P.F. —
Marilyn Gaston
memo

Joyce

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
Public Health Service

BUREAU OF PRIMARY HEALTH CARE

Memorandum

Date SEP 14 1994

From Director, Bureau of Primary Health Care

Subject Bureau of Primary Health Care Response to the HIV Crisis

To Patsy Fleming, Interim National AIDS Policy Coordinator

I appreciated our meeting last week and wish to respond to several of the issues that you raised.

The philosophy which undergirds the mission of this Bureau is that comprehensive primary health care includes services which emphasize prevention, early detection and early intervention for the broad spectrum of health and medical conditions, including HIV disease, which affect our target, underserved populations. The HIV epidemic has had a major impact on the populations served by the Bureau programs and, as such, I believe, as you do, that HIV prevention and care must be incorporated as a routine component of all of our primary care programs. Given the future projections for this epidemic, it is the expectation of the Bureau of Primary Health Care (BPHC) that primary care providers will continue to serve as essential health resources for HIV-infected individuals.

Legislation authorizing the 329 and 330 programs states that community or migrant health centers (C/MHCs) must provide either directly, or through firmly established arrangements with other providers, the following basic set of services: primary care services; diagnostic laboratory, radiologic and pharmacy services needed to complete treatment; preventive health services; emergency medical services; transportation services for users who might otherwise lack access; preventive dental services; patient case management; and translation services. The BPHC has always interpreted this legislation to mean that anyone who presents at a C/MHC with a primary health care problem must be cared for regardless of their ability to pay. That interpretation certainly holds for persons who are HIV infected or at risk for contracting HIV disease. To emphasize this longstanding commitment, the BPHC issued a program guidance dated January 27, 1988, which clearly delineated program expectations of BPHC grantees related to the care of people with HIV infection. An updated guidance is in the final clearance process and will be released this month. A draft copy is attached.

Additionally, BPHC staff are developing HIV-related education needs assessment and training for BPHC grantees. We have also incorporated pertinent HIV-related questions into the Primary Care Effective Review (PCER) documents. The PCER is the tool by which the BPHC identifies technical assistance needs, provides onsite consultations and monitors quality to permit continuous improvement. A pool of consultants who are knowledgeable about HIV are currently being identified and trained to conduct PCER site visits.

Health care providers working in community and migrant health centers are currently providing care to people with HIV disease. A recently completed survey indicated that 382 (67%) of C/MHCs are serving HIV+ clients. Of the 140 C/MHCs located in Title I eligible metropolitan areas (EMAs), 128 (90%) are serving HIV+ clients. With the release of the new guidance, and continued emphasis as I visit programs and as I speak from the podium, we anticipate that a higher percentage of C/MHCs will provide care to HIV+ patients. The BPHC will be conducting another survey to determine the type of clinical services that are being provided to HIV+ patients in C/MHCs.

As mentioned, we are concerned about participation of C/MHCs in Titles I and II. Currently, only 17 (12%) of C/MHCs in Title I EMAs receive Ryan White Title I funds. Five (1%) of all C/MHCs receive Ryan White Title II funds and 59 (10%) receive Ryan White Title III(b) funds. Of the 69 new applicants for Title III(b) funds in FY 1994, 19 C/MHCs submitted applications. Although the Fiscal Year (FY) 1995 President's budget request for the Title III(b) program was $66,968,000 which represented an increase of $19 million over FY 1994, we do not anticipate receiving that amount. Consequently, most of the 69 new applicants for funds will not be funded this year.

For your information, we are nearing the completion of the grant cycle for the Title III(b) program for FY 1994. We anticipate funding approximately 133 organizations; we currently fund 130 programs. If the FY 1995 budget contains an increase over the FY 94 amount for the Title III(b) program, we will immediately fund additional organizations to provide comprehensive primary care services for people with or at risk for HIV disease.

Given the unmet need for funding, as documented by the number of approved/unfunded applications for Title III(b) dollars, the BPHC has consistently requested higher appropriations for this program. The FY 1996 request for funding is chronicled below:

4/94	BPHC request to HRSA	$93,755,000
6/94	HRSA request to OASH	$90,868,000
6/94	OASH request to Dept.	$66,968,000
8/94	Department Allowance	$62,568,000

The original BPHC request for $93,755,000 was to extend primary health care services to an additional 48,600 individuals who are at risk for infection or are already infected with HIV in cities and communities that do not receive funding from Titles I or II of the Ryan White CARE Act. These cities/communities would be in "second tier" areas. As you are aware, Title II funds are insufficient in many low and moderate incidence states and do not necessarily provide primary care to HIV+ and at-risk individuals. Also, due to diverse priorities of the Title I and II grantees, primary care including dental care, nutritional assessment and intervention, mental health and substance abuse treatment may or may not be supported. These additional funds would allow a significant increase in providing HIV early intervention services to individuals in rural areas and to migrant and seasonal farm workers. Presently, only eight of the III(b) grantees are also migrant health centers (329) and only 13 III(b) grantees are in rural areas throughout the country.

You spoke about your particular interest in the Bureau's gay and lesbian adolescent initiative. The BPHC is sponsoring a conference December 5-6, 1994, in Washington, D.C. to develop sample protocols, standards and indicators of quality care for this targeted population. I would like to take this opportunity to invite you to speak during the opening plenary session of that conference. As an outcome of the conference, guidelines on caring for gay and lesbian adolescents will be developed and disseminated to all BPHC-funded primary care programs. I will keep you informed about the conference and hope that you can attend.

If you have further questions, concerns or suggestions about the Bureau's response to the HIV crisis, please feel free to contact me.

Marilyn H. Gaston, M.

Attachment

Speaking request 6/1 VOOT

DRAFT

POLICY INFORMATION NOTICE #94-
DATE:

SERVICES FOR PATIENTS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

I. PURPOSE

The philosophy which undergirds the mission of this Bureau is that comprehensive primary health care includes preventive and therapeutic services for the broad spectrum of health and medical conditions which affect our target, underserved populations. The HIV epidemic has had a major impact on the populations which we serve and, as such, HIV prevention and care must be incorporated as a routine component of all of our primary care programs. Given the future projections for this epidemic, primary care providers will increasingly serve as essential health resources for HIV-infected individuals.

II. BACKGROUND

The last program guidance which was disseminated from this Bureau regarding the program expectations of Bureau grantees related to the care of people with HIV infection was Regional Program Guidance Memorandum (RPGM) 88-03, dated January 27, 1988. That memorandum emphasized the importance of assessing the needs of the Community and Migrant Health Centers (C/MHC) service populations related to HIV/AIDS and developing strategies to address those needs. It stressed the need for staff and board member education on matters related to HIV/AIDS, both in general and specifically as related to the Centers' service populations. It also mandated that HIV be addressed in the overall health care plan submitted by the grant applicants, and that the applicants' needs assessment specifically address HIV as appropriate. The C/MHC's health care plan was required to include a description of HIV-related services in the community and which services would be provided by the applicant directly, or through arrangements with other organizations.

The RPGM emphasized prevention, including HIV testing and counseling. There was also an emphasis on health education for the communities served. C/MHCs were strongly encouraged to coordinate and collaborate with other organizations which were involved in the reduction of HIV transmission and the care of HIV-infected persons.

Finally, C/MHCs were instructed to develop and implement infection control procedures for all transmissible diseases,

such as Hepatitis B and HIV, to reduce the risk to health workers and patients.

HIV continues to be an epidemic of major proportions, and addressing the problem has become an increasingly urgent priority of the United States Public Health Service. The cumulative number of reported AIDS cases since the beginning of the epidemic in the United States now exceeds 360,000. Over 221,000 deaths from AIDS have now been reported in the United States. It is estimated that in excess of one million Americans are infected with HIV.

Since the issuance of RPGM 88-03 there have been major developments related to the treatment of HIV disease and secondary prevention and treatment of its complications. Also, public policy related to the prevention of HIV transmission and the care of persons with HIV infection have seen significant changes such as:

- The epidemic in its early stages primarily affected men who have sex with men; it has increasingly moved into other populations, notably ethnic minority groups, women, and children.

- Antiretroviral agents, in addition to AZT, have been developed which are used either in combination or alone for the treatment of HIV disease.

- Results of a recent study (ACTG 076) in a select group of HIV positive pregnant women have been released. It has shown that the use of AZT during pregnancy, labor and delivery, both in asymptomatic HIV-seropositive women and their neonates, can significantly reduce the probability that the infant will be HIV-infected. HRSA will be issuing additional information and guidance for all grantees on the results of this study.

- Improved treatments have been developed to prevent and treat many opportunistic infections associated with HIV disease.

- Increasing emphasis has been placed on early detection of HIV disease so secondary preventive measures, prophylaxis and treatment can be instituted as early as possible.

- The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 was enacted, authorizing the Federal Government to make substantial sums of money available to cities, States, and local organizations for the care of people with HIV/AIDS.

- Title III(b) of this act, which authorizes funding for HIV early intervention/primary care services, is administered by the Bureau of Primary Health Care.

- There have been recent releases by the Public Health Service related to standards of care for HIV-infected individuals. (See Attachments)

III. GUIDANCE FOR ALL BUREAU GRANTEES

The expectations for all Bureau primary health care programs excluding Title III(b) grantees, responsiveness to the needs of their HIV-infected populations, are subsumed within the following:

1. Needs Assessment: Bureau supported primary health care programs are specifically designed to meet the primary care needs of their community or specific populations, and to assure continuity of care throughout the complex health care system. Understanding the needs of the community as well as the needs of people using primary health care services is an essential prerequisite to assuring a responsive health care system and one which targets priority health care needs. Although operational primary health care programs have already demonstrated need for purposes of funding eligibility, Bureau supported primary health care programs must periodically reassess community and user needs.

It is essential that all grantees specifically include HIV disease as a condition to be monitored among their service populations in their ongoing needs assessments. Administrative and clinical staff must assess the needs of their populations precipitated by the HIV epidemic and must develop strategies to meet those needs. These strategies should encompass community education and health services, ranging from risk reduction, behavioral risk assessment and HIV prevention for all clients to the provision of comprehensive primary care for those who are HIV-infected. Ongoing relationships with local school systems and church leaders are encouraged.

2. The System of Care: Bureau supported primary health care programs must have a system of care that contributes to

the desired outcomes of availability, accessibility, quality, comprehensiveness and coordination. BPHC supported primary health care programs must assure that basic primary care services, coordination with other levels of care, and support services appropriate to defined health care needs, are available and accessible to their clients. The program also must have qualified providers and a clinical management system that ensures quality and continuity of care.

In order to ensure that resources are being applied in the most effective possible way to the needs identified, every primary care program must develop health care goals and objectives as part of the organization's planning process. The goals and objectives need to consider both the role of the primary health care program in the community's system of care and the specific efforts the program will undertake on behalf of its own user population and the community.

It is essential that programs include the following HIV related services and HIV risk reduction education within their system of care:

- Behavioral Risk assessments must be completed on all grantee clients.

- Programs must include in their prevention/health promotion programs specific elements pertaining to prevention of HIV transmission and preventing/delaying onset of HIV associated illnesses.

- HIV antibody testing, pre- and post-test counseling which includes an appropriate process for frequent contact and support for patients who are seropositive.

- Programs must assure that HIV counseling and testing are easily accessible to their clientele and encourage their acceptance. Clients should be offered anonymous testing either on site or by referral.

- Initial medical work-up must be conducted on all HIV seropositive patients.

- Periodic/ongoing medical monitoring of HIV seropositive patients is required.

- Antiretroviral therapy and prophylaxis against opportunistic infections conforming to established clinical protocols, including breast feeding advice and

PCP prophylaxis especially for newborns must be initiated.

- o Patient Care Protocols regarding all aspects of care should be in writing, available and used by all providers.

- o Appropriate specialty and subspecialty referrals for diagnostic and therapeutic procedures, with the center assuming the ongoing primary care responsibility for the client.

- o Health maintenance activities appropriate for HIV-infected individuals including, but not limited to, influenza vaccine, diphtheria/tetanus update, pneumovax, routine pap smears, TB screening and oral health.

- o Programs must demonstrate an awareness of other HIV care resources within their respective communities, and must assure that their services are optimally coordinated with such other resources.

- o Programs must demonstrate that infection control policies and procedures are in place which include the OSHA mandated universal infection control precautions, and staff must be oriented to adhere to such procedures and precautions.

- o Case-management services should be comprehensive and formalized in a written care plan, with objectives carefully defining types of services required. Services should include intake, assessment of patient needs, development, implementation, monitoring and periodic assessments.

IV. PCER INTEGRATION

The expectations contained in Regional Program Guidance Memorandum 88-03 continue in force. Also, since HIV care is an integral part of comprehensive primary care delivery, issues related to HIV care have been made an integral part of the Primary Care Effectiveness Review process for Section 329/330 Centers and for other grantees of the Bureau of Primary Health Care.

V. TECHNICAL ASSISTANCE AVAILABILITY

If a grantee desires technical assistance to develop improved HIV care capacity, the Regional Office Project

Officer should be contacted. To the extent possible, the Bureau of Primary Care will make technical assistance available to such grantees. The AIDS Education and Training Center program provides HIV primary care training and ongoing continuing education opportunities.

VI. OPPORTUNITIES FOR ADDITIONAL FUNDING

Primary health care programs which are located in areas of high HIV impact, and which can demonstrate a significant HIV impact on their primary care programs, are encouraged to seek funding under the Ryan White CARE Act, State or local sources, or through Section 330 enhancement funds. Such programs are also strongly encouraged to participate in local and State HIV planning efforts.

Attached is a listing of resource materials which may assist grantees in responding to the HIV epidemic in their communities.

Attachments

RESOURCES

Early HIV Infection Clinical Practice Guidelines

A four-part publication from the Agency for Health Care Policy and Research. To obtain guidelines contact the National Clearinghouse for Primary Care Information
8201 Greensboro Dr., Suite 600
McLean, VA 22102
703-821-8955

Clinical Management of the HIV-Infected Adult: A Manual for Mid-Level Clinicians

Collaborative effort of The Emory AIDS Training Network, Grady Hospital, the Midwest Training and Education Center at the University of Illinois at Chicago, and the US Department of Health and Human Services. To obtain manual contact the National Clearinghouse for Primary Care Information
8201 Greensboro Dr., Suite 600
McLean, VA 22102
703-821-8955

AZT Reduces Rate of Maternal Transmission of HIV

National Institute of Allergy and Infectious Diseases (NIAID)
NIAID News Office of Communications 301-402-1663

Antiretroviral Therapy for Adult HIV-Infected Patients,
JAMA, December 1, 1993

Occupational Safety and Health Administration

Occupational Exposure to Bloodborne Pathogens; Final Rule
29 CFR Part 1910.1030. To obtain a copy contact the National AIDS ClearingHouse 1-800-458-5231

State & Territorial AIDS Directors

Provides assistance in obtaining a wide array of information about HIV-related resources available in your community and state, including but not limited to information concerning pharmaceuticals covered under the state reimbursement program, transportation and housing and other programs for HIV-infected individuals. (List Attached)

AIDS Education and Training Centers (AETCs)

The AETCs which serves your state should be able to assist you with any HIV-related training for health care providers in your facility. (List Attached)

National AIDS Clearinghouse

To obtain HIV-related educational material.
1-800-458-5231

AIDS Clinical Trials Information Service

Information about HIV clinical trials.
1-800-TRIALS-A

Public Health Service Regional Offices,
HIV & Clinical Coordinators (List Attached)

THE WHITE HOUSE

WASHINGTON

For Immediate Release

Contact: Richard Sorian
Office of National AIDS Policy
(202) 632-1090

President Clinton Releases First-Ever National AIDS Strategy

On December 16, 1996, President Clinton released the first-ever National AIDS Strategy, establishing six "broad but vital goals" to guide Federal AIDS policy for his second term in office. The document also outlines numerous "opportunities for progress" under each of the goals to be accomplished in the next 12 months.

The National AIDS Strategy is the product of more than a year of work by the Office of National AIDS Policy, directed by Patricia S. Fleming. The Office was created in 1993 by the President to provide greater focus to the national response to the challenges presented by HIV and AIDS.

In a letter accompanying the Strategy, the President said, "We have made tremendous progress in our understanding of HIV and HIV disease, improving treatments and preventing infections, and we have increased federal funding for AIDS research, prevention, care, and housing by more than 50 percent in the past four years. But we have much more work to do."

As of September 30, 1996, the Centers for Disease Control and Prevention had received reports of 566,002 cases of AIDS among persons in the U.S. More than 343,000 of these persons were reported to have died as a result of complications related to HIV. An estimated 40,000 to 80,000 Americans become infected with HIV each year.

According to the Strategy, the epidemic of HIV and AIDS "presents unique social, economic, and public health challenges to governments and individuals here in the United States and around the world. While significant progress has been made in understanding the disease and developing treatment, HIV remains a deadly infections for which there is no vaccine, no cure, and for which there is an expanding, but still limited, inventory of available treatments."

Development of the National AIDS Strategy required the participation of 28 Federal Agencies involved in AIDS programs including the Departments of Health and Human Services, Housing and Urban Development, Veterans Affairs, Defense, State, Energy, Justice, and others. The Strategy also reflects the input of numerous national and community-based AIDS organizations and the proceedings of 13 regional town hall meetings that sought the input of people living with HIV/AIDS, their families and caregivers, and other concerned citizens.

- more -

The National AIDS Strategy sets forth six national goals:

- To develop more effective treatments for people living with HIV/AIDS, a preventive vaccine for the uninfected, and a cure for those who are currently infected through strong, continuing support for HIV-related research;

- To reduce the number of new HIV infections in adults and children in the U.S. until the rate of new infections reaches zero by providing strong, continuing support for effective HIV prevention efforts;

- To ensure that people living with HIV have access to services, from health care to housing and supportive services, that are affordable, of high quality, and responsive to their needs;

- To ensure that all people living with HIV are not subject to discrimination;

- To provide strong, continuing support for international efforts to address the HIV epidemic; and,

- To ensure that research advances are translated into improved HIV prevention programs and enhanced care for HIV-positive persons.

In each of these target areas, the National AIDS Strategy includes specific opportunities for progress in the year ahead. These actions are intended to move us toward the goals enunciated by the President. They include:

PREVENTION

- **Targeting vulnerable populations.**

  The HIV epidemic continues to have a disproportionate impact on certain populations where infection rates are rising at a rapid pace. Congress has approved the President's request for an additional $32 million in AIDS prevention funding specifically for programs targeting such vulnerable populations as adolescents, women, gay men of color, and substance abusers and their sexual partners.

- **Strengthening community-based programs.**

  Community prevention planning is one of the key innovations in CDC's prevention programming. This partnership with local communities puts Federal funds to work based on locally-designed priorities. This year, CDC will be providing its partners with additional technical assistance and resources needed to improve the performance of this vital initiative.

- **Reducing transmission of HIV from mother to child.**

  There has been a significant reduction in the number of infants diagnosed with AIDS as a result of perinatal (mother-to-child) transmission of HIV. Between 1991 and 1995, the number of such infants declined 27 percent, including a 17 percent drop in 1994-95 alone. Research sponsored by the National Institutes of Health determined that the use of AZT by HIV-positive pregnant women and their newborns can reduce the risk of perinatal transmission by two-thirds. In the coming year, the Public Health Service will be working in conjunction with major medical and public health organizations to reduce this number further.

RESEARCH

- **Accelerating AIDS Vaccine Development**

  The National Institutes of Health will establish a restructured AIDS vaccine effort headed by Nobel Laureate David Baltimore of MIT to accelerate progress in research and development of an effective AIDS vaccine. Vice President Gore will continue his high-level work with the pharmaceutical industry, researchers, clinicians, and patient advocates to move increase private-sector research and development of AIDS vaccines.

- **Maintaining the Office of AIDS Research**

  One of the most important developments of the past four years was the enactment of legislation strengthening the Office of AIDS Research (OAR) at the National Institutes of Health. In the year ahead, the Administration will seek reauthorization of the OAR and retention of the Office's authority to develop and carry out the AIDS research budget at NIH.

- **Developing Topical Microbicides**

  The National Institutes of Health and the Centers for Disease Control and Prevention will begin a four-year $100 million effort to accelerate research and development of safe and effective barriers to HIV transmission for women and men.

- **Advancing Prevention Science**

  The National Institutes of Health is developing a comprehensive prevention science agenda that will address the biomedical, behavioral, and social approaches to AIDS prevention interventions.

CARE AND SERVICES

- **Expanding the Infrastructure of HIV/AIDS Care**

  Nearly 200,000 Americans living with HIV/AIDS rely on the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act for some or all of their care. Funding for the CARE Act has been increased by 31.5 percent in FY 1997, including a 221 percent rise in funding for AIDS Drug Assistance Programs (ADAP). The Health Resources and Services Administration will work with state and local governments and community-based organizations to ensure those new funds significantly increase access to HIV treatment and care.

- **Preserving Medicaid and Medicare**

  Medicaid provides health care coverage for more than 50 percent of Americans living with AIDS and more than 90 percent of children with AIDS. The President will continue to fight to preserve the vital Federal guarantee of eligibility for medical coverage for people living with disabilities, including HIV/AIDS. Medicare is a rapidly growing source of care for people living with AIDS and the President will work with Congress to preserve the Medicare program without harming beneficiaries. The Administration also is exploring options to make Medigap insurance policies more accessible to people with disabilities.

- **Assessing Social Security Administration Programs**

  Combination drug therapies show enormous potential for improving and extending the length and quality of life of many people living with HIV/AIDS. This progress will require an assessment of such programs as Supplemental Security Income and Social Security Disability Insurance regarding their flexibility in meeting the needs of individuals as they seek to move off and on to disability. The Administration is exploring mechanisms to ensure that Federal programs support people with disabilities who wish to return to work.

- **Supporting Housing for People with AIDS**

  Without stable housing a person living with HIV has diminished access to care and services and a diminished opportunity to live a productive life. The Housing Opportunities for People with AIDS (HOPWA) program is an essential element of the HIV treatment safety net. Funding for HOPWA has increased 196 percent in the last four years; reauthorization of the program and continued, stable funding is a priority for the year ahead.

- **Enforcing the Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act includes important protections for people living with HIV/AIDS who have private health insurance. Limits on the use of pre-existing medical conditions exclusion clauses and requirements for renewal of existing policies will extend new protection to people living with HIV/AIDS. The Administration will aggressively implement this new law and work with the states to enforce its protections.

CIVIL RIGHTS

- **Enforcing Rights**

Enforcement of the civil rights of people with HIV and AIDS must be ever-vigilant. In the past four years, the Administration has resolved nearly 1,000 charges of AIDS-related discrimination. In the year ahead, the Justice Department and the Department of Health and Human Services will launch a joint effort aimed at access for people with AIDS to nursing homes.

- **Protecting Workers**

The Office of National AIDS Policy is working with Federal Agencies to examine current employment policies involving HIV testing to determine whether they are consistent with Federal public health guidelines.

INTERNATIONAL ACTIVITIES

- **International Leadership**

The U.S. will continue to strongly support the newly established Joint United Nations Programme on HIV/AIDS (UNAIDS) and bilateral AIDS programs in developing countries.

- **Sharing Technology and Bringing Lessons Home**

The U.S. Agency for International Development will work with domestic and international groups to expand the exchange of information and technology between the U.S. and other nations on AIDS prevention, treatment, and research.

TRANSLATION OF RESEARCH INTO PRACTICE

- **Developing Treatment Guidelines**

  One of the most critical tasks for clinicians and patients is interpreting the patchwork of data and articles regarding treatments and converting it into a therapeutic strategy for their patients. The Administration has begun a three-pronged strategy to develop information for clinicians and patients. The National Institutes of Health has held the first of a series of conferences to bring together current scientific information about new AIDS treatments. The Office of HIV/AIDS Policy at the Department of Health and Human Services has begun a process to develop clinical practice guidelines in conjunction with relevant Federal Agencies and private sector representatives. And the Forum for Collaborative HIV Research, a public-private partnership involving researchers, clinicians, and patient advocates, will identify additional clinical trials to be supported by the Forum participants, which include Federal Agencies, pharmaceutical manufacturers, clinicians, researchers, and patient advocates.

Individual copies of the National AIDS Strategy and its appendices are available by calling the National AIDS Hotline, 1-800-342-AIDS, or by writing to the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD, 20849-6003. The National AIDS Strategy can also be viewed or downloaded from the CDC National AIDS Clearinghouse World Wide Web site address: http://cdcnac.aspensys.com:86.

# # #

Office of HIV/AIDS Policy

Office of Public Health & Science
Office of the Secretary
200 Independence Avenue, S.W., Room 736-E
Washington, D.C. 20201

Deliver To: Eric Sushy

Fax: (___) 632-1096

Phone: (___)_____-_____

May be pertinent to meeting in San Francisco
Finley

From: Deborah von Zinkernagel
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Date: ____/____/____

This fax contains 1 **page(s) + cover**

If transmission problems occur, please call: Shellie Abramson @ (202) 690-5560

Comments:

drug to patients.

"New Virus Found in Blood Donor"
United Press International (03/03/97); Wasowicz, Lidia

Researchers at the University of California, San Francisco have detected human herpesvirus-8, which has been associated with the AIDS-related tumor Kaposi's sarcoma, in blood donated by a healthy young man who had never had sexual intercourse with men and had never received a blood transfusion. Jay Levy and colleagues say that although the virus appears to occur in healthy people, new research indicates that HHV-8 has been isolated from the donor's blood, indicating that it may also be transmitted via blood transfusions.

"Red Cross Using Public Cash to Fight Hepatitis C Lawsuits"
Toronto Globe and Mail (02/28/97) P. A4; McIlroy, Anne; Immen, Wallace

Canada's Red Cross Society reports that it is using public funds to pay for the legal challenge that forced a British Columbia woman to drop a lawsuit against the organization, rather than lose the doctor who was caring for her hepatitis C-infected son. Eight-year-old Jarad Gibbenhuck contracted the virus from a blood transfusion he received shortly after birth. He is among the 12,000 Canadians thought to be infected with the potentially fatal liver disease following the use of contaminated blood products in the late 1980s. Leslie Gibbenhuck was one of the plaintiffs in a lawsuit hoping to get compensation from the Red Cross and federal and provincial governments. She dropped the suit, however, when the family's doctor said he could no longer treat Jarad because the Red Cross has named the doctor as a third party in the case.

"5,000 HIV/AIDS Cases Detected in Vietnam"
Xinhua News Agency (02/28/97)

A total of 5,113 cases of HIV infection or AIDS has been reported in Vietnam, including, for the first time, cases reported in the country's northern provinces. The highest number of cases was reported for Ho Chi Minh City, which had 1,853 cases, followed by the central coastal province of Khanh Hoa with 402, and the southern province of An Giang which had 306. Vietnam's Deputy Prime Minister Nguyen Khanh has called for improved treatment and care for people with HIV and AIDS.

"High-Powered Support for AIDS Vaccine"
Science (02/21/97) Vol. 275, No. 5303, P. 1055

The National Institutes of Health's new vaccine committee, chaired by Nobel laureate David Baltimore, met for the first time on Feb. 17 to discuss topics ranging from the 1998 budget to the possibility of creating an AIDS vaccine institute. The 11-member committee was joined by NIH director Harold Varmus; Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases; and Richard Klausner, who heads the National Cancer Institute. Baltimore noted that by appearing at the meeting, the directors demonstrated "great interest in seeing the vaccines move to a very prominent position in the AIDS program."

"Kaposi's Sarcoma in Patients With the Acquired Immunodeficiency Syndrome: The Hong Kong Experience"
Journal of the American Medical Association (02/26/97) Vol. 277, No. 8, P. 607; Chan, L.Y.

Kaposi's sarcoma, which has become a common AIDS-defining illness, was the primary or subsequent defining illness for 13 percent of the 130 AIDS cases reported in Hong Kong between February 1985 and December 1994. L.Y. Chan and colleagues in the Department of Medicine at Queen Elizabeth Hospital in Hong Kong reported in the Hong Kong Medical Journal that HIV was contracted sexually in every case. In 88 percent of the infections, HIV was transmitted via homosexual or bisexual contact. The mean survival after Kaposi's sarcoma diagnosis was 14.4 months.

AIDS Daily Summary
March 3, 1997

A Letter to Friends

Vol. 3 No. 14 AIDS Issues & Events in D.C. March 3, 1997

Needle Exchange Program Contract Finally Approved

After five years of misstarts and delays, the District finally awarded Whitman-Walker Clinic and Koba Associates a contract to operate a clean needle exchange program with approximately $200,000 in local funds.

D.C. finally joins other cities in reducing IDU transmission of HIV

The contract was activated by the Financial Authority on Feb. 25.

Over 80 other cities have needle exchange programs already in operation. Studies show that these programs reduce HIV transmission among intravenous drug users (IDUs) by 30-50%, by cutting down on the use of shared contaminated needles.

Baltimore City, which has a needle exchange program, has seen its HIV infection rate among IDUs drop 40%, whereas in the surrounding Baltimore County, which does not have a program, the infection rate remains the same. Baltimore's program, which was expecting 500 participants, was overwhelmed by over 3,000 IDUs, and exchanged over 600,000 needles.

In 1993 and 1994, the last years with completed reporting, over 500 IDUs in D.C. were reported with full-blown AIDS each year.

In 1992, then Mayor Kelly launched a needle exchange program that was so restrictive that only about 50 of the District's 16,000 IDUs signed up. In 1994, IDUs became the largest group of new AIDS cases. In June 1995, most of these restrictions were relaxed and the District Council passed legislation to allow CBOs to run the program.

DHS did not get around to publishing a request for

continued on p.3

Rental Assistance Vouchers Closer to Distribution

Last Thursday, the local field office for the U.S. Department of Housing and Urban Development (HUD) gave final approval for the District's contract with Building Futures to provide 20 rental assistance certificates to PWAs. The money is part of the FY 1996 Shelter-Plus-Care grant, which was announced last September.

AHA is now forwarding the contract to the DHS Grants Office for finalization.

More rental assistance on the way

Community Partnership, the CBO designated by the District to run various HUD projects, including Shelter-Plus-Care grants, has finalized the project list for the long-delayed FY 1993 and FY 1994 Shelter-Plus-Care grants, totalling $11 million, and will submit the list to HUD this week for approval. Over 100 AIDS housing units are expected to be in the final package, including over 25 rental assistance certificates.

HOPWA payments delays

Several housing providers remain unpaid since December due to slow processing of the HUD Housing for People With AIDS (HOPWA) Year 4 contract. *(see editorial)*

Correction

In our last issue, we used a figure of $8.3 million for the GY 1997 Ryan White Title I formula award for the EMA. We have received a revised figure of $8,411,575, which increases the amount of money above last year to $3,129,901, or 24.6%. D.C. gets about 56% of the total, after AHA's administrative fee, the rural initiative, and cross-jurisdictional projects are taken off the top.

Will Expiring Contracts Be Replaced On Time?

The Testing of Wanda Moorman

All eyes are on Wanda Moorman as the April 3 deadline to have expiring Ryan White contracts replaced rushes toward us.

Wanda Moorman is the procurements guru that City Administrator Michael Rogers transferred from the Department of Administrative Services to DHS to clean up the embarrassing backlog of hundreds of expired DHS vendor contracts. So far, Moorman has proven to be a meticulous screener of procurement details but hardly an expediter. A large backlog of expired contracts still exists at DHS.

There are an estimated 30-50 vendor contracts in the grant year (GY) 1997 Ryan White package, replacing a similar number of expiring GY 1996 grants. The unprecedented urgency in getting the new contracts in place arises from a firm determination by the Financial Authority that no city vendor will be paid without a current contract in place. Recent District Council legislation calls for the termination of any city employee that authorizes payment to a vendor who does not have a city contract.

The upshot is that vendors will stop being paid on April 4 if Wanda Moorman hasn't got the replacement contracts in place. Life-sustaining services like medical visits, lab tests, medications, home care, and meals delivered to home-bound PWAs will stop.

As we indicated in our last issue, there are still a number of hurdles that must be jumped after Moorman approves the contracts, including Financial Authority review and loading into the Financial Management System (FMS).

Critical Housing Contracts Also Pending

Several AIDS housing vendors already have their backs to the wall because they haven't been paid since December due to failure to approve the HOPWA Year 4 grant from HUD. This 100% HUD-funded project, using FY 1995 funds, supports the largest cluster of AIDS housing in the District. The contract with the D.C. CARE Consortium, which subcontracts with individual housing providers, has been in Moorman's office since last November.

Several housing providers are in the process of going to their boards of directors to get permission to either suspend services or to terminate their contracts due the arterial flow of red ink. Most have no financial reserves or credit lines with which to hang on. It takes years to get projects going.

The DHS Grants Office will receive early next week a separate contract for Building Futures to provide rental assistance vouchers to 20 PWAs now on the long waiting list for the housing lottery. This is a simple contract that is virtually identical to other contracts we have had for years for rental assistance projects with HUD. Rapid approval of the contract will get very sick people off the streets and out of the homeless shelters into safe housing. We got our grant announcement last September. Let's get people out of the wintry weather on the fast track.

Lastly, we trust Moorman will not fight using the DOH option to use the HHS Program Support Center (PSC) to help cut through the backlog of other expired contracts awaiting approval of RFPs. We could stabilize the whole situation rather quickly with this option.

A Letter to Friends is written, edited, published, and circulated by Hank Carde. No public funds are involved. Inputs from readers are encouraged. Call/fax (202) 547-7971.

Needle Exchange Program *from p. 1*

applications (RFA) until a year later, in June 1996. After three months, the grant was awarded to Koba, only to be rescinded in December after questions were raised about the financial viability of Koba and ACT UP, the other finalist bidder. The RFA was redrafted and reissued in January. This time Whitman-Walker Clinic led the WWC/Koba bidding group and won.

Currently, no federal funds can be used to fund needle exchange programs but Congress authorized the U.S. Department of Health and Human Services in 1988 to lift this restriction if studies showed benefit and the programs did not increase drug usage. Secretary Shalala recently acknowledged that numerous studies confirmed both requirements, but HHS has not lifted the ban.

AHA Still Unscathed In Latest Health Dept. Cuts

If the District Council, the Financial Authority and Congress agree to the revised FY 1998 budget submitted Friday by Mayor Barry, the Health Department will face $1.5 million in budgetary cuts but none are slated for AHA.

PLHIVs will undoubtedly feel the pinch in other programs, like the loss of PCAs, GPA, food stamps, etc.

Eric Goosby Named Acting Drug Czar

Eric Goosby, M.D., has been designated the acting National AIDS Coordinator on the White House staff after the current coordinator, Patsy Fleming, left at the end of February.

Dr. Goosby is well-known by the Washington, D.C., AIDS community. He served for several years as the chief of the Division of HIV Services at HRSA, overseeing the Ryan White programs. He gained a national reputation for being responsive to problems brought forward from the diverse groups around the country seeking to improve the Ryan White system.

He is currently serving as HHS Secretary Donna Shalala's assistant for HIV affairs. Despite the requirements of that job, Dr. Goosby has devoted at least half a day each week to treating HIV patients at D.C. General Hospital. He is one of the few government bureaucrats who has maintained a frontline knowledge of how federal HIV programs are working on the local level.

We welcome his interim appointment and would be favorably disposed to seeing it made permanent. Dr. Goosby has the kind of vision and compassion we need to move the national AIDS agenda forward.

AIDS Watch '97

Coming in early April

Let's lobby Congress for More than the 4% Increase in Ryan White funds proposed by the President

Watch for dates, registration

TENTATIVE TIMETABLE

SUNDAY, NOVEMBER 26, 1995

Morning:	Pre-Conference Institutes
Noon:	ISAE Council Meeting
Afternoon:	Registration and Distribution of Conference Material
Evening:	Get-Together Reception

MONDAY, NOVEMBER 27, 1995

Morning:	Scientific Sessions
Noon:	Poster Session, AIDS Education Market, Lunch Break
Afternoon:	Scientific Sessions and Workshops on Special Issues

TUESDAY, NOVEMBER 28, 1995

Morning:	Scientific Sessions
Noon:	Poster Session, Video/Film Sessions, Lunch Break
Afternoon:	Scientific Sessions and Workshops on Special Issues
Evening:	Visit to the Israel Museum

WEDNESDAY, NOVEMBER 19, 1995

Site visits:	Exploratory Visits and Mini Seminars in Institutions with HIV/AIDS related programs throughout Israel.

THURSDAY, NOVEMBER 30, 1995

Morning:	Scientific Sessions
Noon:	Poster Session, AIDS Education Market, Lunch Break
Afternoon:	Scientific Sessions and Workshops on Special Issues

FRIDAY, DECEMBER 1, 1995

Morning:	World AIDS Day: Special Sessions and Activities

GENERAL INFORMATION

VENUE

The Jerusalem Renaissance Hotel, Jerusalem, Israel

Tel: (972 2) 528111, Fax: (972 2) 531976

LANGUAGE

The official language of the Conference is English

CLIMATE

The weather in Jerusalem in November is mild, sunny and pleasant during the day. Rain is possible.

Temperatures range from 12-20 °C (53-70 °F)

PROGRAM FOR ACCOMPANYING PERSONS

A wide ranging program of social events will be offered to all registered accompanying persons. In addition, a special program of tours is planned to coincide with the scientific sessions

TRAVEL AND ACCOMMODATION

KENES TOURS, P.O. Box 50006, Tel Aviv 61500, Israel
Tel: (972 3) 5140014, Fax: (972 3) 660325/5175674

KENES TOURS is the official travel agent for the Conference and will provide all necessary services to participants. Kenes Tours is offering package services including hotel accommodation, transportation and tours. (Specially reduced room rates are available through Kenes Tours, otherwise individual room rates will apply)

OFFICIAL CARRIER

El Al Israel Airlines is the official carrier for the Conference

EXHIBITION AND "THE AIDS EDUCATION MARKET":

A Professional/Commercial Exhibition will take place within the framework of the Conference.

Parallel to the exhibition, a unique "market" will be open during the Conference. It will allow individuals, companies, NGOs, etc., to informally share with other participants innovational AIDS education materials (eg: video cassettes, curricula, games, books, posters).

SECRETARIAT

The Secretariat will be pleased to provide any information required.

Please address all correspondence to:

The Secretariat

The 9th International Conference on AIDS Education
P.O. Box 50006, Tel Aviv 61500, Israel
Tel: (972 3) 5140014, Fax: (972 3) 660325/5175674

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First Announcement

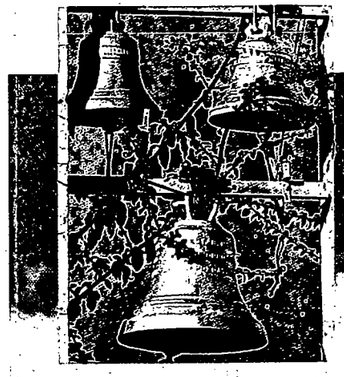
EL AL

aids
EDUCATION • JERUSALEM '95

9th INTERNATIONAL CONFERENCE ON
AIDS EDUCATION:
INTERVENTIONS IN MULTI-CULTURAL SOCIETIES

JERUSALEM, ISRAEL, NOVEMBER 26 - DECEMBER 1, 1995

SPONSORED BY : THE INTERNATIONAL SOCIETY FOR AIDS EDUCATION



ISRAEL IS ...

a treasure house filled with historical and archaeological echoes with Bible and other Ancient Civilizations blended with modern cities which bustle with a unique contemporary rhythm, all contained within a surprisingly small frame, at the cross-roads of Asia, Europe and Africa.

JERUSALEM IS ...

archaeology and art, sacred sites and superb shopping, panoramic sun-swept promenades and moonlit concerts under the stars, classic dining and fast-food restaurants, daytime walking tours and night-club entertainment.

Jerusalem is all this and more.

THE INTERNATIONAL SOCIETY FOR AIDS EDUCATION (ISAE) IS ...

the proud sponsor of the conference. The society was established in 1987 to promote HIV/AIDS education and counseling and enhance service delivery skills. ISAE also serves as an informational and professional network for researchers, practitioners, and HIV/AIDS educators and counselors. It is the only organisation representing the needs and concerns of HIV/AIDS educators. The society's journal: "Journal of AIDS Education and Prevention" is a major source for information on the work of researchers and others in the field world-wide.

Jerusalem is an excellent place for us to meet while we discuss the successes and the challenges in implementing HIV/AIDS interventions in multi-cultural societies. I invite you to share in this meaningful exchange.

Larry K. Brown, M.D.
ISAE President

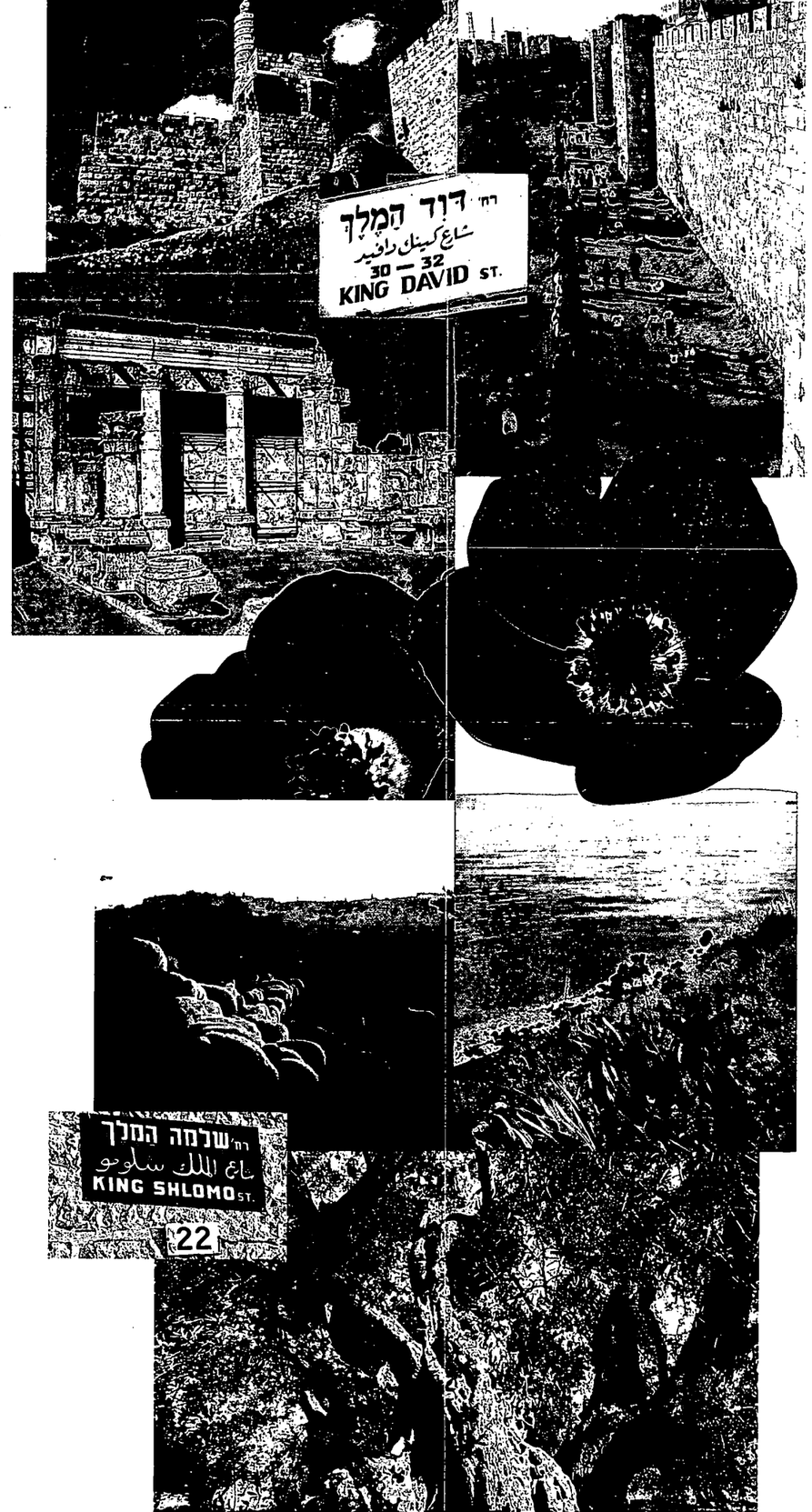
THE 9th INTERNATIONAL CONFERENCE ON AIDS EDUCATION IS ...

special.

AIDS education and prevention in many parts of the world are already targeted at diverse groups within one society. Our Conference's main theme is INTERVENTIONS IN MULTI - CULTURAL SOCIETIES. We hope to meet people from all over the world who will come to Jerusalem to share with colleagues their research, innovations, experiences, expertise and dilemmas.

The 9th International Conference on AIDS Education will focus on people, target groups, culturally sensitive approaches and age-related topics: pregnancy and perinatal HIV/AIDS prevention, early childhood, adolescence, youth and specific adult groups. I look forward to your active participation which will contribute to the success of the Conference. Looking forward to seeing you in Jerusalem in 1995.

Inon I. Schenker, Ph.D. (Can), M.P.H.
Conference Chair



MAIN TOPICS:

- Youth and Parent Education
- Training of HIV/AIDS Educators
- Prevention Programs for Sex Workers, Drug Users, Prison Inmates
- Socioeconomic Impact
- HIV/AIDS Policy
- Religions and Ethical Issues, Human Rights
- Methodology and Evaluation of Interventions
- Skill Building
- International Networking
- Mass Media and the Arts
- Condoms
- Mother-to-Child Infection
- Counseling and HIV Testing

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Research Office

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Date: 12/21/94

Pages: 5

TO: Kathy Fleming, National AIDS Policy Director

FROM: Art Ammann

Comments: I will call you regarding the attached. (not urgent)

From Art Ammann

TO Art — From Tri

LOOKING GOOD ...

by Lori Levine

A POPULAR TOPIC at support groups has always been the annoyance of looking good when you feel so bad. I hear complaints from HIV+ people who have been told how good they look while they are experiencing devastating symptoms of HIV; such as endless fatigue and debilitating fevers, or toxic reactions to anti-virals, and side effects of the toxic anti-fungals and anti-biotics. It is so irritating when you have the energy of a snail, feel like you are dying, and your loved ones respond with, "Oh but you look so good!" Is that supposed to wipe away the pain and suffering of living with a potentially fatal disease which is attacking our physical and emotional defenses in the most insidious ways - because we look good? Sure, many of us look good - its genetics, or we've spent thousands of dollars on cosmetics, or we don't have wasting syndrome and are retaining some extra poundage.

There are many reasons why we look good, but it doesn't mean we aren't as sick as we feel. People have trouble believing what they don't see. Appearances may not always reflect what's really going on inside.

The first support group I attended was populated with all men and myself. There was a memorably handsome man who looked fantastic, yet was always complaining about how sick he was feeling. He hadn't had the energy to work in several months and most days he couldn't get out of bed. He was fighting a losing battle with his employer for disability. He looked so good, nobody believed he was ill. When he went to see his doctor, the office staff remarked about how good he looked, consequently his case didn't take precedence over the "really sick cases". He never received the same attention as his emaciated peers. Nobody really believed he was sick, he looked so good. He died less than a month later. Guess he really was sick, eh?

> ***"I don't believe the expression about if you look good, you'll feel better. Whoever thought this up didn't have HIV."***

Did you ever notice how the really sick-looking patients get all of the doctors time and the healthier looking ones have to make due with whatever time the doctor has left? Imagine the dilemma of the healthier-looking yet sicker individual.

I heard a story of a previously robust individual who had just recovered from a severe bout of wasting syndrome, consequently he was told by several "friends" how much better he looked without the extra weight that he had been saving up for just such an occasion. What kind of message is this? Should we do what we can to be thin regardless of the circumstances? No thanks. I lost 30 pounds after a bout of MAI and I was grateful to have had them to lose. If I didn't, I guess nobody

WOMEN ARE BEGINNING TO BE RECOGNIZED AS PART OF THE AIDS PANDEMIC. WE, AS WOMEN INFECTED AND AFFECTED BY HIV/AIDS, HAVE YET TO JOIN TOGETHER EFFECTIVELY TO SEE THAT OUR SPECIAL NEEDS ARE MET. WOMEN ALIVE IS INTENDED TO INFORM WOMEN AND TO HELP US FIND EACH OTHER FOR ENCOURAGEMENT AND SUPPORT. WE HOPE YOU ENJOY THIS NEWSLETTER AND WILL CONSIDER GETTING INVOLVED IN ITS PUBLICATION.

▲

In memory of
Jayne Ann Little
Deborah Eli
Linda Luschei

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If you have articles you would like to submit to Women Alive Newsletter, or if you just want to help, please contact the Being Alive office during business hours.

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Circulation 10,000

WOMEN ALIVE STATEMENT

Women Alive is a newsletter written by and for women infected or affected by HIV/AIDS. We understand the pain and fear, how easy it is to hide, how difficult it can be to come to terms with this disease and reach out.

This newsletter and "Women Alive" programs are the means we have created to help us connect with each other, bring others like us out of isolation, and take charge of our lives, our care, and our destiny.

Readers are invited to contribute articles for the newsletter.

WOMEN CHALLENGE RESULTS OF TRIAL 076

ACTG TRIAL 076 is a study of the effectiveness of AZT in the prevention of HIV transmission from a mother to her infant. Questions were raised from the beginning of this trial. It was not a good study to begin with. Preliminary results were made known to the public through a press release, which boasted that AZT therapy resulted in a significant reduction in the number of HIV positive babies born to HIV+ women.

BAD SCIENCE

A certain amount of the data was projective. Researchers said they had data on 400 children. Four hundred children were born to HIV + mothers, but the scientists only collected data on 75 of the kids. They projected the data on the rest of the 376 kids, assuming they will follow the same pattern as the first 75. What kind of science is that?

People want to feel that something is happening with HIV research; that progress is being made. There is very strong evidence that if AZT did work at all, that it worked during the birth process. AZT therapy must not be approved for a long term regimen of several months during pregnancy, exposing women and their developing fetuses to a highly toxic drug. We need to determine when the mechanism of protection occurred, if it did at all. The data that was released was very hasty.

COERCION

The informed consent application from Los Angeles was 9 pages long. The papers must be signed in order to participate in any drug study. The first paragraph stated that there is a 30 to 60% chance that babies born to HIV+ mothers will be born with HIV infection. This is contrary to the actual facts of a 30 to 20% chance of babies being born infected. The next line states that 90% of these babies die within the first year. This is a scare tactic and it reeks of coercion. The majority of women who participated in this trial were teen-age mothers, some as young as 13 years old. These women weren't given fair or accurate information on which to base their consent to join this trial.

THE NEGATIVE KIDS

We know one child in Ohio whose mother was on trial 076. The child is 3 and continually tests negative for HIV. Yet, the child is showing signs of immune suppression, including plummeting T-cells. We know of a child in California whose mother wasn't on this study, but was persuaded by care providers to take high doses of AZT during her pregnancy. The child continues to test negative yet, has only 40% of a normal immune system. The child has to have tumors removed on a regular basis. The pathologist said, he has never seen tumors like this in a 4 year old.

There are more kids who were exposed to highly toxic AZT in early development stages. Who is documenting the adverse effects? We need to get this information to the medical community. We do not have any faith in the Buroughs Wellcome registry or in the AIDS Clinical Trials Group to get this information out to women and their doctors. There has to be a guaranteed funding source for long term follow up of kids born to mothers on this study.

FUTURE CONCERNS FOR MOM

The women that were given these massive doses of AZT had high T-cell counts. It is against the standard of care to take AZT with high T-cell counts. Are these women going to have cervical cancer as a result of this exposure? Will they be able to use the drug for themselves when they need it? They may not know that they are at increased risk for cervical problems and that AZT may not be effective for them if and when they need it. No one has told them that by taking this drug now, they can be excluded from a number of other trials that may prolong their lives.

It's rapidly becoming standard for HIV positive pregnant women to take this drug. All concerned need to take a serious look at this situation. We have states that are trying to mandatorily screen pregnant women for HIV and mandatorily put them on a regimen of high dose AZT during their pregnancy.

ALERT THE COMMUNITY

Our immediate demand is to put a hold on all activity surrounding policy based on these prematurely released results of this one study. If AZT is relabeled to say that it is effective in reducing the rate of transmission it will create a whole set of subsidiary problems. We must put a hold n going forward with any recommendations. We must get the message out to people that they need to think very carefully and seriously about this. We need to do some further investigating so that things don't spiral out of control and lead to mandatory testing. We need to avoid putting pregnant women on AZT automatically. We need to think about the 80% of these kids who would be born HIV negative anyway, and that could dye from unnecessary exposure to highly toxic drugs. We want you to put things on hold until you can really look at all the issues surrounding this trial. These issues are serious and complex.

We want a sense of urgency about putting things on hold. Alert the pediatricians as to these negative kids who were exposed to AZT. Release a medical alert and encourage a medical watch. We seriously question the reliability of AZT as a possible prophylaxis for mother to infant transmission.

OTHER OPTIONS

There are studies showing a reduction in the rate of transmission by the same percentages. These studies are being done with vitamin A. HIV positive pregnant women can become vitamin A deficient. Given enough vitamin A to make up for this deficiency, helps to reduce the rate of mother to fetus transmission. HIV positive women who want to have children should be aware of all their choices.

ULTIMATE RESPONSIBILITY

It's now incumbent upon the FDA as the regulatory agency to ensure that a clinical alert be implemented. AZT must not be re-labeled as a prevention for mother to infant transmission based on this study. There's increasing evidence that the methods used in this study can endanger the lives of HIV+ women and their children. No guidelines for the use of AZT during pregnancy should go forth based on this one trial, 076.

The entire public health services including the FDA, HHS, CDC, and the NIH must take responsibility for releasing a clinical alert and a policy hold on AZT in pregnant women. ■

The Fourth Annual Los Ange
WOMEN & HIV: WE ARI

Conference P

Francess E. Page, BSN, MPH
Service Fellow
Prevention Specialist

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Executive Office of the President
Washington, D. C. 20503
(202) 690 5580
Fax (202) 690-7560

Morning Program

8:00 - 8:45 — *Registration* - Lobby Area
Continental Breakfast - Second Floor

8:45 - 9:00 — *Welcome & Introductions*
Patricia Griffin - L. A. Shanti, Trustee for the National Community AIDS Partnership, Women at Risk

9:00 - 10:00 — *Personal Stories*
A Panel of Women Living with HIV

10:00 - 11:15 — *General Medical Overview*
Frances Page, R.N., A.D.N., D.S.N., M.P.H., Service Fellow/Prevention Specialist, Office of National policy, Washington, D. C.

11:15 - 11:45 — *Update on Women's Health [illegible]*
Judith Currier, M.D., Associate Medical Director, 5P21 Clinic LAC/USC County Hospital

11:45 - 12:00 — **BREAK** - Please visit the information & exhibit tables located all around the hotel.

12:00 - 1:00 — **LUNCH** - Plaza Room, Tulips Restaurant

Afternoon Program

Track A: Medical Issues 1:10 - 2:10

1. *Gynecological & Obstetric Issues, Update '94*
   Coordinator: Jessie Grutadauria, AIDS Healthcare Foundation
   Speaker: Rose Vasquez, R.N., Family Nurse Practitioner, Director of Women's Clinic, Downtown AIDS Healthcare Foundation Clinic

2. *Nutrition & Complementary Therapies*
   Coordinator: Rubén Gamundi, M.D., Bilingual Treatment Advocate, AIDS Project Los Angeles
   Speakers: Laura Vazzo, R.D., Harbor UCLA
   Carla Neumeier, R.D., Santa Monica Hospital
   Jennifer Furin, M.A., UCLA

3. *Basic Medical Therapies: A Community Perspective*
   Coordinator: Arlene Frames, L. A. Center for Alcohol & Drug Abuse
   Speaker: Deborah Y. Wafer, R.N., B.S., C.N.P., Nurse Practitioner/Clinical Researcher, UCLA Department of Pediatrics Nurse
   Cynthia Ramirez, B.A., Research Data Specialist, AIDS Clinical Trials Group - 5P21 Clinic

Track B: Psychosocial/Cultural Issues 2:20 - 3:20

1. *Family, Friends, Lovers, & Me: For Women Both Infected with & Affected by HIV, a Workshop Addressing Relationships, Fears, Stresses, Coping, Growing, & Getting Support*
   Coordinator: Damian Goldvarg, M.S., Latino Family Network, LAPAN
   Speakers: Milly Stoller, Ph.D., M.F.C.C, Addictive Behaviors Coordinator, AIDS Project Los Angeles
   Sylvia Perez, Case Manager, South Bay Free Clinic & Member of Board of Directors, Women at Risk

Financial Sponsors

The planning committee members of *The Fourth Annual Los Angeles Conference of Women & HIV* would like to thank the following for their generous financial assistance:

AIDS Project Los Angeles
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The Audrey Lorde Lesbian Health Clinic of
the Los Angeles Gay & Lesbian Community Services Center
Caring for Babies with AIDS
Tuesday's Child

We want to thank and acknowledge the hard work and generous accommodation of the Radisson Wilshire Plaza Hotel to the conference.

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USCM AIDS/HIV PROGRAM

AIDS INFORMATION EXCHANGE

November 1994
Volume 11, Number 4

Safer-Sex Relapse: A Contemporary Challenge

Though gay and bisexual men were once thought to be a population no longer in need of HIV prevention education, relapse, the term commonly used to describe a reversion from the practice of safer sex to unsafe behaviors, has now become a significant challenge for the HIV prevention community. Researchers and HIV prevention specialists are now investigating the causes of safer-sex relapse among gay and bisexual men. Most agree that the causes of relapse are numerous, but psychosocial characteristics appear to be a common denominator. Safer-sex relapse is a challenge that will require long-term strategic thinking to minimize its consequences.

The use of the term relapse in addressing these instances of unsafe sex is itself subject to contention. Much of the debate stems from utilizing the traditional models of relapse and addictive behaviors to address unsafe sexual practices and long-term behavior maintenance problems. Some perceive the term as having many negative connotations, as well as implications of failure. Others have readily adopted the term to describe a kind of behavior that is now frequently witnessed. But whatever the terminology, educators and researchers believe that consistent and population-specific interventions are necessary to address the problem. This is especially important since research indicates that accurate education, behavioral change support, environmental support, and positive reinforcement that leads to personal decisions for long-term behavior maintenance are necessary to prevent a reversion to unsafe sexual practices.

There is also a political side to the relapse issue. For many years, funding to programs targeting gay and bisexual men has been reduced or remained constant. The apparent success of programs targeting gay and bisexual men coupled with the need to reach other communities that had not received targeted HIV prevention messages often motivated these funding decisions. An attitude that HIV prevention could be carried out as a hit-and-run operation (target one community and then move on to another) emerged. The apparent failure of this approach indicates that HIV prevention efforts will require long-term funding commitments if behavior change is to be maintained. This comes at a time when there is fierce competition for what many consider to be insufficient HIV prevention funds. The need to sustain or in some cases re-initiate programs targeting gay and bisexual men will mean added stress to those setting priorities and making decisions at the local level.

HIV continues to devastate the gay community. Between July 1993 and June 1994, of the 11,546 HIV infections in men reported to the U.S. Centers for Disease Control and Prevention (CDC), 47 percent were among men who have sex with men. Given the number of HIV infected gay and bisexual men and recent studies indicating that many younger gay and bisexual men are not adopting safer sex behaviors, the issue of relapse is an especially important and timely problem. The recent experiences of the gay and bisexual community with relapse may provide valuable insight in designing both current and future HIV prevention programs. This issue of ***AIDS Information Exchange*** (AIX) will examine relapse from safer to unsafe sexual behaviors by exploring issues related to this challenge, reviewing selected studies, and discussing programs addressing relapse at the local level.

Prevention Theory: Understanding Current Efforts

The gay/bisexual community's AIDS prevention efforts have been praised as one of the most successful education efforts in the history of public health. The apparent success of these efforts has made relapse difficult for some to acknowledge and address, especially as the demand for resources has increased and as new populations in need of prevention education have