugs to AIDS patients at no cost. “Right now, we have 600 people on antiretroviral therapy,” said Scheld, a professor of internal medicine. “We hope to expand that to 10,000 if we get the funding. For me, it’s a humanitarian effort that’s screaming for help. There is a huge disparity in treatment between the U.S. and Africa, and it shouldn’t be that way,” Scheld added.

Asia Facing Higher HIV Risk as Youths Become More Sexually Active. As Asia’s youth increasingly shirk their parents’ values by having premarital sex, often with multiple partners, they are becoming increasingly susceptible to HIV, regional health experts warn. Some governments have responded by implementing education programs and launching school and community campaigns, but the World Health Organization says this is not enough. “There needs to be bigger political commitment, more education and information and more resources for care and treatment,” said Bernard Fabre-Teste, WHO’s Western Pacific advisor on HIV/AIDS. Fabre-Teste’s comments follow the January release of a WHO report warning that Asian youths lacked the knowledge to avoid be-
behavior that puts them at risk for HIV infection. In that report, WHO Western Pacific Director Shigeru Omi noted, “Social norms regarding sexual activity and sexual behavior have changed, but the environment to support the adolescents to face these changes has not.” The WHO report cited studies showing 23% of Filipinos between ages 15 and 24 had engaged in premarital sex, and 70% of them did so without using contraceptives. A separate 2003 UNAIDS report said a survey among Vietnamese ages 15 to 25 showed just 26.3% had basic knowledge of HIV prevention and transmission. The survey also found that only half of males and a third of females used a condom in their last sexual intercourse with a non-regular sex partner. According to Angelike Ackermans, HIV/AIDS advisor for UNAIDS Malaysia, because most reported HIV cases involve high-risk groups such as sex workers or drug users, many in the general population do not see themselves as being vulnerable to the disease. Young people are more likely to fear pregnancy than HIV.

With AIDS Spreading Relentlessly, India Launches Free Drug Program. On April 1, India's government took its first steps toward distributing antivirals to 100,000 people. At the new Lok Nyak AIDS clinic in New Delhi, the drug supply was sufficient for only 200 patients a year, and doctors launched the program by providing medication to six people. The medications—generic copies of combinations of drugs used in the West—cost the Indian government approximately $1 a day per recipient. Both India and South Africa, which launched its free-drug program the same day, are part of the World Health Organization’s “3-by-5” goal of treating three million HIV/AIDS patients in the developing world by 2005. Less than 1% of India’s population of one billion has HIV, but that is 4.6 million cases. India is second only to South Africa in its number of HIV infections. In India, the epidemic is concentrated in pockets, mostly in high-prevalence states in the south. Close to 80% of India’s infections are believed to have been transmitted heterosexually, which suggests the start of a generalized epidemic. Delhi is the only state in northern India participating in the national treatment program. Officials worry that people from neighboring states will flock to the Lok Nyak clinic. During the first phase of the national program, the drugs will be distributed with first priority to HIV+ mothers who participated in a program that gave a short course of drugs to them during childbirth. Second priority will be HIV+ children below age 15. Third priority will be fully developed AIDS cases. Initially, many who get free treatment may be among the estimated 15,000 Indians currently receiving AIDS drugs through private charities.

Cambodian Workers Say “No” to Bill Gates-Funded HIV Drug Study. On Monday, March 29, a Bill and Melinda Gates Foundation-funded study of the HIV drug tenofovir DF in Cambodia suffered a setback when a group of sex workers refused to participate. One hundred-fifty members of Women’s Network for Unity (WNFU) said they would only take the drug if given insurance to treat possible side effects for 30 years. The drug is currently used to treat HIV patients. The study, a joint effort by Cambodia’s Health Ministry, the University of California-San Francisco and Australia’s University of New South Wales, is a multinational test to see if tenofovir DF reduces HIV risk among noninfected sexually active adults who are regularly exposed to the virus. Kimberly Page Shafer, a University of California professor who attended the WNFU meeting, said the drug could cause stomach gas and nausea, and that women would be treated for side effects during and after the trial. The U.S. Health Department said that when the drug is taken to treat HIV, its side effects range from diarrhea and rashes to liver or kidney failure. Shafer told the Associated Press that it was impossible to provide insurance to participants. Cambodia was selected for the trial due to its high rate of HIV infections, according to Khol Vohith, a researcher at the country’s National Center for HIV/AIDS and Sexually Transmitted Diseases. Though it has dropped to 2.6% in 2002 from 3.8% in 1997, Cambodia’s infection rate remains Southeast Asia’s highest. The research team said it would keep trying to recruit some 960 sex workers for the year-long study, set to begin in June.

China to Abolish Forced Isolation of AIDS Patients. Xinhua News Agency reported Friday, April 2, that China’s National People’s Congress will amend a 15-year-old contagious disease prevention law to abolish the forced isolation of AIDS patients. Some 300 local and central government laws regulate AIDS prevention and control, including some that impose restrictions on employment, education, marriage rights and privacy for those with the disease. The amendment represents “an institutional start to eliminate the stigma and discrimination against HIV/AIDS patients” that help spread the disease, said one member of congress. Xinhua also repeated expert forecasts that cases of HIV in China would reach ten million in 2010 “in the best case” scenario and possibly 20 million “if drastic actions were not immediately taken.” A fundamental obstacle to China’s HIV/AIDS fight is discrimination against people with the disease, said Koen Vanrommelen, chief of UNICEF’s Health and Nutrition Department in China.

JAG Episode Takes on HIV Discrimination. The Friday, April 2, episode of the CBS drama JAG addressed HIV discrimination in the military. “We felt it was important to tackle the issue of HIV/AIDS-related discrimination. As this is a global epidemic, military personnel are not immune,” said Donald P. Bellisario, executive producer and creator of the series. Viacom, which owns CBS, is carrying out an HIV/AIDS public information campaign—created with the Henry J. Kaiser Family Foundation—through its television, radio and other units.
Cruising with Lazarus

Abbott Laboratories’ Pricing Malfunction

In case you were wondering if there could be anything more shocking than a “wardrobe malfunction” during a Super Bowl halftime show, there is. Last December, well over a month before Janet Jackson exposed her breast to 89 million television viewers, pharmaceutical giant Abbott Laboratories increased the U.S. wholesale price of its HIV drug Norvir by 400%. Overnight. Just like that. Biggest price hike in the history of lifesaving drugs. That beats Miss Jackson, even when she’s nasty.

Norvir is a protease inhibitor that helps suppress HIV, the virus that causes AIDS. Norvir is unique in its class because it seems to boost the effectiveness of other protease inhibitors. Originally approved by the United States Food and Drug Administration (FDA) in 1996 for use in HIV antiretroviral combination therapy, Norvir has generated estimated sales of over $1.3 billion in its eight years on the market. The drug, widely considered too toxic to take at full dose, is used at 1/3 to 1/4 of its original dose to boost the effectiveness of other protease inhibitors, often in people who are treating drug-resistant HIV. Abbott Laboratories makes another protease inhibitor, Kaletra, whose formulation includes Norvir, but the price of that drug was unaffected. Hmm... so what’s behind the unprecedented price increase of Norvir?

Abbott spokesperson Lauren Cassidy said the higher price helps pay for the development of new drugs and new formulations of existing drugs. “This is about preserving patient choice,” she said, then added, “There is an escalating cost for bringing new drugs to market for the world, both domestically and for developing countries, and Abbott has been very much a part of the solution, including increasing access initiatives in the developing world.” Cassidy concluded by asserting that the new price of Norvir “better reflects current market value.” Sure, Lauren, it’s all about the cost of research and development of other drugs. But wait, you forgot to explain how it takes eight years to figure out the market value. And by the way, since Kaletra contains Norvir, why not raise the price of both?

Poor Lauren Cassidy, she’s all confused. Bless her heart, she’s out of the loop. She must not know that a National Institute of Allergy and Infectious Diseases (NIAID) grant funded development of Norvir. NIAID is a component of the National Institutes for Health (NIH), which is part of the U.S. Department of Health and Human Services. Government money bought us Norvir, not Abbott money. Manufacturing and marketing costs aside, whatever else Abbott makes off Norvir has been pure profit since the drug was approved eight years ago. So that whole 400% price hike thing just looks blatant, unethical and greedy.

Maybe someone else at Abbott Laboratories can better explain why they boosted the wholesale price of Norvir from $1.75 a day ($52.50 for a 30-day supply) to $8.57 a day ($257.10 a month). “It’s allowing us to make investments in future innovations—novel therapies, drugs with less side effects—and to bring those to market so patients have access to more and better medicine,” said Heather Mason, Vice President, Specialty Operations Pharmaceutical Products for Abbott Laboratories. “We did not make this pricing decision lightly,” Mason claimed. “We carefully considered many things, and ultimately our very complex decision process allowed us to reach this difficult conclusion that this new price is necessary to be able to support our ability to continue research to bring the next generation of HIV medications to market.” Oh, to be a fly on the wall during their complex decision process!

Is it possible Mason and other Abbott officials never considered that their other protease inhibitor, Kaletra, might benefit from Norvir’s price increase? Mason says no. She would have us believe no one at Abbott saw this as an opportunity to steer patients and the doctors writing their prescriptions toward Kaletra, which already contains the amount of Norvir used to boost other companies’ protease inhibitors. Switching to Kaletra would ultimately be cheaper than combining Norvir with protease inhibitors like Viracept or Crixivan—all made by other pharmaceutical giants. The main effect of the Norvir price hike will be to raise the cost of drug combinations that include Norvir. That’s not about research and development; it’s just a way for Abbott to gain market share for Kaletra.

“That’s simply not the case,” declared yet another Abbott spokesperson, Ann Fahey-Widman. “This action is specific to Norvir. It does not impact Kaletra.” And you know what belched out of her mouth next: “This pricing action supports our ability to continue research and development.” Quite a few people have disagreed with Mses. Fahey-Widman, Mason and Cassidy—Abbott’s Axis of Evil Mouthpieces. Attorneys General for Illinois and New York are investigating whether Abbott Laboratories’ 400% price increase for Norvir violated antitrust law. The Los Angeles-based AIDS Healthcare Foundation (AHF)—one of the nation’s largest AIDS-care providers—filed a federal antitrust lawsuit claiming the hike threatens the lives of HIV-infected people. Even the AIDS Treatment Activists Coalition sent a letter to thousands of HIV physicians, researchers and pharmacologists across the United States, urging them to consider boycotting Abbott drugs and diagnostics when it does not present a risk to patient safety.

What does Abbott spokesperson Ann Fahey-Widman have to say about all that? It’s all “without merit.” “Abbott has acted lawfully,” Fahey-Widman proclaimed. She’s smart enough to know American pharmaceutical companies like Abbott have never had to disclose exactly how they set the price of their drugs for the U.S. marketplace. Yet, they sell the same drugs to Europe and Canada for considerably less. Why? Europe and Canada negotiate lower prices for their citizens. Canadians, for instance, pay an average of 45% less for the same drugs your doctor routinely prescribe in America.

The United States government does not hold pharmaceutical companies accountable for much of anything. According to Public Citizen, a national nonprofit consumer advocacy organization, the drug companies spent over $91 million on federal lobbying activities and another $29 million on political campaign contributions to Republicans and Democrats alike in 2002. Number of Big Pharma lobbyists in 2002: 675. Members of Congress: 535. Do the math. Pharmaceutical companies, like Abbott, have a powerful, incalculable influence on politicians.

Abbott spokespersons Fahey-Widman, Mason and Cassidy repeatedly argue that raising the price of Norvir 400% is necessary because the research and development costs of new drugs are so high. Every spokesperson for every U.S. pharmaceutical company regurgitates this bogus double-talk every time they’re forced to defend their increasingly reprehensible manipulation of the prescription drug market. The amount of money they spend buying off Congress is a matter of public record, but not once have they been forced to reveal the true research and development cost of a drug or present a formula for setting its price. It’s like that secret recipe for Kentucky Fried Chicken—they won’t give it up.

Sit down in front of your television for one hour and count the number of prescription drugs ads you see. It won’t be less than a half dozen, guaranteed. Since the Food and Drug Administration relaxed direct-to-consumer advertising regulations for prescription drugs back in 1997 (thanks to expensive lobbying efforts), Big Pharma has bludgeoned Americans with commercials directing us to ask your doctor or tell your doctor, effectively turning your health care provider into something like a pusher. They spent more than $2.5 billion on that kind of advertising in 2002—approximately 15% of all U.S. advertising! (Source: Associated Press)

One last thing misinformation mavens like Cassidy, Mason and Fahey-Widman don’t want to talk about: profits. According to Fortune magazine’s annual analysis of America’s 500 largest companies, drug companies had $35.9 billion in profits in 2002.
compared with $37.2 billion in 2001, a drop of 3.5%. By comparison, all companies in the Fortune 500 suffered a combined loss of 66.3% in profits from 2001 to 2002. Stunningly, profits registered by the top ten drug companies were equal to more than half of the $69.6 billion in profits netted by the entire list of Fortune 500 companies. In 2002, drug companies made a profit of 17¢ on every dollar of revenue. The median profit for all other Fortune 500 companies that year was 3.1¢ for every dollar of revenue.

Year after year, pharmaceutical companies like Abbott Laboratories are the most profitable companies in the world. Acknowledging this indisputable fact, how can Abbott possibly justify a 400% price increase for an eight-year-old drug they spent nothing to develop in the first place?

P.S. A little research turns up an interesting development: in 2003, Abbott Laboratories’ Chief Executive Miles White received a 4.5% salary increase and bonus, raising his total pay to $3.4 million, up 20% from 2002. (Source: Chicago Tribune)

David Salyer is an HIV+ journalist and AIDS educator living in Atlanta, Georgia. He leads safer sex presentations for men and has facilitated workshops for people infected or affected by HIV since 1994. Reach him by e-mail at CubScout@mindspring.com.
Steven Allen Floyd died of AIDS in 1988. I buried my first lover in the company and comfort of all our family.

Albert Henry Kaps, Jr., died of AIDS in 1991, after months of being bedridden and weighing less than half his normal body weight.

Jeffrey David Boyd, unemployed and unemployable due to his AIDS-related facial eczema, committed suicide in 1996.

Ronald G. Day died of AIDS in 1998. He had just moved to Washington, DC, to start an exciting new chapter in his career.

These men are just a handful of the many friends I’ve known who have died of (or because of) AIDS in the last twenty years. There are so many more—“Buttons” Lee, Jim Thomas, Barry “Bear” Weldon, Mark Bigler, Dennis Stabler, Karl Lipinski, Phil Eley, Stan Deach—far more than I can count.

With every funeral, every burial, every cremation, every memorial service—with every tearful, painful goodbye—another piece of my heart dies and goes down with them, and I continue to wonder how it is that I’ve managed to outlive so many of my friends and loved ones for so long. With ever-increasing guilt and grief, I honor their lives, cherish their memories and continue to mourn their deaths.

If you would like to remember, honor and cherish the lives of your own loved ones who have died of AIDS at this year’s upcoming Atlanta Pride Festival, send us their photos. ASP will have them reproduced, enlarged and mounted on placards that will be used in the annual Pride Vigil on Friday night, June 25, in our booth in the Pride Market. For more information, call Rob Nixon at (404) 874-7926 ext. 16. To submit photos, bring them to the ASP office for scanning, send via e-mail, or mail to the ASP office address. Photos sent by mail will be returned.

Giving Credit Where Credit’s Due

Sharp-eyed readers might have noticed an addition to the Survival News masthead back on page 2 starting this issue. When ASP management asked me to take over the production duties of this fine publication last summer, one of the transparent changes that came with that transition was that its production was to be handled off-site, e.g., not at the ASP offices, as it had always been done before. As a result, I edit and produce Survival News in my home office; that’s why I don’t have an ASP e-mail address or phone extension. While this arrangement works exceedingly well for a bimonthly publication, it also means that my day-to-day contact with ASP staff is actually rather limited. Ever since the September/October 2003 issue, I’ve been working closely with Rob Nixon, ASP’s Communications Manager, to coordinate and manage such staff-sensitive issues as deadlines, topic decisions and printing and distribution matters, while I have focused on publication design, layout and production. Inasmuch as Rob’s contributions to the production of Survival News are just as vital as my own, we’ve decided to add his name to the masthead as Managing Editor. The only actual change being made is finally giving appropriate credit to Rob for all the fine work he’s been doing all along, anyway. So, let me be the first to publicly thank Rob for all the tremendous help and support he’s given me this past year... and we both hope you’ll continue to rely on Survival News as your leading reference source for news and information on HIV/AIDS advocacy, education, peer support and treatment activism.
**Classified Advertisements**

**CLASSIFIED AD POLICIES:** All classified ads are printed free of charge and will run in two consecutive issues per submission [1/2, 2/2]. Ads may be renewed by resubmitting. To place an ad, use the form at right and send to Classified Ads, c/o ASP, 139 Ralph McGill Blvd #201, Atlanta GA 30308-3339 or e-mail TrekBearGA@aol.com. E-mailed ads must include a daytime phone number for verification. Do not call the ASP office to place an ad. Deadline for all ads is the first workday of the previous month. ASP reserves the right to edit ads as necessary and is not responsible for the content or credibility of any ad.

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**POSITIVELY PERSONAL**

**MALE SEEKING FEMALE**

Black male, 49, comic book artist. Seeking HIV+ woman for love and happiness. Race unimportant. If you like traveling, movies and dinner, call me. Larry, (310) 324-2813. [2/2]

**SEEKING PEN PALS**

BM, 27, mature. Seeking correspondence with someone earnest in pursuit of life’s fulfillments. Love for self is vital; age, race not important. Craig Partridge, GDC844679 I-C, Scott State Prison, PO Box 417, Hardwick GA 31304. [2/2]

Straight black male, 6’ 2”, 195 lbs., handsome, optimistic, non-judgemental, open-minded, diligent, romantic, caring. Seeking correspondent and not someone to exploit. I will reply to all letters. Charlie Roberts, GDC408997, Ingram Bldg. C-23, Scott State Prison, PO Box 417, Hardwick GA 31304. [2/2]

SWM, 39, 5’ 9”, 165 lbs. Dark hair, blue eyes, sense of humor, lots of steamy stories to tell. Soon to be released. Looking for male pen pal, maybe more. Frankie Wayne, GDC718622, Georgia State Prison, 2164 GA Hwy 147, Reidsville GA 30499. [2/2]

**SERVICES**

Reid Michael’s Cleaning—1 or 2 bedrooms; townhomes, apts., houses. Your basic cleaning; dusting, mopping, vacuuming, etc. Prefer regular schedule. Ask for Larry at (404) 373-1032. [2/2]

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**EMORY UNIVERSITY SCHOOL OF MEDICINE**

**VOLUNTEERS NEEDED**

Are your HIV medicines not working for you anymore? Are you thinking about changing your anti-HIV drug combination?

**IF YOU:**

- are HIV+ or are 18 or older
- have tried at least two anti-HIV drug combinations, including a PI, that have failed to control the HIV infection in your body
- have been on your current anti-HIV drugs for the last 12 weeks

The Emory AIDS Clinical Trials Unit is studying whether increased doses of protease inhibitor (PI) drugs will more effectively lower your viral load than standard doses of PIs. The dose increases of the PI drugs will be based on Therapeutic Drug Monitoring (TDM), which measures your blood levels of PIs. This 48-week clinical research trial will also study whether it is safe to increase the doses of PI drugs based on TDM. This trial will not provide any medications.

For more information, contact: Dale P. Maddox, LCSW, (404) 616-6333

Ponce IDP Center, 341 Ponce de Leon Ave, 3rd Floor, Atlanta GA 30308

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**EMORY UNIVERSITY SCHOOL OF MEDICINE**

**Are your HIV medications not working?**

If you:

- are HIV+
- are 18 years of age or older
- have been taking a protease inhibitor for the last 8 weeks

You are invited to participate in a research trial to study the safety and effectiveness of an investigational protease inhibitor.

**THIS 48-WEEK RESEARCH STUDY IS NOW SEEKING VOLUNTEERS TO ENROLL**

For more information, contact: Dale P. Maddox, LCSW, (404) 616-6333

Ponce IDP Center, 341 Ponce de Leon Ave, 3rd Floor, Atlanta GA 30308

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**SHOP AT KROGER—SUPPORT AIDS SURVIVAL PROJECT!**

Every time you use your Commitment Card, Kroger donates a percentage of your purchase to ASP, at no additional cost to you!

Thanks to you, ASP received almost $1,300 from Kroger last year.

Call Greg Carraway at (404) 874-7926 ext. 18 to get your free card!

**AIDS Survival Project** is incorporated in the state of Georgia as a 501(c)3 nonprofit corporation. All donations are tax-deductible. A large percentage of our annual budget is funded solely by your contributions; the rest is supplemented by grants solicited from private foundations.

We are happy to provide the newsletter to anyone who cannot afford a subscription; however, we ask that anyone who can afford to subscribe, please do so.

- I am a person living with HIV/AIDS and want to be a member of AIDS Survival Project.
- Enclosed is $30.00 for a one-year subscription.
- I cannot afford to pay for a subscription. Please enter my free subscription.
- I would like to make a donation in memory of: ________
- I would like to make a donation in honor of: ________
- I have other special skills I would like to offer: ________
- I am: __________
- Gender: __________
- City/State/ZIP: __________
- Phone: Day __________ Evening __________
- E-Mail: __________

Please send me information on how I can include AIDS Survival Project in my will or planned giving.

Please contact me about volunteering for the following:

- Survival News Committee
- Treatment Advisory Committee
- Advocacy Committee
- Special Events Committee
- I am a person living with HIV/AIDS and want to be a member of AIDS Survival Project.
- Enclosed is $30.00 for a one-year subscription.
- I cannot afford to pay for a subscription. Please enter my free subscription.
- I would like to make a donation in memory of: ________
- I would like to make a donation in honor of: ________
- I have other special skills I would like to offer: ________
- I am: __________
- Gender: __________
- City/State/ZIP: __________
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Please send this form to AIDS Survival Project, 139 Ralph McGill Blvd, Suite 201, Atlanta GA 30308-3339. Thanks!
MAY 2004

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SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY

CALL (404) 874-7926 FOR MORE INFORMATION ON ANY OF THESE EVENTS