

We are diverse people living with HIV, united to promote self-empowerment and enhanced quality of life for HIV-affected individuals through advocacy, education, peer support and treatment activism.

ASP's Big Night: Annual Membership Meeting 2005

by Rob Nixon, Communications Manager

This is a very special night, not just for me, but for all of AIDS Survival Project, because it is a night about transition, welcoming new board members and honoring new young leaders in a time of hope and in the spirit of the founders of this organization."

With these words, **Jeff Graham** began his final State of the Agency address as executive director of ASP after eleven years and handed over the reins to **Molly Casey** at our annual membership meeting on September 26, a date that held special significance for him.

"On Monday, September 26, 1994, the board of AIDS Survival Project asked me to serve as interim director," he told the crowd. "I was 30 and green at this. There were only four others on staff; we had very little technology or infrastructure; we were housed in a small space that was shared by several staff members, volunteers and programs at once. I got put in charge of this thing and I did not know how I would get through the next couple of weeks, let alone eleven years!"

After noting the tremendous growth and evolution of ASP through the past years—and especially since last year's annual meeting—Jeff credited five individuals who were among those who offered him so much support and inspiration in those early days, people who gave everything they had to building ASP despite dealing with their own critical health issues, because they believed in the agency's mission and vision. All of them—**John Kappers, Dave Wagner, Greg Stowers, Kurt Suchier** and **Stephanie Morrison**—died within the first year of Jeff's term. He noted especially how, at Stephanie's funeral, her husband read a short speech she prepared before her passing in which she invited everyone to take a butterscotch candy from a bowl at the service and hold onto it, instructing them to taste its sweetness and bitterness in their toughest times and think of her up in heaven, "advocating for you with the Big Guy."



Passing the torch: Molly Casey (left) began her first day as ASP's Executive Director at the Annual Meeting on Monday, September 26, and Jeff Graham (right) moved into his new position as Senior Director of Advocacy and Communications.

PHOTO: JENNIFER HAYES

"There were so many times the past eleven years I took this out and wondered if this would be the day I needed it," Jeff said, holding up the sweet. "But I never had to, because of the support and help I've gotten from all of you. And now it's time not to retire it, but to pass it on." With that, he handed the candy to Molly Casey.

Emotions ran high throughout the evening as we commemorated the past, celebrated the present and expressed hope and commitment for the future, and this was especially evident in the presentation of the annual John Kappers AIDS Community Service Award, the highest award granted by this agency. The award is named for the late John Kappers, a founder and former board president of AIDS Survival Project, whose tireless work helped to shape the provision of AIDS services in the early days of the epidemic.

Nominees are those considered to be knowledgeable and vocal on vital HIV issues. Individuals also are considered who have contributed to the HIV/AIDS community a significant amount of time and/or money to support the self-empowerment of individuals infected with or affected by HIV. These nominated individuals must have utilized their energy and

resources to ensure a better quality of life for those in the HIV community through advocacy, education, support services or treatment facilitation.

This year's nominees were:

- **Stephen M. Brown**, who has served as board president and fundraising chair at **Jerusalem House** since 1998, using his talents, expertise and extensive network in the public relations field to garner that organization important media attention, donors and new board members and volunteers.
- **Anica Leitch**, a 17-year-old high school senior who has volunteered with **AID Gwinnett** since 2003 and has excelled as a youth leader, HIV prevention trainer and founder of a youth volunteer program that has inspired many others into service in the AIDS community.
- **Mona Bennett**, activist, educator and longtime stalwart of the Atlanta AIDS community through her work with ACT UP, ASP, Georgia Shares and as one of the founders and now Outreach and Volunteer Coordinator for the **Atlanta Harm Reduction Center (AHRC)**.

CONTINUED ON NEXT PAGE



IN THIS ISSUE OF SURVIVAL NEWS: *Click on these hyperlinks to get there!*

From the Executive Director	3	The Backbone	10
Dateline: ASP	4	Chronicles	11
Prevention Counseling	6	Cruising with Lazarus	15
Peer Counseling Perspectives	7	HIV + Me	16
Treatment News	8	Classified Advertisements	17
Community Forum	9	November/December 2005 Calendar	18

- **Mary Leslie**, who as a staff member of the City of Atlanta's Office of Grants Management has been responsible for funding of HIV-supportive housing programs since 1994, encouraging and fostering new and innovative residential programs to serve people living with HIV/AIDS.
- **B. Andrew (Drew) Plant**, writer and public relations professional who has used his time and talents in support of a number of community agencies, including important fundraising activities for ASP and others, and who has used his position to keep important AIDS issues in the public eye for many years.

After presenting certificates to each nominee, Jeff Graham announced this year's winner to thunderous applause—Mona Bennett.

"AHRC does some of the most difficult work in our community," noted Graham, who nominated her. "Mona Bennett's commitment to the concept of harm reduction and AHRC's willingness to work directly on the streets with injection drug users is laudable. Everything she does comes from the philosophical viewpoint of supporting self-empowerment of all individuals and communities."

Upon accepting the award, Mona brought two other AHRC staffers up to share the moment with her—Executive Director **Janice Shomo** and Prevention Case Manager **Harry Ethridge**.

"Do one thing for me," Mona urged those at the event in her inimitable style. "Raise your right hand, put it over your liver. Love your liver! Let's not forget the vital role of viral hepatitis in all this health care madness."

The Kappers Award is accompanied by a \$1,000 honorarium, provided every year by the **Atlanta AIDS Partnership Fund of the Community Foundation for Greater Atlanta** and **United Way of Metropolitan Atlanta**. The honorarium is donated to the award recipient's AIDS service organization of choice. "Of course, I'm giving mine to AHRC!" Mona said.

The evening was also a chance to honor the service of those within AIDS Survival Project. Every year, the agency awards the Antoniette Sinclair Vol-


unteer of the Year Award (named in honor of our longtime volunteer extraordinaire, who is the first face many who access ASP's services see upon entering the front door). In this past year of growth and transition, it was appropriate to honor several people who have contributed so much in a very busy time. Led by Associate Director **Carmen Giles**, awards were presented by **THRIVE! Weekend Manager Sarah Biel-Cunningham** to **THRIVE! Facilitator Jim Faulkner**, by Peer Counseling Manager **Mary Lynn Hemphill** to counselor and trainer **Richard Anderson**, and by Treatment Education Manager **Cara Emery** to Treatment Resource Center volunteer **Bonnie Olsen**.

Board members are also essentially volunteers, and Graham honored one who has been such a major presence at the agency, serving as board secretary for six years: **Joan Campitelli**, who is stepping down from the position this year, but will remain on the board and continue various volunteer service duties for ASP (as well as a number of other organizations).

The remaining order of business was the election of new and returning board members. ASP is proud of the fact that we are unique in having our members (i.e., anyone who is HIV+) elect our board. ASP's bylaws state that the board of directors shall consist of no less than 50% individuals living with HIV. This year, five board members were re-elected: **Michael Baker**, **Craig Eister**, **James Powell**, **Jill Royer** and **Barron Segar**. Three new people were also elected to the board: **William Golden**, **Philip Montgomery** and Dr. **Barbara Rubin**.

At the end of the evening, it was Molly Casey's opportunity to speak to board, staff and members for the first time as the agency's new executive director.

"I am not here to replace Jeff—one one could," she began, noting Jeff's exciting transition to a new position in the organization, Senior Director of Advocacy and Communications, in which he will be able to expand the vital advocacy work he has led on the local, state and national levels for so many years. She also stressed the important role she will fulfill in diversifying and expanding ASP's funding base. (For more of Molly's comments on taking the new position, please see her message on page 3 of this issue.) Then she gave an indication of her enthusiasm, commitment and spirit as she faces the challenges of the future with an organization that has already impressed her for its focus, its mission, its inclusiveness and its wealth of human resources.

"In my days at the Red Cross, we had a series of posters based on various African proverbs. My favorite was from Cameroon: 'Knowledge is better than riches,'" she noted as a key component of not only what motivates her, but what drew her to ASP. Then, holding up the butterscotch candy passed to her earlier in the evening by Jeff Graham, she smiled warmly and added, "I don't doubt there will be days when I open my drawer and consider this. But I am looking forward to a great relationship with all of you and I thank you for your warm welcome." 



A beaming **Mona Bennett** accepted her well-deserved **John Kappers AIDS Community Service Award for 2005**.
PHOTO: JENNIFER HAYES

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First Impressions

INFORMATION


What an exciting time to be joining the team at AIDS Survival Project! We have so many stimulating opportunities and challenges ahead of us. We are well-poised to meet them. ASP has grown and matured over the years and is now a trusted leader, service provider and advocate for the AIDS community. With the transition of **Jeff Graham** to Senior Director of Advocacy and Communications and my appointment as executive director, we now have the ability to expand our advocacy work as well as our grassroots outreach to people living with AIDS.

Jeff's new role will afford him the opportunity to provide focused leadership to the **Campaign to End AIDS**, enhance advocacy training at a statewide level and actively address other advocacy issues and concerns affecting the AIDS community. In the coming year, ASP will be challenged by changes in funding streams and requirements to meet funding demands. Addressing issues posed by the reauthorization of the Ryan White Care Act and changes in Medicaid/Medicare will be key priorities for us. I will devote energies on expanding our funding base, increasing our visibility, enhancing and developing key collaborations and continuing to diversify our outreach. My attention to our most valuable resources—our staff, volunteers and members—will be evident through support, recognition and development opportunities.

I am very pleased to assume the position of executive director for AIDS Survival Project. The road to this position was itself challenging, but ultimately an opportunity well-conceived and implemented by the search committee, staff, volunteers and community representatives. From the onset of my candi-

dacy process, I was impressed with so many aspects of ASP. While I related strongly to our mission and high standards, I also spent time researching the organization, finding it to be well-managed and held in high esteem by other agencies and professionals in the field. I spoke with friends, colleagues and strangers, volunteers, associates and members, all the while gaining more respect for the work and mission of ASP. In the end, I was sure that this was where I wanted to make my professional home and am delighted that the ASP board placed their trust in me.

My favorable impressions of ASP have really just begun. I had the wonderful experience of attending *THRIVE! Weekend*. As you know, this is an exhausting yet energetic weekend full of education, resources, support and hope—all leading to the foundations of self-empowerment. As an incoming ED, seeing the high level of professionalism, commitment, expertise, caring and collaboration of staff was gratifying. And where do I begin to describe the volunteers? Their compassion, professionalism, support and dedication is inspiring. I sensed a great fit for me with ASP prior to *THRIVE!* Afterwards, these feelings were confirmed and my enthusiasm for working with everyone connected with ASP—staff, board, volunteers, members, collaborative partners and community agencies—grew exponentially.

Thank you all for the warm reception that I have received. My door is open and I welcome your comments, questions, expertise and support, and appreciate your patience and flexibility with our transition. I am looking forward to continuing my learning process and to being a part of ASP and meeting and working with all of you. 

AIDS Survival Project Extends Its Gratitude to the Following Sponsors of the 2nd Annual Halloween Affair
October 21, 2005

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PHOTO: PETER STINNER

Jeff Graham (fourth from left) was recognized by the Atlanta City Council for his years of service to AIDS Survival Project and the AIDS community. Councilmember **Anne Fauver**, who sponsored the proclamation, is to the right of Jeff in the photo. Be watching for Jeff's advocacy updates in future issues of Survival News. And stay current with all the issues affecting the HIV/AIDS community by checking Jeff's updates and alerts on our web site (www.aidssurvivalproject.org/advocacy/advocacy.html) and by signing up for our listserve.



A Tribute to Jeff Graham

On the evening of Sunday, August 14, 2005, the skies turned an ugly shade of greenish yellow, the wind began to howl and without much warning, the rain came down in torrents. In spite of such nasty weather, a crowd of approximately 150 friends, colleagues, board members, staff and volunteers turned out for "Stir It Up," an evening to celebrate and support **Jeff Graham** as he stepped down as executive director to take on the

newly developed position of Senior Director of Advocacy and Communications within the AIDS Survival Project organization.


Never an organization to lose sight of a possible fundraising opportunity, early in the evening there was a commotion including bells, sirens and whistles where guests could seek to have other guests "arrested" for the sum of ten dollars. The "police" would come and get them and cart them off to a corner of the room that had been set up as a "jail." Then, when the jailed guest was ready, anyone could make a contribution of ten dollars or more in order to get out of jail and go free.

The reception took place in the Trolley Barn, a beautifully renovated building in the Inman Park neighborhood of Atlanta. As the guests wine and dined on a variety of beverages and delicious hors d'œuvres, as well as chocolate-dipped strawberries, there was ample time to meet and greet new people or reconnect with a few of the many familiar faces in the room, including **Jamey Rousey** (Atlanta AIDS Partnership Fund), **Dorothy Zeimer** (Grady Hospital), **Carla Johnson** (Grady IDP) and **Nick Danna** (Living Room). The highlight of the evening was a panel consisting of people who had worked closely with Jeff and had known him for many years. Given the opportunity to share stories about Jeff's accomplishments, the audience was treated to anecdotes about ACT-UP, Jeff's advocacy work and civil disobedience arrests, and his accomplishments as executive director of AIDS Survival Project. There were

even stories about the newest member of Jeff and Peter's family: a dog named China, as well as pictures of Jeff in drag!

The master of ceremonies for the esteemed panel was current board member **Barron Segar**. Panel members included **George Burgess**, a current staff member; **Alicia Culver**, former Associate Director; **Steve Moore**, a former board president; and **Jackie Muther**, a current board member. After the stories were told and the laughs quieted down, it was Jeff's turn to speak.

Ever the eloquent speaker, Jeff graciously thanked everyone involved with his efforts and emphasized that he could not have managed any of his accomplishments without the assistance and support of his friends, family, staff and supporters. He spoke of being excited about the prospect of having a new role to play in the organization that he had helped to mold. He also spoke of his continued unbridled passion to assist persons infected with HIV/AIDS and to ensure that they can maintain the services and benefits they so desperately need.

The evening ended as it had begun, with a few well-chosen remarks by current board president **Susan Cornutt**. She thanked Jeff for his vision and leadership capability, and she reiterated that the work of AIDS Survival Project could never be accomplished without the dedication, commitment and cohesive attitude amongst everyone affiliated with the organization. It quickly became evident that we were all part of one big love fest and a good time was had by all. 

"Stir It Up!"

Our heartfelt gratitude goes out to these sponsors and supporters of our reception honoring Jeff Graham, held Tuesday, August 16, 2005, at the Trolley Barn.

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Longtime ASP volunteer **Lola Halpin** (left) and **Jeff Graham**.



Development Director **Greg Carraway** (left) pleads for release from the fundraising jail as fellow inmate **Jack Pelham** (center) and "cop" **Cara Emery** take it in stride.

EMORY UNIVERSITY SCHOOL OF MEDICINE

ARE YOU HIV+ AND READY TO START HIV MEDICATIONS FOR THE FIRST TIME?

Are you?

- HIV+
- 18 years of age or older
- Never taken HIV drugs
- Have a viral load of more than 1,000 copies

The Emory AIDS Clinical Trials Unit is enrolling volunteers for a 96-week clinical research trial to study four different HIV drug combinations. The purpose of this study is to learn whether the combinations work just as well in patients who have never taken HIV medications before. It will also look at how easy the medications are to take and their side effects. All combinations are taken once a day and are provided by the study at no charge.

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- Reyataz 300 mg with Norvir 100 mg + Ziagen 600 mg/ Epivir 300 mg + Emtriva / Viread placebo once daily.

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EMORY UNIVERSITY SCHOOL OF MEDICINE

ARE YOUR HIV MEDICINES NOT WORKING FOR YOU ANYMORE? BE ONE OF THE FIRST TO TRY A NEW INVESTIGATIONAL ENTRY INHIBITOR!

Are you?

- HIV+
- 18 years of age or older
- Have a viral load of more than 5,000 copies
- May have failed any number of prior anti-HIV drug regimens or have never been on anti-HIV drugs
- Must be off all anti-HIV medications for at least 14 days
- Have 50 or more T-cells

The Emory AIDS Clinical Trials Unit is studying an investigational anti-HIV medication known as an X4 co-receptor entry inhibitor, which means it blocks one of the ways HIV enters a T-cell (the blood cells that fight infection). This phase I clinical research trial will assess the safety and antiviral activity of several dose levels of this drug which will be given over a period of 10 days in a local hospital. A fee will be given for time and travel.

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ASP board members, staff past and present and supporters gathered to celebrate Jeff Grabam (third from left).



From left: Georgia Rural Urban Summit executive director Larry Pellegrini, Jeff Grabam and activist Deepali Gokhale.



ASP Prevention Department's First Year!

As HIV/AIDS in the United States and other countries continues to rise, HIV prevention is a never-ending mission. There is so much work for many of us to do in an effort to stop the spread of HIV/AIDS.

AIDS Survival Project recognized this challenge and in 2004 was awarded a Centers for Disease Control and Prevention (CDC) grant to begin a Prevention Services department. Adding Prevention Services to the ASP structure has resulted in a lot of growth, including six new staff positions and additional office space. This new department first implemented an HIV counseling, testing and referral program, then a "Healthy Relationships" intervention.

Taking on the project of Prevention Services while focusing primarily on African-American women and African-American MSM (men who have sex with men) was challenging. It meant we had to find creative ways of informing the community that ASP, primarily known for its programs directed to people living with HIV, was now offering *free* HIV counseling and testing. ASP had been, for the most part of its history, an organization that focused its services primarily on empowering people who were affected by HIV with resources on HIV and how to manage living with the virus, as well as obtaining healthcare needs. Making the change into prevention had its ups and downs.

Among many issues, one that we considered as essential was managing a person's comfort level when entering the ASP office and having to ask for an HIV test. It was important to us to maintain a person's confidentiality and comfort upon entering our agency. We knew it would be challenging enough for a person to get the courage to make up their mind to take an HIV test, but since our agency's name alone indicated that our work is HIV/AIDS-specific, we knew that this would be a barrier to testing for some people.

So we put careful thought into someone's first few minutes in our agency. We also decided that we would make our waiting area comfortable so that it wouldn't seem so clinical. Much time was taken in selecting the furnishings and the décor to help individuals feel relaxed. We even thought to select a soothing paint color for the walls and music playing on the radio. At times, juice, water and coffee are offered.

In keeping with the ASP philosophy, many résumés were reviewed and interviews conducted to ensure a culturally diverse counseling and testing team. In March of 2005, we began to provide surveys to our clients to see how they felt about the quality of service that they received during the counseling and testing process. Over 240 surveys were collected and reviewed over a three-month period. All of the counselors—**Clay, Joe, Tracy**, our Director, **Greg Smith**, as well as myself—have received

excellent comments: "Kevin English was an excellent counselor, impeccable!" said one client. "The counselor, Clay, was wonderful! He made me feel very comfortable and at ease." "Great initial counseling session, Greg!" "Joe Greenwood listens well!" "Nice compassionate counselor. Tracy was very sweet!"

Also while reviewing the client surveys, we discovered that the majority of our clients were referred to Prevention Services through friends. It is obvious that these referrals are a result of the care that is given to the clients, in addition to our counselors encouraging clients to be advocates and encouraging their family and friends to get tested. We've also received over \$500 in donations from our clients within a four-month period. These donations are always appreciated and are used to offset costs for purchasing items such as condoms, which are distributed among the clients, as well as doing outreach to the community.

Not only were comments made about the staff, but also many people were glad to see that we provide OraSure's OraQuick Rapid Test, which provides results within the same visit versus having to wait five days for results. This change in testing has made it much easier, not only to the client, but to the organizations providing the testing. We no longer have to make telephone calls to clients to convince or remind them to return for their results. Also, no longer do we have a large number of clients who have tested anonymously and may have tested positive for HIV without a way of contacting them to return for their results and get them into care. All of our clients are counseled prior to taking an HIV test and then again after receiving their results.

The Prevention Services department is an ever-evolving program. We strive to ensure ASP has the capacity to serve anyone who enters our doors. When a client is newly diagnosed with HIV, they are immediately referred to **Pamela Morse**, our Linkage to

Care Coordinator, who helps newly diagnosed individuals get linked to a primary care provider within three to six months of their diagnosis. Here, clients are educated about basic facts of HIV. The Linkage to Care Coordinator supports the client in overcoming barriers that might prevent them from accessing medical care.


Another program that the Prevention Services department offers is the "Healthy Relationships" intervention, funded by the CDC. This intervention is a five-session, small-group intervention with men and women living with HIV/AIDS. In this intervention, participants work on developing coping skills needed to make decisions regarding whether, when and how to disclose to family and friends, disclose to sexual partners, and to help build healthier, safer sexual relationships. In the intervention, participants focus on identifying stressors and developing coping skills when deciding to divulge to sexual partners, family and friends. Participants engage in role-plays; they are taught decision-making skills and view movie clips from popular movies that set up scenarios around disclosure and risk reduction to stimulate discussion among the participants.

During the month of June, two "Healthy Relationship" interventions were done simultaneously. One group was with African-American women and the other was with a group of African-American MSM. Both groups maintained at least 50% participation during the completion of all five sessions. At the end of each session, participants were given incentives for their participation, and after the fifth session, participants were given a certificate of completion. Look on our web site for future dates of upcoming "Healthy Relationships" workshops.

From November 2004 until the end of the contract year in June 2005, the Prevention Services department served over 600 people. We have had a 6% positive rate, which is above the requirements of CDC.

Going into our second year of the Prevention grant, the Prevention Services department expects to double the number of people that we tested in the previous year. We have updated and tailored our forms and plan to increase our outreach efforts.

As the days of HIV counseling and testing continue for AIDS Survival Project, the Prevention Services department will continue to adapt and tailor itself to accommodate the needs of the individuals that enter through our doors. We are looking forward to increasing our outreach services to the communities where we see the need.

In closing, I would like to thank all of you for assisting and supporting the Prevention Services department, especially during the early months. Let us all continue to strive for the greater good in the work that we do. 



Prevention Counseling Manager Kevin English (right) worked with ASP volunteer Carolyn Morgan (left) on counseling techniques in the early days of ASP's Prevention Services Department.



Harm Reduction All Around

PEER SUPPORT

Until there's a cure for HIV, equal parts creativity and pragmatism are essential for maximizing the health of people who are HIV+ while minimizing the spread of the virus. The theory and application of harm reduction techniques support both.

A very broad definition of *harm reduction* is "a public health concept of lowering the health consequences resulting from certain behaviors" (www.druglibrary.org). Almost all people practice some type of harm reduction in their lives without labeling it as such. The concept of a designated driver or the use of a taxi to transport people who've been drinking alcohol are commonplace. The use of seat belts and airbags makes cars safer, and people use sunscreens in an effort to lower their risk of skin cancer without giving up a tan or time in the sun. These interventions are personal and social tools that lower risk while allowing people to do things they value.

The term *harm reduction* originated in the 1980s in the European IV-drug-using community where needle exchange programs were developed in response to the spread of HIV and hepatitis C among users who shared needles and syringes. While harm reduction philosophy views abstinence from IV drug use as an eventual goal, it focuses on achieving specific behavior changes that lower the individual, social and community risks as long as people are using IV drugs. Because drug use of all types and sexual practices are intertwined in terms of risky behaviors, interventions based in harm reduction have been incorporated into a number of HIV prevention, care and education programs around the world.

The harm reduction perspective is radically different from two more dominant approaches to dealing with drug use and addiction. A "supply reduction" approach focuses on drug control through law enforcement and the criminal justice systems (i.e., "the war on drugs"). A "demand reduction" approach aims to rehabilitate drug users to eradicate the desire or demand for drugs. Most drug treatment programs see addiction as a disease, require complete abstinence and discharge participants from programs if they continue to use.

Instead of waiting for individuals to choose to

be abstinent from drugs or sex, a harm reduction approach provides an opportunity to take immediate steps toward behavior change that lowers any risk in an individual's life. It does not require the services of legislators, law enforcement, medical or psychological professionals. Risk reduction *does* require a motivation to avoid some negative consequences. In terms of drug use, these consequences might include infection, loss of income, physical danger or abandonment. Experts in the development of harm reduction tools are often the individuals and social groups (including drug users and people living with HIV) who have suffered the most from these negative consequences.

Probably the most high-profile intervention in the harm reduction toolbox is needle/syringe exchange. While needle exchange has been embraced as a public health policy in some places, it remains highly controversial in the United States. Many people contend that harm reduction techniques such as needle exchange only perpetuate behavior that should be totally eradicated. Harm reduction proponents acknowledge that there have always been and will always be people who use drugs or practice other high-risk behaviors and that the moral imperative is to reduce the harm those behaviors cause individuals and communities.


Harm reduction practitioners acknowledge that drug use and sexual practices can have profound negative consequences. With an eye toward reducing those negative consequences, practitioners work

use, acknowledging that people take risks and that stigma related to those behaviors increases those risks. It strives to create a safe place where people can explore their ambivalence about personal behaviors and learn about ways to make their behavior less risky. It counts improvement in personal quality of life and community well-being as measurements of success, rather than considering abstinence as the only success. It recognizes the personal and social destruction and tragedy that are associated with drug use and unprotected sex, while understanding the forces that fuel those behaviors. It can be a slow process involving attention to everyday needs such as health care, shelter and food that support an individual's progress toward health. Many people view harm reduction programs as pre-treatment efforts.

Tools for the reduction of risk associated with IV drug use include needle/syringe exchange, cleaning needles with bleach, methadone treatment and moving to methods of drug ingestion that do not involve injecting. Techniques for lowering the risk associated with other drug use (including alcohol) include lowering the frequency of use, being knowledgeable about and avoiding drug interactions, staying hydrated, keeping medical appointments, not driving or conducting other tasks that put you or others at risk and maintaining good nutrition. Some common strategies for sexual risk reduction would be knowing your HIV status, lowering the number of sexual partners, increasing condom use, lower-

ing incidence of higher risk behaviors, minimizing or eliminating substance use, keeping medical appointments and reducing other health risks.

Assessing one's personal risk factors requires education and a safe source for information. In addition to a number of excellent Internet sites, journals and magazine articles, there are harm reduction coalitions throughout the United States, including the Atlanta Harm Reduction

Coalition and the Harm Reduction Coalition in New York. Many AIDS service organizations base their programs in harm reduction, providing information about safer sex and safer using. They exist to serve you and they need your support as they struggle to meet the needs of their communities. 



with people to make gradual, manageable changes—small steps in the direction of maximum safety. Tips on reducing risk from drug use and sex are both usually available from harm reduction-based programs.

Characteristics of a harm reduction philosophy include a pragmatic attitude about sex and drug



Salvage Therapy Update



If you're on your second or third (or more) antiretroviral combination, there is some good news. There are some new drugs for those of us who are developing resistance.

Aptivus

Aptivus® (tipranavir) is a new protease inhibitor that was approved by the FDA this past June. Aptivus has been available in expanded access for a while, but FDA approval means that it may be easier to get now for those who receive their drugs through the state drug assistance program (ADAP) or private insurance. Basically, your care provider should be able to prescribe it like any other antiretroviral such as Sustiva® (efavirenz) or Reyataz® (atazanavir). The difference, as far as treatment goes, is that Aptivus is FDA-approved for those who have developed resistance to other antiretrovirals. This means that if you're just starting therapy, Aptivus isn't one of the drugs that you would consider. The only exception might be in cases where someone is infected with multiple drug-resistant virus, which is rare. Bottom line: Aptivus is for salvage therapy. You won't be using it unless you've tried other options.


Aptivus needs to be boosted. If you are taking it, you'll also be taking Norvir® (ritonavir) to keep the level of drug up enough to fight the HIV. And of course, like other antiretrovirals, it should only be used in combination therapy. This can be sort of a "Catch 22" for anyone considering Aptivus. We know that adding one drug to a combination when you're resistant to the others already isn't the best way to go. What generally happens is that you will develop resistance to the new drug (in this case, Aptivus) pretty quickly, since it's the equivalent of monotherapy. And of course, you wouldn't consider Aptivus unless you have resistance to a fair number of antiretrovirals.

There are a couple of strategies that can help you get as much mileage as possible when using Aptivus. Resistance testing can help, because it can show what antiretrovirals may be effective as far as keeping HIV suppressed in a particular individual. And clinical trials that combined Aptivus with Fuzeon® (enfuvirtide, T-20) showed better results than other combinations, especially for people who have never taken Fuzeon before. Some people are reluctant to get involved with Fuzeon (it's only available as an injection), but the benefits of the combination certainly make it worth serious consideration, even if you don't like needles. If you're taking a regimen that includes Aptivus and your viral load begins a steady increase, you'll have a very limited range of options. There are other drugs in development now, but they are only available through clinical trials.

CCR5 inhibitors

One area to watch if you are running out of treatment options is the new class of antiretrovirals that block HIV from attaching to CD4 cells. They work at a point very close to where Fuzeon does, but they target a protein called CCR5. Drugs from this class should work against HIV that is resistant to everything currently available, including Aptivus and Fuzeon. But if you're ready to toss your pillboxes, timers and the whole idea of adherence out the window because "they're coming up with new drugs," you might want to think again. First of all, you might end up where a lot of people who are considering Aptivus now are... a great new drug, but nothing else to combine it with. It'll be very effective for a short period of time, but quick resistance is all but guaranteed. Second, this class of drugs is still not completely tested, so anything can happen.

GlaxoSmithKlein recently issued a press release concerning their CCR5 entry inhibitor, aplaviroc. It's being tested in clinical trials, and there have been enough reports of hepatotoxicity (liver problems) for them to stop the involvement of anyone who is antiretroviral-naïve. This may sound great if you're antiretroviral-experienced, since it means more opportunity for you to get into future trials that involve aplaviroc. The not-so-great part is that... well, aplaviroc can be hard on your liver. If you have hepatitis C or anything else that might cause liver problems, you may not be able to tolerate this drug; at the very least, you will likely be excluded from clinical trials due to safety concerns while GlaxoSmithKlein sorts everything out.

There are other CCR5 entry inhibitors in development. The pharmaceutical company Pfizer is developing one called maraviroc which has reached phase III clinical trials, the last stage before FDA approval. Vicriviroc, Schering-Plough's CCR5 inhibitor, is at about the same stage. If there are no problems, we may see them on the market in two to three years. If you want more information on antiretrovirals under development or have a question about treatment education, please call or stop by our Treatment Resource Center. 

For more information on the Internet:

- The popular web site TheBody.com has a section on what drugs may be next. www.thebody.com/treat/newdrugs.html
- The Department of Health and Human Services main page has some good links. From here, you can find information on current clinical trials, antiretrovirals that are being developed, and a whole lot more. www.aidsinfo.nih.gov/

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Cell Protection: Antioxidants and Your Health

You may have heard the terms *antioxidant* and *free radical* before, but you may not know exactly what they are and how they relate to HIV and your overall health. In simple terms, *free radicals* are highly reactive, unstable molecules that are roaming around your body. These molecules are unstable because they are missing an electron and they want to “steal” electrons from other healthy cells in your body. When a free radical steals an electron from a healthy cell, that healthy cell then becomes a free radical, and a chain reaction occurs. This chain reaction, called *oxidation*, can cause damage to the cells of the body. Unfortunately, there is an increase in oxidative stress among people with HIV.

So where do these free radicals in our bodies come from? Just the simple act of breathing results in the production of free radicals. During respiration, some electrons leak away from the normal respiratory pathway during electron transport. These electrons latch on to free oxygen molecules, resulting in the production of free radicals. Under normal conditions, approximately 1% to 3% of oxygen molecules are converted into free radicals. The air that we breathe is polluted with toxins, which can increase free radical production during respiration. Other environmental factors such as alcohol, cigarette smoking and radiation can also lead to an increase in free radical formation.

In some cases, our bodies actually produce free radicals on purpose. For example, the body’s immune system purposely creates free radicals to destroy unwelcome organisms, such as infections. The problem for people with HIV is that excess free radicals create a breeding ground for HIV. HIV thrives in an oxidized environment and uses free radicals to replicate.

Fortunately, our bodies have a defense system to protect our cells from oxidative damage. Antioxidants, which are manufactured within our body or extracted from the food we eat, help neutralize the free radicals in our bodies. The term *antioxidant* means “against oxidation.” Antioxidants work by giving up one of their electrons to free radicals, but unlike free radicals, antioxidants do not become harmful and reactive when they lose an electron. Unfortunately, the normal antioxidant defense system is compromised in people with HIV and antioxidant levels decrease as the disease progresses.

In order to protect and repair the cells in your body, it is important to make sure you are getting enough antioxidants through the food you eat and/or nutritional supplements. The most studied antioxidants are vitamin C, vitamin E, beta-carotene and

selenium. Vitamin C, which is a water-soluble vitamin, cannot be stored in the body, so it is important to get some regularly in your diet. Sources of vitamin C include citrus fruits, green peppers, broccoli, green leafy vegetables and strawberries. Vitamin E is a fat-soluble vitamin, which means that it can be stored in the liver and other tissues of the body. Sources of vitamin E include wheat germ, nuts, seeds, whole grains and green leafy vegetables. Beta-carotene, which is converted to vitamin A in the body, is a scavenger of a particular type of free radical and has been found to decrease free-radical damage associated with HIV. Food sources of beta-carotene include green leafy vegetables, carrots and other yellow and orange fruits and vegetables. Selenium is a trace element with antioxidant properties. A selenium deficiency is associated with immune dysfunction and decreased CD4+ counts. Food sources of selenium include seafood, brazil nuts, eggs, meats and whole grains.


It is important to get as many antioxidants as you can from the foods you eat by choosing a well-balanced diet including whole grains, lean meats and 5 to 10 servings of fruits and vegetables everyday. Since people with HIV have a higher need for vitamins, minerals and antioxidants, a supplement regimen may be beneficial, including a multivitamin/mineral supplement (without extra iron) with antioxidants and trace elements. Other antioxidant supplements that are gaining popularity among people with HIV are alpha-lipoic acid, N-acetyl-cysteine, coenzyme Q-10 and pomegranate juice. Megadosing on supplements can be dangerous, so it is important to discuss your supplement regimen with your doctor or dietitian.

There are many different types of antioxidants, including vitamins (C, E, beta-carotene), elements (selenium), amino acids (N-acetyl-cysteine, alpha-lipoic acid), herbs (green tea) and phytochemicals (flavonoids, polyphenols, allyl sulfides). It is important to find a regimen that meets your individual needs. You also need to reevaluate your food and supplement intake as your health status changes. It is important to do research and/or consult with a dietitian or other health care professional before starting a supplement regimen.

If you are eating all of your fruits and vegetables and taking your multivitamin, you may be wondering if the cells in your body are healthy and benefiting from the antioxidants. Unfortunately, it is not very convenient for you to extract a sample of your cells and slide them under a microscope at a moment’s notice, but you can get a good overall picture of the health of your cells by getting a bioelec-

trical impedance analysis (BIA) test. A BIA is a simple test that measures lean muscle mass, fat mass and fluid levels in your body. A BIA can also measure cell capacitance. *Cell capacitance* is a measure of the integrity of your cell walls. A low cell capacitance (unhealthy cell walls) is associated with oxidative stress and can be an indication of poor health and/or disease progression. A high cell capacitance (healthy cell walls) is associated with adequate antioxidant support and can be an indication of good health.

For more information on optimizing your antioxidant intake through food and supplements and/or BIA testing, contact AIDS Treatment Initiatives (ATI) at (404) 659-2437.

Michele Babns, MS, RD, LD, is a dietitian at AIDS Treatment Initiatives (ATI). 

**AIDS Survival Project’s
Healthy Choices=Healthy Lives**
series presents

Understanding Medicare Part D: The New Prescription Drug Plan

**Thursday, November 17, 2005
5:00 p.m. - 7:00 p.m.
AIDS Survival Project
139 Ralph McGill Boulevard
Atlanta, Georgia 30308-3339**

An interactive panel discussion to help you understand the basics of Medicare Part D and to get the answers to these questions and more!

- What does this new prescription drug plan mean for people living with HIV?
- What will the impact be to the AIDS Drug Assistance Program (ADAP)?
- How do you choose the best prescription plan?
- What is available if you need financial assistance?

Light refreshments will be provided. Workshop is free but requires pre-registration. For more information or to register, call (404) 874-7926.

Funding for this program is provided by Pfizer, Inc. and the LiveWell Fund.



Volunteers—You Need to be Committed!

This column provides updates and information about our volunteers and staff, as well as persons in the community. If you have information to share, please call, e-mail or write to ASP.

Thanks to all of the volunteers who came out for the fish fry on Saturday, September 24! We had a great time.

Volunteer award winners

Congratulations to ASP's Antoniette Sinclair Volunteer of the Year Award recipients for 2005:

- **Richard Anderson**
- **Bonnie Olson**
- **Jim Faulkner**

A hero among us

We're very proud to note that board president **Susan Cornutt** was one of ten women honored on Saturday, August 20, as "Unsung Heroines" by the metro Atlanta chapter of the National Coalition of 100 Black Women. These remarkable women were



recognized for making a positive impact in their communities through the unflinching dedication of their volunteer service. Our most heartfelt congratulations to

Susan, although we have to say the honor comes as no surprise to us—she has always been and will continue to be a hero to all of us at ASP, as well as all those whose lives she has touched over the years.

He's movin' on up!

Congratulations to board treasurer **James Powell** for making partner at KPMG.

Holiday office closings

ASP will be closed on Thursday and Friday, November 24-25, and from noon on Friday, December 23, through 10:00 a.m. on Tuesday, January 3, 2006.

Mark your calendars!

Volunteer Appreciation Holiday Party

Please plan to attend a holiday dinner at AIDS Survival Project on Thursday, December 15. Call our office at (404) 874-7926 for more details.

Consider making a New Year's resolution and stay committed!

I can't believe that 2005 is almost over! This

has been a year of change for us at ASP. For those of you who've been around over the last twelve months, you understand how real that statement is... we've really been through a transition and finally, it seems the dust is settling. Don't misunderstand—change is good and good things are happening at ASP. We are beginning to look deeper at the effectiveness of our programs and hope to enhance them over the next year. Hopefully you know and maybe have had a chance to meet our new executive director, Molly Casey. We are all establishing new relationships with Jeff Graham and can't wait to see the impact he makes now that he's doing advocacy work fulltime. So, change is good.

Although it made me think whether I've achieved some of the important goals I had for 2005. I was a little disappointed that I didn't do a good job of committing to my goals this year, so I've decided to make New Year's resolutions for 2006 and follow through with them this time!

Need a New Year's resolution?

Good, because we would like for you to consider these volunteer opportunities at ASP.

- **Become a peer counselor.** If you are HIV+ and would like to offer support, compassion and understanding to others who need your help, please contact Mary Lynn Hemphill at MLHemphill@aidssurvivalproject.org or give her a call at (404) 874-7426, ext. 12. Training is required. Shifts are from 10:00 a.m. to 2:00 p.m. and from 2:00 p.m. to 5:00 p.m. weekdays.
- **Become a *THRIVE!* Weekend peer facilitator.** If you are HIV+ and would like to empower others by leading small breakout support groups during the course of *THRIVE! Weekend*, a bimonthly program, please contact Sarah Biel-Cunningham at SBiel@aidssurvivalproject.org or give her a call at (404) 874-7426, ext. 14. Peer facilitators are present during the entire weekend and are asked to commit to two weekend programs over a six-month period. We especially need female facilitators.

Back to me. This year, I really want to stick to my resolutions, so I did some research on ways to help. Here's what I've learned; maybe it will help you follow through with yours.

- **Be specific and realistic:** Think hard about your resolution and set a realistic goal. For example, if you want to become a peer counselor, ask yourself if you have the available time necessary to complete the training and if you'll be able to dedicate four hours of your time each

week to helping someone else. If not, is it better that you set a realistic goal of committing to only one shift a month? If so, commit to being a peer counselor once a month during 2006. That's 48 hours! You will be surprised at the number of people you will impact; you could change someone's life.

- **Attach a deadline to your resolution:** When will you contact Mary Lynn Hemphill about becoming a peer counselor? If you don't set a deadline, you may put it off and like me, realize at the end of the year that you haven't really committed to your goals. So determine a realistic date and set a deadline so you can get started; not "someday," but by your set deadline.
- **Don't overwhelm yourself!** There's only so much we can do in a year; we all have limitations. Set two or three resolutions and stick to them!
- **Believe in yourself:** Do you see yourself being a peer counselor? If so, pick up the phone and begin the process today. We believe you can make a difference.

Good luck to you and to me! I hope we both accomplish our New Year's resolutions. At least we are giving it more thought this year.

To all of you who won't be able to make the holiday dinner, thanks for all of your support and AIDS Survival Project wishes each one of you a happy holiday season and a joyous new year!

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

In November:

Johnny B.	Alfred B.	Michael B.
Keith B.	John E.	Kyle R.
Rick J.	Beth W.	James C.
Calvin H.	David J.	Abeni T.

In December:

Allen T.	Ira B.	Eva H.
Jefferey S.	Harold S.	Brent A.
Bryant R.	Abid B.	Wanda W.
Edith B.	Randall D.	Derran H.
Gerry H.	Juan J.	Carl M.
April M.	Margaret M.	

If you have exciting things going on in your life that you'd like us to know about, or if you know what's going on in the lives of any ASP volunteers or members and know they would like to be mentioned here, please call me at (404) 874-7926, ext. 20 or e-mail me at CGiles@aidssurvivalproject.org and give me the details.

Approximately 8,000 AIDS and HIV-Infected Patients Displaced. According to estimates by the AIDS Alliance for Children, Youth and Families (AACYP), about 8,000 people with HIV/AIDS who were displaced by Hurricane Katrina are now trying to find care. These people face the difficult challenge of trying to manage their disease without their doctors, clinics and support systems. Providers say they are struggling to ensure that displaced patients receive treatment and do not slip through the cracks. When HIV patients stop taking their medication, the virus can multiply and become drug-resistant. "There are many immediate, midterm and long-term issues that will literally be life and death for people living with HIV/AIDS," said Terje Anderson, executive director of the National Association of People with AIDS, in a letter requesting urgent assistance from Health and Human Services Secretary Michael Leavitt. Federal officials say they are doing their best to streamline care for HIV patients. Several drug companies are offering free medicines. AACYP is working to get money and supplies to providers. New Orleans' NO/AIDS Task Force, the oldest HIV/AIDS service organization in the Gulf South, has temporarily relocated to the Montrose Clinic in Houston. Montrose's executive director, Katy Caldwell, said evacuees have been arriving by the dozens. Providers in Florida, Tennessee, Alabama, Mississippi, Georgia and elsewhere report that displaced patients are turning up at their clinics and asking for new prescriptions, quickly. Social stigma may limit access to care for some patients. "People are not going to walk up to the American Red Cross and say, 'Hi, I have HIV.' More likely, they're going to try to find an HIV provider," said AACYP's Diana Bruce. Those who do seek providers at emergency centers could end up with doctors who are unfamiliar with HIV care. Dr. Nicholas Bellos, president of Southwestern Infectious Disease Associates in Dallas, helped develop an online triage program for patients and providers. The web site advises doctors working in emergency shelters how to care for and medicate HIV patients. It also includes information and maps directing patients to specialized care. Like many providers, Caldwell said lack of funds will not affect any patient's access to care. "We treat them first, worry about the money later," she said. For more information, visit www.hrsa.gov/katrina or www.noaidtaskforce.com.

AIDS Vaccine Test to Be Expanded on Upeat Results. Merck & Co.'s MRKAd5 AIDS vaccine candidate elicited a stronger-than-expected immune response in trials among healthy volunteers, researchers said recently. The good news has led Merck to double enrollment in the trial to 3,000. The trial began in January. MRKAd5 is an adenovirus-based vaccine containing three engineered genes based on North and South American HIV strains. The HIV genes are designed to provoke a "killer" T-cell response that would destroy HIV-infected human cells. The strong response occurred even among volunteers who already had adenovirus antibodies from previous in-

fection by the common cold virus. MRKAd5 boosted the number of T-cells by 50- to 100-fold, an immune response comparable to that of successful vaccines against smallpox or measles, said Lawrence Corey, principal investigator of the HIV Vaccine Trials Network. The Seattle-based research group, supported by the National Institutes of Health, is overseeing 15 active vaccine trials. The MRKAd5 trial is a collaboration of Merck, HIV Vaccine Trials Network and the National Institutes of Allergy and Infectious Diseases.

Glaxo Halts Trial of AIDS Drug Due to Liver Risks. In mid-September, GlaxoSmithKline PLC announced that it had halted safety and efficacy trials of an HIV medication after two of the 250 treatment-naïve trial patients developed severe liver toxicity (see page 8). However, studies of the drug aplaviroc—GSK's candidate in a new class of drugs that will attempt to block HIV's infection of cells via the CCR5 co-receptor—are continuing among 40 HIV patients whose virus is resistant to currently standard treatments. Previously, European AIDS advocates had criticized Pfizer's use of newly diagnosed HIV patients to test its rival CCR5 blocker drug candidate, arguing the patients should not be given an experimental product if they could still benefit from standard drugs. In a statement to the HIV patient community, GSK said it halted the aplaviroc study in the treatment-naïve subgroup following discussions with the U.S. Food and Drug Administration. No patients died from the liver problems or required liver transplants, said GSK. The aplaviroc studies were conducted in the United States, European Union and Canada. In addition, GSK "has taken immediate steps to protect the welfare of patients in clinical studies of aplaviroc," including increased safety monitoring among the remaining trial patients. Among patients with drug-resistant HIV—half of whom are in a control group receiving standard therapy—aplaviroc trials are continuing because they have fewer treatment options, said the company. GSK is also updating informed consent forms, which patients must sign to continue participating in the trial, explaining the potential for side effects. A GSK spokesperson said the firm is not contending that severe liver toxicity was limited to treatment-naïve subjects, and in fact, it is too early to speculate whether the problem is aplaviroc-related. "It may be the death knell for GSK's entry inhibitor," said Martin Delaney, founder of the San Francisco-based HIV/AIDS group Project Inform. "It may be a warning about the whole class of drugs. Right now, GSK is saying the problem is only in the [treatment-] naïve population. But there is virtually no medical logic for this to be the case."

Child-Friendly Drug Tentatively OK'ed for HIV/AIDS. Zidovudine oral solution, a generic version of a child-friendly HIV/AIDS drug, has received tentative approval from the Food and Drug Administration. The FDA's action means that while existing patents or exclusivity agreements prevent the product's marketing within the United States, the drug meets the

agency's standards for quality, safety and effectiveness. In addition, the decision means the drug can now be made available for use outside the United States through the President's Emergency Plan for AIDS Relief. For more information, visit www.fda.gov/bbs/topics/news/2005/new01230.html.

Challenges in Motivating Treatment Enrollment in Community Syringe Exchange Participants. While participants in needle exchange programs exhibit high rates of substance abuse disorder, they remain very ambivalent about seeking treatment (see page 7). In the current study, researchers evaluated the effectiveness of motivational interviewing (MI) for encouraging needle exchange program participants to enroll in programs for substance abuse treatment. In the Baltimore Needle Exchange Program, 302 new opioid-dependent registrants completed the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (fourth edition), and the Addiction Severity Index. The participants were randomly assigned to one of the following: MI, job readiness (attention control), or standard referral. In each of the three conditions, participants who expressed an interest in treatment were referred to a treatment readiness group that offered encouragement and provided referrals to programs that were accepting new admissions. Researchers tracked the participants for one year following the intervention. While follow-up found that 10.9% of study participants were enrolled in treatment for substance abuse, no condition effects were observed. Among those most likely to enter treatment were white patients and those diagnosed with major depression. The results suggest that although a single motivational interview is insufficient to motivate this population to seek treatment, identifying the predictors of treatment enrollment merits further investigation.

Agency Dedicated to Women with HIV. Babes Network, a Seattle agency devoted to supporting women with HIV/AIDS, began as a small group of HIV+ women gathering for potluck dinners at friends' houses in 1987. In 1989, the network applied for a grant through Northwest Family Services. Three years later, Babes became an independent nonprofit organization. Currently, about 285 women take advantage of the group's services, which include support group meetings, peer counseling and picnics. "We're basically just like each other's friends," said peer counselor Nicole Price, who runs Babes' new co-ed support group. In March, due to funding concerns, Babes Network relinquished its independent nonprofit status and became part of the YWCA of Seattle • King County • Snohomish County. Pat Migliore, a founding member who is now on the group's advisory board, said the transition to a larger organization means security for Babes and continuity for its clients. Around 10% of King County's 5,808 HIV/AIDS cases are female—a group increasing faster than others. Gary Goldbaum, an epidemiologist at Public Health—Seattle & King County, said African-

CONTINUED ON NEXT PAGE

born immigrant women are “at potentially increased risk” for HIV. “They’re coming from parts of Africa where HIV is rampant,” said Goldbaum. That does not surprise Lina Ali, a Tanzania native who is HIV+. As a member of the King County HIV/AIDS Planning Council and a volunteer at Babes, Ali said persistent cultural stigma and concerns about seeking treatment without legal immigration status keep many African immigrants from getting tested for HIV or discussing their status. Ali aims to spread the word among other immigrant women that medical assistance and support are available.

Black Gay Leaders Express Discontent with HIV Efforts. More than 70 gay black leaders met with senior CDC officials at an agency-sponsored meeting Monday through Wednesday, August 29-31, in Atlanta to discuss the CDC’s role in reducing HIV among black men who have sex with men (MSM). A CDC survey, released in June, of black MSM in five major U.S. cities found that 46% were HIV+. A 1994 CDC study found that 21% of black MSM were infected, and the figure had climbed to 30% six years later. “We recognize that this is not business as usual,” said Ron Valdiserri, the CDC’s acting director for HIV, STD and TB prevention. “As a nation, we need to take a serious look at the state, local and community level. That’s why we called this meeting.” Earlier, in an open letter to black MSM, “Nearly Half of Us May Already Be Infected. Who Gives a Damn?,” posted on the Black AIDS Institute (BAI) web site, 50 black gay leaders vowed to make that high infection rate resonate. “I was shocked that there wasn’t any reaction from anyone” following the study’s release, said Phill Wilson, BAI’s CEO. “Not from the black community, gay community or straight community. This data demanded front page coverage.... The prevention program was designed for gay white men, and we were told to make it work for gay black men. It didn’t,” said Wilson, a signatory to the letter and a conference participant. “Many people are taking from this data that gay blacks are engaging in riskier behavior, but that’s not the case. HIV prevention in the black community was delayed, which is why there’s higher incidence.” “We’ve modified our research to understand the high rate of infections in the black community,” said Valdiserri. While he empathized with the frustrated leaders, Valdiserri said the CDC also needs community help fighting new infections among African-Americans. The vast majority of the CDC’s prevention budget goes to state and local health departments, he said. To reduce new infections, the leaders recommended that:

- The CDC should establish an office for gay black health issues.
- The CDC should set a goal of a 50% reduction in new HIV infections among black MSM over five years.
- President Bush should speak about HIV among black MSM on World AIDS Day, Thursday, December 1.
- The Presidential Advisory Council on HIV/AIDS should immediately address black MSM HIV rates.

Valdiserri said the CDC is reviewing the recommendations and gave the group an update in September.

HIV Message Designed for Latinos. This summer, a Mecklenburg County (North Carolina) Health Department program aimed at Latinos helped to spread the word that HIV/AIDS and other STDs are a growing threat to the Hispanic community. Infectious disease educators Jorge Patino and Mayra Rodriguez took this message to Latinos, especially young people, in community centers, churches, jails and other places. They discussed abstinence, condoms and the need for those who have STD symptoms or have engaged in risky sexual behavior to seek testing. “We don’t have firm numbers, but we think about 10% of the HIV cases in Mecklenburg are Latinos—and that population is growing,” said Rodriguez, who with Patino believes cultural behavior and legal issues contribute to the spread of the virus among Latinos. “In our culture, drinking alcohol is a normal way of relaxing, especially at the end of a work week,” Rodriguez explained. “And of course, drinking is a behavior that puts people at risk of contracting STDs.” Patino said another problem is “Latino male macho behavior.” “We advise them to use condoms, but a lot of Latino men, for some reason, see that as not being macho,” he said. Immigration issues are another problem. Some Latinos in the United States illegally are concerned that testing for HIV and other STDs will bring them to the attention of immigration officials, said Rodriguez. “Their privacy is maintained,” she assured. “We’re interested in preventing [STDs] and treating those who are infected.” The health department offers free educational sessions to any interested organizations. For information about these sessions or places to get tested, call (704) 432-4251 or (704) 432-3024.

New AIDS Strategy: If We Can’t Scare Them, Let’s Make Them Proud of Their Pride and Joy. AIDS Vancouver and Rethink Advertising are leading a national “Gay Men Play Safe” campaign in Canada this year. In the process, they created funny safer-sex messages in an explicit shift from more than 20 years of occasionally dramatic, controversial and confrontational HIV prevention discourse in the gay community. Last year’s campaign asked gay men “How do you know?” a variety of assumptions about how safe unprotected sex is. In bathrooms and on billboards, campaign posters were “very hard-hitting,” said Robert Smith, HIV Edmonton’s research and development chief. “The visuals and some of the controversy around the visuals created an impact as well.” “The last campaign was aiming at the 25% of gay men who are not practicing safer sex,” said Smith, who finds the new campaign a breath of fresh air. “What about the other 75%? How do we make them feel good about what they do? We decided, this time around, to celebrate and to thank them for keeping themselves safe.” In the new campaign, nicknames for the penis form the lighthearted basis for telling gay men who practice safe sex, “Whatever you call it, thanks for keeping it safe.” The campaign lasts until November. Materials will be distributed strategically, in clubs and bars throughout Vancouver—an

effort to avoid exposing them to people who might be offended. “We’re far too serious about sex,” said Smith. “It’s using humor to reaffirm sexual health and sexual behavior, and it’s taking away from that ‘sex is bad’ scenario. I think humor is a great way to go with sexual education.”

African First Ladies Launch New AIDS Drive. On Thursday, September 15, in New York, 40 African first ladies launched the “Treat Every Child as Your Own” campaign, which will seek to help AIDS orphans and children with the disease. “We can’t stand silently by while more and more youth are infected,” said Janet Kagame, wife of Rwandan president Paul Kagame, in announcing the new initiative. Although “people don’t want to talk about it for the simple reason that we have a society that is very judgmental on this issue,” Kagame said, “everyone has had a member of their family who is infected. It’s so sad that after 20 years, people feel really they don’t trust others on discussing their symptoms.” The Organization of African First Ladies Against HIV/AIDS, which Kagame heads, introduced the new effort on the sidelines of the UN’s world summit. The campaign’s goal is to stop new infections among young people, Kagame said, noting that a crucial part of the work will be to educate adults about protecting children. Community programs will back a continent-wide mass media campaign, she said.

In Africa, AIDS Programs Target Fathers. Throughout sub-Saharan Africa, health professionals are recognizing that programs initially designed to prevent mother-to-child HIV transmission must now involve families. “What we hope to do is save the family,” said Dr. Atiene Solomon Sagay, who runs a U.S.-funded program in Jos, Nigeria, aimed at halting HIV transmission from mother to infant. “It’s not just the babies that we want to save. The babies give us access to everyone.” Dr. Richard Marlink, a Harvard AIDS researcher and scientific director for care and treatment at the Elizabeth Glaser Pediatric AIDS Foundation, said special efforts are needed to bring men into the fold. “You have well-baby clinics for babies, antenatal centers for pregnant women, but you have nothing for men,” said Marlink, who suggested that treatment centers set up separate programs for men that include counseling and support groups. At Jos University Teaching Hospital, where Harvard supports an AIDS program that treats an average 750 patients per week, Dr. John Idoko and his staff have long noted that approximately two-thirds of those receiving treatment are women. “We asked ourselves, ‘Where are the men?’ It has really struck us how hard it is to reach them,” he noted. Idoko and his staff have tried various methods of getting men in for HIV testing. They now provide their HIV+ female clients with “love letters” that are to be given to husbands or boyfriends, inviting them to accompany the women on their next visit. Idoko said more men are taking up the offer, but the process is going slowly. During the first seven months of 2005 in the Jos region’s antenatal clinics, 90% of the 1,553 women arriving for prebirth check-ups agreed to be tested for HIV. Of the 103 who

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tested positive, just 19—or fewer than one in five—were able to convince their male partners to come in for testing.

Angola Records 3,000 New HIV/AIDS Cases.

Angola, whose estimated HIV infection rate of 5% of the population is far lower than the 20-30% rates found in other southern African nations, has recorded 3,000 new infections this year. Dulcelina Serrano, coordinator of the National AIDS Combat Program, said the upturn follows the opening of new testing centers around the country. The 27-year civil war that isolated Angola from outsiders also helped keep its infection rate low, say health experts. But that conflict ended in April 2002, and the reopening of the diamond- and oil-rich nation puts it at risk for a massive spread of the virus. In response, the government has boosted funding for AIDS education and treatment.

UN: Lesotho Will Miss AIDS Drug Treatment Target.

On Wednesday, September 21, in Lesotho's capital of Maseru, the UN said the tiny mountain kingdom will probably not meet its target of providing drugs to 28,000 HIV patients by year's end. Jim Kim, global HIV/AIDS director of the World Health Organization, said that while the goal will not be met, the current figure of 6,500 in treatment "is a start." Lesotho, which is surrounded entirely by South Africa, has an adult HIV infection rate of almost 30%. Death has depleted the ranks of medical personnel and farmers and increased the number of orphans. The government is struggling to deal with rising unemployment and the closure of textile mills.

AIDS Infections Have Not Peaked, Says Study. Old Mutual Healthcare (OMH)'s most recent survey of 100 South African companies provides the latest snapshot of HIV in the corporate sector. The medical insurance company reported that 25 of the firms conducted workforce HIV prevalence studies. Despite a guarantee of anonymity, only 12 of the firms released prevalence data, revealing 19.4% of workers were infected, up from 15% two years ago. Lydia Footman, an OMH risk manager, said she believes the prevalence figures were an accurate "reflection of what is happening out there." She acknowledged any extrapolation would be difficult, since companies conducting prevalence surveys could employ more high-risk groups in areas such as mining and transportation industries. In some companies, unions oppose prevalence testing, fearing the results could be used to discriminate. Despite the high prevalence rate,

OMH executive Paul la Cock said new infections could actually peak in two years, followed by a peak in those falling ill. Those increases would in turn lead to the peak cost effect of HIV/AIDS in the private and public sectors. Among other survey findings:

- 71% of the companies have specific strategies to counter the effect of the pandemic.
- 80% of companies said developing an AIDS strategy was a "key focus."
- Only 18% had specific disease management programs.
- All employees had insurance coverage providing for antiretroviral treatment, reflecting a minimum benefits law that came into effect this year.

Rights Group: Zimbabwe Slum Demolitions Disrupt Treatment of HIV/AIDS Patients. Scores of HIV/AIDS programs in Zimbabwe have been disrupted by the country's widely condemned Operation Murambatsvina ("Drive Out Trash") slum demolition campaign, according to a report released Sunday, September 11, by New York-based Human Rights Watch (HRW). The 40-page document, "Clear the Filth: Mass Evictions and Demolitions in Zimbabwe," said hundreds of thousands of Zimbabweans have been forced to destroy their properties—often at gunpoint—without due notice, process or compensation, driving them into rural areas without basic services such as clean water, health care and education. The campaign, which began Thursday, May 19, has displaced some 700,000 Zimbabweans, according to UN estimates. Almost a quarter of Zimbabwe's 12 million people are HIV+. While home-based treatment programs have provided care to urban patients, the report said many people are now sleeping out in the open or have moved to rural areas that lack access to antiretroviral drugs. "Hundreds of people are now going to die because they will develop resistance because they can't get access to the drugs," said a health official with a local aid group, who asked not to be identified for fear of retribution. Thousands are now displaced and without access to humanitarian assistance, particularly in rural areas where food shortages threaten, the report said. Zimbabwe officials have compounded the problem by refusing to cooperate with the UN and aid groups seeking to assist the displaced, said HRW. On Friday, August 26, President Robert Mugabe's government rejected the terms of a draft UN emergency appeal designed to help hundreds of thousands of those affected. "The Zimbabwean government has caused untold suffering to poor and vulnerable

people," said Tiseke Kasambala, an African researcher at HRW, which urged UN Secretary-General Kofi Annan to establish a commission of inquiry to identify those responsible for the campaign.

Fear of Knowing AIDS Status Causes Blood Shortages in Zimbabwe. The National Blood Transfusion Service (NBTS), Zimbabwe's primary reservoir of blood and related products, is appealing for donors as the country faces a critically low blood supply. The majority of Zimbabweans avoid donating blood for fear they might learn of their HIV status. Zimbabwe is among 39 countries in the world that have blood donation systems that are 100% voluntary, as recommended by the World Health Organization. It was also the first African country to screen for HIV before using donated blood in transfusions. But in a country where around 90% of the estimated 1.8 million people with HIV are unaware of their status, many are avoiding donating blood, seemingly feeling that "ignorance is bliss." To combat the trend, NBTS is campaigning to collect as much blood as possible in remote areas, at schools and other places where people gather in large numbers. NBTS has designed programs to reduce transportation costs for donors and enhance awareness of the importance of a steady supply of safe blood for Zimbabwe's blood bank. The service is also planning on stepping up donations among uniformed forces. In recent years, the country's blood supplies have mainly come from young people, especially school children, since adults now shun donation. Youths now contribute 75% of total blood stocks.

Study: Asia Firms Must Gird Now for Spread of AIDS. A World Economic Forum (WEF) report released Friday, September 9, called on Asian companies to prepare to fight AIDS now, while infection rates are well below 1% on most of the continent. Of the 1,300 firms in 15 nations polled, 37% said they expect AIDS to affect their operations in the next five years. "This is the quiet time. Now is the time to act to push back the tide of HIV in Asia," said the report's main author, David Bloom. A professor of economics and demography at Harvard's School of Public Health, Bloom called AIDS a "dark cloud hanging over the regional economy." "If you wait till it's in your face, it's too late: You'll have an Africa-style epidemic," Bloom said in Beijing at a WEF conference. He encouraged countries to follow the example of Thailand, where quick action by authorities helped curb the

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spread of HIV and avert a huge shock to the economy. To lessen the effects of the epidemic, Bloom said, businesses need better information on AIDS and its impact. In addition, they should partner with governments and nongovernmental organizations and work to fight AIDS discrimination.

World Health Organization: Asian Nations Face Deadly TB-HIV Threat.

Drug resistance and HIV-TB coinfection pose a serious threat to Cambodia, China, Vietnam and the Philippines, the World Health Organization said Friday, September 16, at a conference in Nourmea, the capital of New Caledonia. In the Asia-Pacific region, TB is the main cause of death among HIV-infected persons. Once HIV patients contract TB, each disease speeds up the progress of the other. Growing resistance to a variety of drugs has compounded the problem. "HIV and TB are the leading killers among the infectious diseases today and together they form a deadly partnership," the WHO report said. "In the region, TB-HIV has not reached epidemic proportions, but is already serious in some areas." The Asia-Pacific region comprises a third of TB cases worldwide, with Cambodia, China, Vietnam and the Philippines representing 80% of the region's cases, said WHO. In the Western Pacific, which stretches from China to Fiji, at least 1.5 million people had HIV by the end of 2004. A WHO goal of reducing global TB prevalence and deaths by half from 1999 to 2010 is in jeopardy because of an increase in TB-HIV cases. "TB-HIV coinfection threatens to reverse the steady progress toward achieving this goal," said WHO Regional Director for the Western Pacific Dr. Shigeru Omi. To control the spread of TB and reduce the death rate, greater surveillance of TB-HIV cases and better access to medicines in developing countries are needed. The emergence of multidrug resistant TB (MDR-TB), particularly in China and Mongolia, is impeding TB control efforts, said Dr. Dongil Ahn, WHO's Western Pacific regional adviser on the disease. WHO found that in three of the Chinese provinces it surveyed, up to 10% of new cases were MDR-TB. In Mongolia, about 18% of prisoners with TB were resistant to multiple drugs.

Clinton Foundation to Provide Free Drugs to China's HIV/AIDS Children.

On Sunday, September 11, officials with the Bill Clinton Foundation's HIV/AIDS initiative announced the expansion of its program to provide free treatment for HIV+ children in China. In June, the former president's foundation began treating 200 HIV+ children in central China, most of whom were infected from birth or unsanitary blood transfusions. Many of the parents were farmers infected in the 1990s through unsanitary blood-buying operations. "It hasn't been publicly announced, but it has been made known to officials in China," said Aaron Patillo, a drug procurement specialist for the foundation. "We don't know the actual number of kids who need the drugs, but we'll treat up to 2,000, and we're actually going to work with the government to try and identify more kids, and if there are more, we will not leave them uncared for. I'm sure there are many more kids who need the drugs." While China produces HIV/AIDS treatments domestically, its phar-

maceutical companies do not make the drugs in pediatric formulations. Foundation officials made the announcement after a Beijing ceremony, which Clinton attended, that recognized the foundation's effort to train Chinese doctors in the United States. Upon their return to China, the doctors will treat HIV/AIDS patients in rural areas and train local doctors. "Most of the expertise in dealing with HIV/AIDS is found in urban areas, but most HIV/AIDS patients are in rural areas," said Clinton. The foundation is also working to help Chinese health officials obtain second-line HIV/AIDS drugs for patients whose virus is resistant to first-line treatment.

Basketball Star Yao Gives Hong Kong Kids Lesson in Life and Hoops.

On Thursday, September 22, the seven-foot-six Houston Rockets center Yao Ming spoke with more than 3,000 Hong Kong children about the perils and prevention of HIV/AIDS. "He is an icon to many youngsters here—they look up to him as an inspiration," said a spokesperson for the Hong Kong AIDS Foundation, which helped organize Yao's visit. Speaking in Mandarin, Yao joked with the children before turning to serious issues such as the importance of avoiding drugs—a growing problem among Chinese youths. After that, Yao, dressed in a T-shirt and shorts, showed off his basketball moves and slam-dunking skills, and invited some of the schoolchildren onto the court with him.

Indian Tribunal Strikes Down Rule Denying Jobs to HIV-Infected People.

On Thursday, September 8, in Bangalore, the Karnataka Administrative Tribunal struck down a 1994 police rule that banned HIV+ people from joining the force. The ruling from the southern Indian state was made public Friday, September 9. Six years ago, the Karnataka police force selected R. Ramesh Rao for a job, but rejected him after a routine medical exam discovered he had HIV. Finding the 1994 policy was "arbitrary, illegal and unconstitutional," the tribunal directed the police force to hire Rao and to no longer discriminate against applicants on the basis of HIV status. Police officials said they would respect the ruling. "The order has exposed the shortsightedness of those in the top who make decisions," said Shakun Mohini of the HIV advocacy organization Vimochana. Of India's one billion population, an estimated 5.1 million people have HIV. Indians with HIV are often ostracized and denied jobs and proper care.

HIV Alarm Sounded.

Around 20% of female sex workers in the Sanam Luang area recently tested positive for HIV, Dr. Parnudee Manomaipiboon of the Bangkok health department said Friday, September 9. The 115 women had volunteered to get tested during an annual checkup conducted from Sunday, May 1, to Wednesday, June 15, said Parnudee, director of the Bangkok Metropolitan Administration's Health Center No. 9. Other area residents considered at high risk—including male sex workers, drug addicts and the homeless—have not yet been tested. Earlier, Bangkok Deputy Gov. Samart Ratchapolsitte called on men not to patronize sex workers in Sanam Luang, which has been closed off at night since Thurs-

day, August 25, after the city reinstated a ban on loitering.

Australian League Stars Spread HIV/AIDS Message in PNG.

Several Australian rugby stars, including retiring Sydney Roosters Captain Luke Ricketson and Bulldogs player Braith Anasta, were visiting Papua New Guinea in mid-September as part of an AIDS education effort funded by AusAID. At Port Moresby National High School, the sports figures were greeted by hundreds of cheering students and talked about HIV/AIDS prevention and stopping violence against women. Papua New Guinea has the Pacific region's highest reported rate of HIV/AIDS: almost 2% of the population is believed to be HIV+. While Ricketson encouraged students to learn about safe sex and guard their health, Anasta spoke about the importance of respecting families, wives, girlfriends and parents. Other league figures visited additional schools and health centers.


AIDS Quilt Group, Founder Settle Lawsuit.

The Atlanta-based Names Project Foundation, which cares for the AIDS Memorial Quilt, has announced the settlement of a lawsuit filed by Cleve Jones, who created the quilt in 1987. Jones sued last year, claiming he was fired by the foundation after complaining that the 50-ton quilt was not being prominently displayed. The wrongful firing and breach of contract portions of Jones' suit were thrown out earlier this year by Superior Court judges in San Francisco. Charles Thompson, the San Francisco attorney who represented the foundation, said no money changed hands in the settlement. However, the agreement grants Jones the right to nominate four finalists for two positions on the board of directors each year, according to Thompson, who is a former director of the foundation.

5,000 at AIDS Walk.

On Saturday, September 17, more than 5,000 people took part in the 2005 AIDS Run & Walk Chicago, together netting more than \$200,000. The event benefited the AIDS Foundation of Chicago's grant-making program. This year, 10% of the proceeds are being donated to the National AIDS Emergency Fund, which is helping provide medication, health care, shelter and food for HIV+ evacuees of Hurricane Katrina. Since 1988, AFC has provided more than \$15 million to local AIDS groups.

500 Walk for AIDS, Raising \$590,000.

On Saturday, September 10, in Seattle, an estimated 500 people raised \$590,000 for the Lifelong AIDS Alliance in the 19th annual walk-a-thon. According to the group's web site, the walk is its largest fundraiser. Lifelong AIDS Alliance was formed in 2001 when the Chicken Soup Brigade and the Northwest AIDS Foundation combined resources to create the largest organization of its kind in the Northwest and the fifth largest in the United States. The organization offers its clients cooked meals, grocery shopping services, transportation to doctors' appointments and secure housing. It also runs community outreach programs promoting HIV/AIDS prevention among young people. 



Medical Marijuana

OPINION

Marijuana has been used as a recreational, ceremonial and therapeutic substance throughout history. Our federal government classified marijuana as an illegal drug with no medicinal use long ago. Researchers wanting to do clinical studies must first get government permission and obtain a supply of pot from the National Institute on Drug Abuse (NIDA), a part of the National Institutes of Health. Yes, the only legal means of obtaining marijuana to do research in the United States is to get it from NIDA. Those NIDA hirelings routinely thwart such research, content to regurgitate the same specious warnings about marijuana's dangers that have been around since 1937.

The National Institute on Drug Abuse—*did you even know there was such an entity?*—is all about the abuse, not so much about the potential benefits of marijuana. They want us all to believe marijuana, or cannabis, has no medicinal value. And to make their point, they employ one of those infuriatingly illogical circular arguments that go something like this: *marijuana has no commonly accepted medical use but more research needs to be done on marijuana's side effects and potential benefits because some of the chemicals in marijuana are clearly harmful to health but because of the adverse effects of smoking marijuana we can't approve your research project.* Huh? Uh huh. And some people have fatal allergic reactions to peanuts, too, but note that we haven't banned them from grocery store shelves, shut down the farms or incarcerated any flight attendants for passing out peanuts to hapless airline passengers.

What we've got here is a government that promulgates all kinds of myths about marijuana. Decade after decade, they tell us marijuana is highly addictive, leads to harder drugs, kills brain cells, damages the lungs worse than cigarette smoking, causes highway accidents and overdoses. In fact, as far back as 1972, a review of the existing scientific evidence about marijuana by the National Commission on Marijuana and Drug Abuse concluded that while cannabis was not entirely safe, its dangers had been grossly overstated. Since then, researchers have conducted thousands of studies of humans, animals and cell cultures without government sanction. None reveal any findings dramatically different from those described by the National Commission in 1972. In 1995, based on thirty years of scientific research, editors of the British medical journal *Lancet* concluded that "the smoking of cannabis, even long-term, is not harmful to health."

So you see, it's not like the science doesn't exist; our government has nothing but contempt for it and simply chooses to dismiss it outright primarily because they didn't approve any of those studies in

the first place and it undermines years of fiction and lies about marijuana. The truth is that different drugs produce different effects and pose different risks. The legal status of any given drug is not necessarily a reliable indicator of its potential for harm. Marijuana has never been shown to cause an overdose death, but alcohol poisoning kills more people every year than all illegal drugs combined.

Over the past decade, ten states—Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, Oregon, Vermont and Washington—have legalized the cultivation, possession and use of marijuana for medicinal purposes. According to the *New England Journal of Medicine*, at least 115,000 people have obtained doctor recommendations for the use of marijuana. Patients use cannabis to manage a wide variety of conditions: chronic pain, eating disorders, epilepsy, glaucoma, arthritis, migraines, schizophrenia, multiple sclerosis, nausea and vomiting associated with cancer chemotherapy and AIDS wasting.



For most of these individuals, marijuana was a last resort measure when first-line treatment didn't work. For some with poor or no insurance, marijuana is the cheaper alternative to pricey pharmaceuticals. States have encountered few problems with access, most having carefully regulated farms and cannabis clubs that dole out measured amounts to patients with doctor recommendations and appropriate identification.

You already know where this is heading. Under the Bush administration, federal agents have raided medical marijuana farms and cannabis clubs in several states. After one such California raid in 2002, Drug Enforcement Administration (DEA) spokesman Richard Meyer crowed, "Marijuana is illegal under federal law regardless of state law." Meyer, however, seemed oblivious to the fact that while federal agents were handcuffing and sticking guns in the faces of cannabis farmers and providers, heroin was easily slipping into the states from as close as Mexico and as far away as Afghanistan.

Remember how George W. Bush spent most of

his 2004 reelection campaign calling Democratic presidential candidate John Kerry a flip-flopper? Bush seems to have forgotten he told *The Dallas Morning News* that medical marijuana didn't warrant national attention back in 2000. "Each state can choose that decision as they so choose," he said. The very next year, he nominated John Walters—on public record opposing states' rights regarding medicinal marijuana—to become director of the Office of National Drug Control Policy, saying, "Acceptance of drug use is simply not an option for this administration. We emphatically disagree with those who favor drug legalization."

John Walters, yet another intolerant, vindictive and deeply obsessive Bush appointee from the bowels of the worst kind of hell your most fundamentalist Christian aunt could imagine... well, he's a punishment-and-prisons kind of guy who considers any sort of drug use a lapse in moral character. Even a cursory glance at his public remarks ought to convince you he's not remotely interested in the lives of chronically or terminally ill people desperate for some relief from debilitating conditions and diseases. "Our national medical system relies on proven scientific research, not popular opinion," spouts Walters. "To date, science and research have not determined that smoking marijuana is safe or effective."

Actually, there *is* plenty of science and research from which to conclude that marijuana can be helpful, not harmful; Walters just refuses to read it or acknowledge it exists. In recent studies, oncologist Donald I. Abrams of the University of California, San Francisco, found evidence of marijuana's effectiveness in the treatment of neuropathic pain among HIV-infected patients. Abrams has also shown that cannabinoids—the active chemical ingredients in marijuana—smoked or taken orally do not adversely affect HIV drug treatments. Beyond that is the anecdotal evidence from people with HIV, cancer and other serious illnesses who claim that smoking marijuana stimulates appetite, alleviates pain and nausea, and may even control grand mal epileptic seizures.

Further, many organizations—Institute of Medicine, American Cancer Society, American Medical Association, Federation of American Scientists, National Academy of Sciences, Lymphoma Foundation of America, National Association of People with AIDS and more—have endorsed medicinal marijuana. A CNN/Time poll published in late 2002 found that 80% of Americans age 18 or older believe that adults should be allowed to legally use marijuana for medical purposes if their doctor prescribes it. Over the last decade, in fact, polls have consistently


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shown between 60% and 80% of Americans support legal access to medical marijuana. In 2004, both a statewide Alabama poll commissioned by the *Mobile Register* and a Scripps Howard Texas poll reported 75% support for medicinal marijuana use. Yes, Alabama and Texas—two of those so-called conservative red states—are filled with individuals who don't care if really sick people smoke some grass to feel better.

But then the president, John Walters and the DEA don't care much about popular opinion or science anyway, unless it just happens to align with whatever arbitrary, fanatical posture they've adopted. Does this vehement opposition to doctor-prescribed cannabis treatment make any sense? Where is the generosity of spirit? Where is the compassion? And ultimately, doesn't it look like they care more about preserving some outdated, uncompromising drug policy than they do about the lives of suffering chronically and terminally ill human beings?

David Salyer is an HIV+ journalist, educator and activist 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. 

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