Bristol Myers file

Secure the Future

Bristol-Myers Squibb Rolls Out a $100 Million AIDS Initiative to Change the Course of the HIV Pandemic in Five Southern African Nations. Will *Secure the Future* Work or Is It Too Little Too Late?

Gordon Nary

When the Bristol-Myers Squibb (BMS) *Secure the Future* initiative was announced May 6, 1999, at a Washington, DC, press conference, the response from AIDS community representatives was generally positive. Initial major media coverage of the initiative was spotty. *The Wall Street Journal* exclusive on the BMS roll-out canceled out *The New York Times*'s interest in the story. CNN was too focused on Yugoslavia and Jenny Jones.

Although there are some exceptions, the US media in general does not have a good track record on Afrocentric issues. Compare the amount of space and time devoted to the ethnic cleansing in Kosovo to the space and time devoted to ethnic cleansing in Rwanda. With the exception of *USA Today* and *Time*, there has been little attention paid to the 11.5 million AIDS deaths in Southern Africa. There has been no Princess Diana or Mother Teresa garnering world headlines about the imminent death of the 20 million people infected with HIV in sub-Saharan Africa who have no access to AIDS drugs. There has been little interest in the nearly 8 million children orphaned by AIDS in Southern Africa other than President Clinton's World AIDS Day promise of US help that was never kept.

The lack of media attention to the pandemic in Africa is compounded by the general cynicism about any story that portrays corporate America, and especially the pharmaceutical industry, as compassionate. The last time in memory that we heard about corporate compassion was in *Miracle on 34th Street* when the Macy's Santa Claus referred Christmas shoppers to rival Gimble's if they had better or cheaper merchandise. But Macy's had Santa arrested and made him undergo a sanity hearing.

In a climate of public apathy and cynicism, Bristol-Myers Squibb announced a plan to invest US$100 million plus over five years in a variety of Afrocentric programs designed to:

- reduce the transmission of HIV;
- provide medical training to physicians to serve as clinical researchers and clinicians;
- develop model programs for HIV/AIDS management that are tailored to the resource limitations within each of the target countries;
- jump-start investigator-initiated trials of AIDS drugs for South African women and children as the primary source of access to such drugs;
- provide care for hundreds of thousands of AIDS orphans; and
- support a wide range of initiatives through local non-governmental organizations (NGOs) designed to empower women.

The five countries targeted to benefit from *Secure the Future* are Botswana, Lesotho, Namibia, South Africa, and Swaziland in which approximately two-thirds of all new HIV infections globally occur, but which most of us may never have heard of previously, could not locate on a map, or even spell (Figure 1).

In announcing its *Secure the Future* initiative, Bristol-Myers Squibb also took time to acknowledge the need for an organization to provide ongoing assessments of the initiative's objectives, activities in and impact on the five participating Southern African countries. The International Association of Physicians in AIDS Care (IAPAC) stepped up to that challenge at the initiative's roll-out May 6, with an announcement that the association will serve as a *Secure the Future* monitor.

"Our monitoring goals will include recognizing objectives met, flagging potential deficiencies, recommending programmatic adjustments, and drawing more widely applicable lessons to guide decision-making around future initiatives," said IAPAC Deputy Director José Zuniga, who visits Uganda in mid-May as an independent observer of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Drug Access Initiative.

Zuniga explained that as a monitor, IAPAC will provide independent, objective evaluations of the context, framework, objectives, activities, impact and, ultimately, sustainability of this model drug access and medical education initiative.

IAPAC will make *Secure the Future* monitoring reports available to Bristol-Myers Squibb; to the partners advancing the initiative; to the governments of Botswana, Lesotho, Namibia, South Africa, and Swaziland; and to IAPAC's more than 6080 members in 43 countries. *Secure the Future* monitoring reports and independent observer features about the UNAIDS Drug Access Initiative will be featured in the *Journal of the International Association of Physicians in AIDS Care* and, subsequently, on IAPAC's Web site at www.iapac.org.

Possibly the most challenging feature of *Secure the Future* is an absence of structure. There is no master plan in place designed to reach the specific objectives of the initiative. The reason is simple—there is no model to follow. However, there is a blueprint for action as laid out by Hoosen Coovadia (see pages 38-40) that could be used as a checklist to assess whether *Secure the Future* is on the right track.

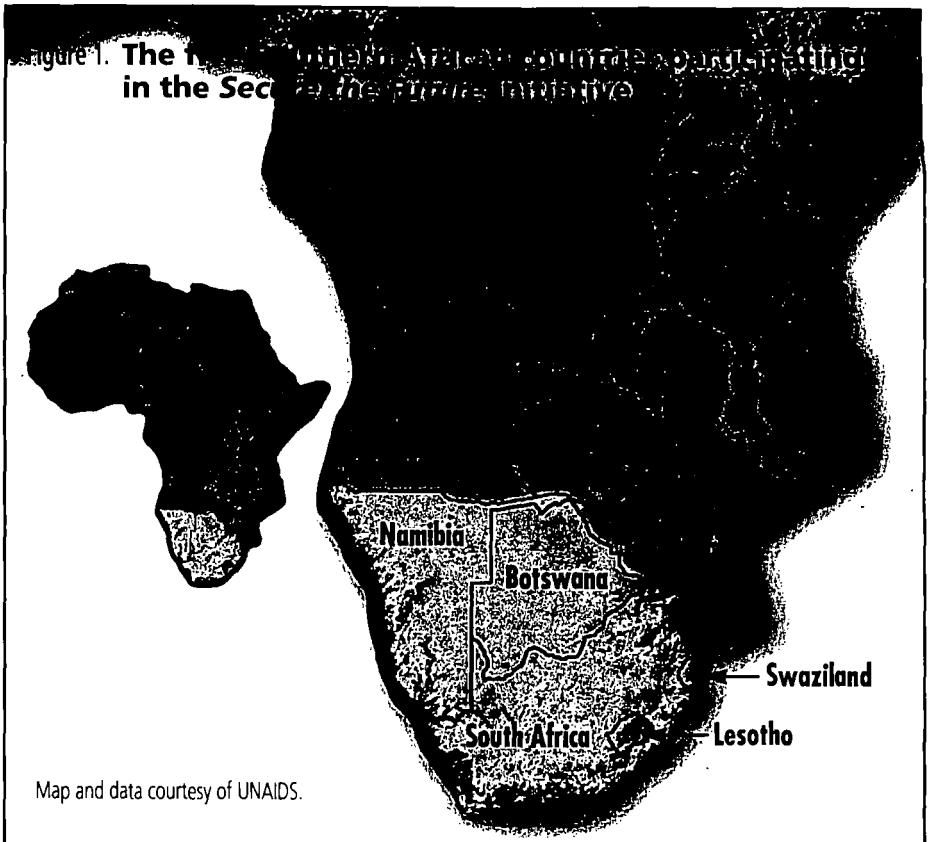


Figure 1. The [illegible] in the Sec[illegible] initiative

Map and data courtesy of UNAIDS.

Botswana

In a country of 1.5 million people, 190,000 (13 percent) were infected with HIV as of year-end 1997. Of these, just under half (93,000) were women ages 15-49. More than a third of the pregnant women were HIV-positive. There were 28,000 living children who had been orphaned by the disease, and another 7300 children infected by HIV.

Lesotho

In a country of 2.1 million people, 85,000 (4 percent) were infected with HIV as of year-end 1997. Of those, 41,000, or just under half, were women ages 15-49. One in five pregnant women were HIV-positive. There were 8500 living children who had been orphaned by the disease, and another 3100 children infected with HIV.

Namibia

In a country of 1.6 million people, 150,000, or nearly one in 10, were infected with HIV as of year-end 1997. Half of those were women ages 15-49. Roughly a quarter of pregnant women were HIV-positive. There were 7300 living children who had orphaned by the disease, and another 5000 children infected with HIV.

South Africa

In a country of over 43 million people, an estimated 2.9 million (7 percent) were infected with HIV as of year-end 1997. Of those, half were women ages 15-49. Among pregnant women, 16 percent were HIV-positive. There were 200,000 living children who had been orphaned by the disease, and another 80,000 children infected with HIV.

Swaziland

In a country of just under a million people, nearly 9 percent (81,000) were infected with HIV as of year-end 1997. Of those, more than half (41,000) were women ages 15-49. More than a quarter of pregnant women were HIV-positive. There were 7200 living children who had been orphaned by the disease, and another 2800 children infected with HIV.

Putting a price tag on the landmark jury verdict against Big Tobacco could take longer than the year-and-a-day trial, but industry analysts predicted yesterday that the Florida state court verdict will not stand.

"The general view is the Miami verdict will end up being overturned by the Florida Supreme Court," said Jonathan Fell, a tobacco specialist at Merrill Lynch & Co., who predicted the slight impact on stock prices would be "short-lived."

Tobacco analyst David Adelman of Morgan Stanley Dean Witter called it likely the state high court will decertify the class action as making it doubtful the strategy would be copied in state courts across the country. The decision was handed down Wednesday in the Florida state court.

"Whether it's three days or three weeks, the marketplace will come to realize that this is not a serious threat to the industry," Mr. Adelman said.

The stock market closed before Wednesday's verdict; yesterday, Philip Morris Cos. closed up 5/16, a 1 percent rise, while R.J. Reynolds Tobacco Holdings Inc. fell ¾, or 2.4 percent.

That trading occurred as Circuit Judge Robert Kaye was hearing the first post-trial arguments about [illegible] to dec

Washington Times 7/9/99 p.A3

[illegible] deserve to collect and, if so, how much.

They would have to prove such specifics as whether they were influenced by any false or misleading documents, and whether they even knew of them, said Washington lawyer Victor Schwartz. He said the final verdict contained serious charges but generally reflects what's printed on the cigarette package.

"What the jury did was provide a skeleton, but they haven't provided a staircase for any one plaintiff to get up to the top of the building," Mr. Schwartz said.

"Now each plaintiff would have to show that her heart disease or his lung cancer was caused by but 50 million people quit so not everybody is beyond help."

Each person's own responsibility in ignoring health warnings will be a key factor, particularly the lead plaintiff, Howard Engle of Miami Beach, a pediatrician with emphysema who presumably knew better.

Another is Tom Keating of Delray Beach, 73, a former Philip Morris representative who blames his nose and throat cancer on 31 years of a two-pack-a-day habit. Each claim must be against the company whose cigarettes were smoked.

Those first hearings should begin in two weeks, argued Stanley and Susan Rosenblatt, attorneys for the nine named plaintiffs and the "class" estimated at 500,000 Floridians who may have tracted some illness from smo

The first-phase verdict wa sixth-ever jury verdict to h company liable for smo health, and the first in a clas tion. Three earlier ones were turned on appeal, the latest in ruary. Two individual ver against Philip Morris, $51.1 lion in California on Feb. 10 $81.1 million in Oregon on M 30, have not gone through the peals process yet.

The husband-and-wife l team sued for $200 billion in name of 500,000 Floridians t estimated became sick by sm ing. Their last clients won noth from a $349 million settlement

"Once again David slew G ath," said Kathleen E. Scheg, a l

Satcher: Churches have been silent on sex

By Larry Witham
THE WASHINGTON TIMES

Surgeon General David Satcher told a national conference on sexuality and black churches yesterday that religion's avoidance of sex issues has allowed AIDS and other diseases to ravage minorities.

"The church has been silent on this issue for a long time — too long," Dr. Satcher said in an address at the Howard University School of Divinity, site of the third National Black Religious Summit on Sexuality.

He said that 64 percent of AIDS victims among blacks are ages 13 to 24.

"It has become increasingly an epidemic of people of color, an epidemic of women and of the young," he said. "If we don't talk about sex, sex can kill."

Dr. Satcher, the nation's top health official, said that death rates from AIDS and heart disease in the black population are high, and that sexually transmitted diseases such as syphilis are 30 times that of the population.

"[AIDS] has become increasingly an epidemic of people of color, an epidemic of women and of the young. If we don't talk about sex, sex can kill."

—Surgeon General David Satcher

"The gaps between the black and whites, the Hispanics and whites, is very wide," he said, calling the trend "disparities in health" that have roots in poverty and discrimination.

Yet he also challenged black church leaders and educators to take responsibility for the sexual, eating and exercise habits of their public. "Over half the deaths in the country each year are due to human behavior," he said.

Dr. Satcher, a former medical college president and head of the Centers for Disease Control and Prevention, was the main speaker at a three-day conference that has drawn 600 participants from 25 states.

Ending today, it is organized by the Black Church Initiative of the Religious Coalition for Reproductive Choice, a group founded by Protestant, Jewish and Humanist groups as a pro-choice policy voice.

Yesterday, 150 black teens were honored for graduation from a seven-week, church-based sexuality course called "Keeping It Real."

The course, led by a youth minister or trained lay leader, relates sexuality to the Bible, family, identity, peer pressure, the church and "life choices."

To expand the black church initiative, a training video for those leading a "Keep It Real" course was produced here this week; in the spring, regional summits on sexuality were held at church and theology schools in Los Angeles, New Orleans, Atlanta and Nashville, Tenn.

In a morning sermon, Howard theology professor Kelly Brown Douglas preached against the "sin of homophobia." The Rev. Amos Jones Jr., a Baptist educator from Nashville, came to the summit to speak on a Sunday School curriculum teaching the Christian ideal of heterosexual marriage.

Organizers said that although such differing views on Christian sexuality are part of the summit, "most of these people are abstinence first" when it comes to responsible and safe sex.

In his talk, Dr. Satcher also emphasized self-esteem, nonsexual friendships and abstinence as the first lines of defense against teen pregnancy and sexually transmitted disease.

"We have to help teen-agers understand there's nothing wrong with abstaining from sex," he said.

What is more, he said, "you should know how to protect yourself and others, and that has to be

David Satcher

a message of the church as well." That suggests information abou condoms and birth control.

Dr. Satcher said young people should be taught that sex is for a "committed relationship." In an interview, he said he avoids the term "marriage" to keep his message culturally broad. "We want to reach people who are in committed relationships," he said.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

October 15, 1998

Todd Summers
White House Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503

Dear Mr. Summers:

I invite you to attend a meeting on Tuesday, November 10, at the Sheraton Colony Square Hotel, 188 14th Street, N.E., Atlanta, GA 30361 to continue planning for the 1999 National HIV Prevention Conference. This conference, scheduled for late August 1999, will provide a venue for sharing new prevention approaches and research findings among governmental, community, and academic partners in HIV prevention. The purpose of our November meeting is to review and provide input into plans that have been developed to date regarding conference format and content. The meeting will begin at 9:00 a.m. and end at 4:30 p.m. Please make your travel plans to allow you to attend the entire meeting.

We have reserved a block of sleeping rooms at the Sheraton Colony Square Hotel for the night of Monday, November 9. Please call the hotel at (404) 892-6000 before **October 23** to confirm your reservation with a credit card. The room rate is $85.08 plus tax. A hotel fact sheet is enclosed.

Please call Karen Turner-Abubakar at (404) 639-2918 to confirm your attendance at this planning meeting. If you are unable to attend, you may send a representative in your place.

I look forward to meeting with you.

Sincerely,

Ronald O. Valdiserri, M.D., M.P.H.
Deputy Director
National Center for HIV, STD, and TB Prevention

Cc:
Dr. Kevin DeCock
Ms. Sue Dietz
Dr. David Holtgrave
Dr. Helene Gayle

Enclosures

RSVP - No

ATLANTA, GEORGIA

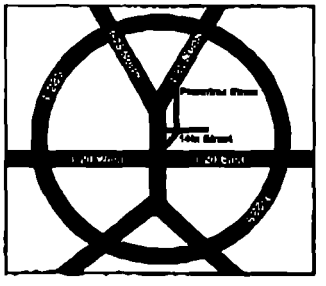
Sheraton Colony Square HOTEL

MIDTOWN ATLANTA

ITT Sheraton

PEACHTREE AND 14TH STREETS • ATLANTA, GA
(404) 892-6000 • (800) 325-3535 • FAX: (404) 876-3276

Owned and operated by Starwood Lodging Corporation



DIRECTIONS: From Hartsfield International Airport: Take I-85 north through downtown Atlanta. Exit at 14th Street, turn right and go three blocks to Peachtree Street. Entrance to hotel is on the left just beyond the traffic light at Peachtree Street.

NEARBY ATTRACTIONS:

- Atlanta Botanical Gardens
- Atlanta Cyclorama
- CNN Center
- Fernbank Science Center
- Georgia State Capitol
- High Museum of Art
- Jimmy Carter Presidential Library & Museum
- Margaret Mitchell House
- Martin Luther King, Jr. Historic District
- Piedmont Park
- SciTrek Museum
- Six Flags Over Georgia
- Stone Mountain
- Turner Field
- Underground Atlanta
- Woodruff Arts Center
- The World of Coca-Cola
- Zoo Atlanta

For reservations at any of our Sheraton Hotels or Resorts worldwide, call toll-free: 800-325-3535 in the USA and Canada, or contact your nearest Sheraton Hotel or Reservations Office, or call your travel agent.

For a free ITT Sheraton Worldwide Directory, write
ITT Sheraton Directory, Sixty State Street, Boston, MA 02109 USA

FACT SHEET

LOCATION:

The Sheraton Colony Square Hotel is located in the heart of Midtown, Atlanta's art and business district. It is only 5 minutes from downtown, 20 minutes to Hartsfield Atlanta International Airport. MARTA (mass transit) is just one block away.

ACCOMMODATIONS:

The Sheraton offers 467 beautifully appointed guestrooms - 27 one-bedroom suites, 3 deluxe suites. These rooms feature in-room coffee makers, iron and ironing boards, remote control cable television and in-room movies; telephone voice mail and dataports.

Also featured are 2 levels of beautifully appointed Concierge Rooms. These rooms offer upgraded amenities, private elevator access, with complimentary American breakfast in the morning and hors d'oeuvres each afternoon. Non-smoking rooms are available.

RESTAURANTS AND LOUNGES:

The Sheraton Colony Square Hotel welcomes you to its 14th Street Bar and Grille featuring American cuisine. Enjoy our bountiful breakfast and lunch buffet.

Hours of Operation:	6:30 am-11:00 am	Breakfast
	11:30 am - 2:00 pm	Buffet Lunch
	2:30 pm - 5:30 pm	Light Fare Menu
	5:30 pm - 10:00 pm	Dinner
	10:00 pm - Midnight	Light Fare Menu

The "Lobby Bar" is open 4 - 10 pm daily.

CONFERENCE BANQUET FACILITIES:

The hotel offers over 36,000 square feet of meeting and banquet space. The Crown Room at the top of the hotel offers one of the most magnificent views of the city.

The Ballroom can comfortably seat 800 people for a banquet.

The Southern Conference Center is sanctioned by IACC as one of the best conference centers in Atlanta.

HEALTH AND RECREATION FACILITIES:

The Sheraton features a fitness center - complimentary to our guests - and a seasonal outdoor pool and sundeck located on the 5th floor.

OTHER AMENITIES:

Valet service, secured underground parking and a mini-mall complex, concierge, safe deposit boxes, business center.

20th ANNIVERSARY
NATIONAL LESBIAN & GAY HEALTH CONFERENCE
and
16th NATIONAL AIDS/HIV FORUM
JULY 25-29, 1998

August 20, 1998

Todd Sommers,
The White House/Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503

Dear 1998 Conference Registrant:

We were pleased that you were a part of our 20th Anniversary National Lesbian and Gay Health Conference and 16th National AIDS/HIV Forum in San Francisco. Your participation contributed to making it quite a memorable event.

I am writing for two reasons. The first is to thank you for your continued support of NLGHA's efforts to provide meaningful educational forums for the LGBT health community and our allies. The second, is to alert you to the fact that our records indicate that we have yet to receive payment of your registration fee.

Please send your payment of $$275 with the enclosed registration form to: Registrar, 20th Anniversary NLGHA Conference, P.O. Box 33022, Washington, DC 20033. To pay by credit card, please fax your form to 202/234-1467 or visit the conference page of our website at "www.nlgha.org".

If you have received this is error, please fax confirmation of your payment and accept our sincere apology.

Sincerely,

Beverly Saunders Biddle

Beverly Saunders Biddle, MHA
Executive Director

Enclosure

Check Sept 15

NLGHA
The National Lesbian & Gay Health Association

Legacy of Leadership

P.O. Box 33022 ■ Washington, DC 20033 ■ 202-939-7880 ■ 202-234-1467 (fax)

20th Anniversary NLGHA Conference Registration Form

Registration Fees

After May 31, 1998:
member/partner: $250
non-member: $275

On-site:
member/partner: $300
non-member: $350

***Members of our partnering organizations register at NLGHA member rates.**

Visit our new website and register online: www.nlgha.org

Please type or print

Name *(to appear on badge)* _____

Credentials (e.g., M.D., Ph.D., PA-C) _____

Affiliation _____

Address _____

City_____ State_____ Zip_____ Country _____

Daytime Phone (Required) _____ Fax _____

○ Yes, I would like my name and contact information added to a list of conference participants to be distributed at the conference.

REGISTRATION FEES* *(check appropriate category)*

○ After May 31, 1998: member/partner: $250; non-member: $275
○ On-site: member/partner: $300; non-member: $350
○ Student: $150

Registration Fee $_____

** All registration fees include admission to one Pre-Conference Institute*

PRE-CONFERENCE INSTITUTE SELECTION:*
(please check one box to indicate ONE full-day institute you will attend)

○ Bisexuality & HIV Prevention ○ Transgendered Health ○ Youth
○ Gay Male HIV Prevention Work in a 'Post-AIDs' Era ○ Ethnic Diversity

If you are only registering for a Pre-Conference Institute, please enclose a fee of $60. Otherwise, it is included in your conference registration fee.

Institute Fee $_____

AWARDS LUNCHEON - Guest Speaker (TBA)
NLGHA will present awards on Tuesday, July 28, 12:30 -2:00 pm.
(No additional charge, included in Registration Fee):

○ Yes, I will attend. ○ No, I will not attend.

ACCESSIBILITY: *The Hyatt Regency in Embarcadero Center is wheelchair accessible. Please indicate below if you need assistance with any of the following. We are unable to accommodate on-site requests.*

○ Childcare ○ Sign Language Services ○ Other _____

MEMBERSHIP: *I am not a member, but I would like to join at the level indicated:*

○ Sustaining Member @ $100 ○ Full Member @ $60 ○ Associate Member @ $35**

Add Membership Fee + $_____

*(**Although we welcome Associate Members, this level does not entitle member to any reduction in conference fees)*

SCHOLARSHIP FUND CONTRIBUTION: *Your tax-deductible contribution will be used to defray registration fees for those who cannot afford the full amount.*

Contribution Amount + $_____

GRAND TOTAL $_____

PAYMENT: ○ Check/Money Order Check Number _____

○ Credit Card ○ Visa ○ Mastercard ○ American Express

Credit Card #: _____ Expiration Date: _____

Signature: _____

The Federal Tax I.D. Number for NLGHA is 52-1968512.

Please mail completed form to:

NLGHA
The National Lesbian & Gay Health Association

Registrar, 20th Anniversary NLGHA Conference
P.O. Box 33022, Washington, DC 20033
Credit card registrations may be faxed to: (202) 234-1467

Fall 1998 Interns
National Aids Policy

Daniel Montoya

LAST	FIRST	DEPARTMENT	START_DATE	LEAVE DATE
Seymour	Emily	National Aids Policy	9/9/98	12/23/98
Stewart	Kelli	National Aids Policy	9/2/98	12/23/98

Dear Sandra

Here are some papers a inmate from the Unit my son was at sent to me. Our paper here is going to run it here and do a interview with me in two weeks about my son Jeremy and his medical care. I just wanted to share these with you. I called the number you sent and left a message. Thank you for every thing you and President Clinton are doing. And we pray that he runs for office again. We need him very much. Thank you very much.

Sincerely
Pam Colvin

Texas Monthly
Reporter
THE STATE OF OUR STATE · EDITED BY EVAN SMITH

Rx for Scandal

The quality of health care in the Texas penal system is criminal.

by Janet Heimlich

Death sentences: *Sixteen inmates who died received "improper care."*

PURELY IN TERMS OF PUBLIC RELATIONS, IT HAS BEEN a lousy ten months for the Texas penal system. First came the revelation last August that guards at the Brazoria County jail were videotaped physically and verbally abusing inmates. Then, in January, former Texas Department of Criminal Justice (TDCJ) chief Andy Collins was indicted on eight counts of conspiracy, bribery, money laundering, and other charges related to the VitaPro controversy ("The Great Texas Prison Mess," *TM*, May 1996). But the greatest scandal may be one only now unfolding. It has to do with health care in the state prisons, and it's a matter of life and death.

Since 1993, in an effort to contain costs that were among the highest in the country—nearly $2,900 per prisoner per year—TDCJ has had in place a system called Correctional Managed Health Care. Under that plan, two public medical schools, the University of Texas Medical Branch at Galveston (UTMB) and Texas Tech University Health Sciences Center in Lubbock, attend to the state's more than 140,000 inmates. (UTMB oversees the prison-heavy eastern half of the state, or 80 percent of all inmates; Texas Tech handles the rest.) The budget for the next biennium: $582 million, enough in theory to ensure that Texas inmates receive the best and most cost-efficient care possible. And, in fact, thanks in part to cost savings implemented by the schools, the per-prisoner cost has dropped to $1,900 a year. But the quality of care has also dropped—dramatically.

Two years ago, for example, investigators at TDCJ and UTMB reviewed the medical records of 24 inmates who had died at the Stiles Unit in Beaumont, where hundreds of prisoners with AIDS are housed, and concluded that 16 had received "improper care." They reported that inmates with serious illnesses—even those displaying such critical symptoms as persistent fever, weight loss, and shortness of breath—were left in their cells unattended or denied visits to specialists. Referring to a case in which a prisoner died from complications related to AIDS and an undiagnosed cryptococcus infection, one investigator wrote: "There was no evidence of any active treatment

at Stiles, and it appears that this inmate was essentially left to die in the infirmary." Likewise, last September the Texas Department of Health found dozens of deficiencies at the UTMB-run Estelle Prison Dialysis Center in Huntsville. According to the investigators' report, prisoners who were hooked up to machines were unsupervised for long periods of time, some of the center's staff were improperly trained, and poor equipment-cleaning techniques could have resulted in patients receiving contaminated blood—even the blood of other sick inmates.

Considering those findings, it's no surprise that from 1993 to 1996, according to TDCJ data contained in a state audit released in January, inmate medical grievances increased by more than 17 percent, and total "medical correspondence"—usually complaints from prisoners, their families, and prison staff—rose by more than 60 percent. Some prisoners said they'd been denied medication, tests, and supplies—one prisoner who had undergone major back surgery said a doctor confiscated his walker, leaving him to crawl or lean on other inmates or use a single crutch to get around—and some prison staffers, especially those at UTMB-managed facilities, admitted to being "shocked" at the low standard of care. Jana Hawkins, a nurse who worked at Stiles until she quit last summer, says UTMB administrators frequently sent out memos reminding the staff not to give prisoners "comfort measures" such as Tylenol for headaches and athlete's foot cream (unless there were "breaks in the skin"). Hawkins says that some inmates who could not walk—including a "brittle" diabetic with one leg—were not allowed wheelchairs. And understaffing was a common problem. "You've got a bunch of very stressed people trying to give good quality health care," Hawkins says, "and that's just not possible."

In an interview, the medical director of UTMB's managed-care program, Dr. Jason Calhoun, denied many of those allegations. He insisted that prisoners are being seen more often, for instance, and that the percentage of staff vacancies has decreased since UTMB and Texas Tech took over. Moreover, he said, AIDS deaths systemwide are dow by 25 percent. "We have significantly improved quality measures, whether we're talking about mortality, access to care, or timeliness of visits," he said.

Yet quality of care isn't the only troubling issue. There's also oversight. "Correctional Managed Health Care lacks a comprehensive monitoring system," the state's audit reported. Critics say the same: They note that four of the six members of the system's oversight body—called the Correctional Managed Health Care Advisory Committee—work for UTMB or Texas Tech, the two schools that have the contracts. "This type of relationship, in the private sector, would raise questions about conflicting loyalties between the parties," said state auditors, who, along with Board of Criminal Justice chairman Allan Polunsky, have suggested that the Legislature look at giving TDCJ (which has the other two seats on the committee) more control—or else disband the committee altogether. Complicating matters is the fact that Dr. Michael Warren, who was TDCJ's medical director from May 1994 until this past January, was a full-time UTMB faculty member. Moreover, both the executive director of the managed-care plan, James Riley, and its chief financial officer, James Lynaugh, have been accused by state officials of being "lobbyists" for the universities. (Riley and Lynaugh refused to be interviewed for this story.)

The financial monitoring of the plan has also come under scrutiny. After reviewing the managed-care contracts signed by TDCJ and the universities, auditors concluded that the providers aren't held responsible for how they spend state funds; last year, for example, UTMB was free to pay out nearly $670,000 in doctor bonuses. Further, the universities can spend the "profits" however they choose: In 1996, when they netted $37.3 million, they gave back $12.5 million to the state, carried $9 million forward as a "catastrophic reserve," and pocketed the remaining $15.8 million. Not surprisingly, state legislators are now taking a harder look at the budget for prison health care. At prisoner-safety hearings last March, when Lynaugh boasted that the state could expect to get back millions more in the future, State Senator John Whitmire of Houston cracked, "Someone could just say, 'You're obviously overfunded.' In fact, I will."

Thanks to the investigation, improvements to the system seem to be under way. A TDCJ follow-up audit of Stiles conducted late last year showed great improvements in the processes used to treat infectious diseases, and the dialysis problems at Estelle have been corrected. Also, in May the staff of the Sunset Advisory Commission recommended that the Legislature make changes to the managed-care oversight committee—including adding three non-university members and giving TDCJ more control. All are hopeful signs—but from the looks of things, it will still be a while before the Texas penal system recovers from its latest PR black eye. ✦

Prison dialysis clinic deficient, report finds

Operators say many problems corrected

By Christy Hoppe
Austin Bureau of The Dallas Morning News

AUSTIN — The state prison's kidney dialysis center, serving 100 inmates, has been operating with serious and potentially life-threatening deficiencies, state health inspectors determined last month.

The inspection report, obtained by *The Dallas Morning News*, states that patients were left on dialysis machines unattended and technicians cut dialysis sessions short before consulting a nurse or doctor.

Dialysis machines also were not being properly maintained, and inspectors found conditions where patients could be "cross-contaminated" with each other's blood. Many of the patients are HIV-positive.

The center, in the Estelle Unit in Huntsville, is one of nine clinics statewide that has been subjected to Level 3 correction, the most stringent allowed, according to health department records.

At the other eight clinics, patients were informed of the serious deficiencies to allow them to change clinics, if they chose, while the problems were being corrected, health department officials said.

Such an option isn't available to inmates.

The prison center is operated by the University of Texas Medical Branch-Galveston through a managed care contract with the Texas Department of Criminal Justice.

UTMB administrators say most of the problems highlighted in the July 7-8 inspection already have been corrected.

"We have responded to this 99-page report. We've responded to it point by point," said Dr. Robert Safirstein, the newly appointed medical director of the Estelle dialysis unit.

Dr. Safirstein was asked by UTMB to assume stewardship of the unit in May and said he had observed many of the same problems underscored in the health inspection. He said he already had begun implementing corrective actions.

He said since the report, he has dismissed some staff, added new personnel, changed suppliers of the treated water system for dialysis

"In many ways [inmate patients] don't have a choice, and that means more pressure on us," Dr. Safirstein said. "There's no compromising on delivering health care to these patients."

Dr. Safirstein said he knows of no deaths or contaminations at the clinic, and that the mortality rate at Estelle is better — 17 percent — than the national norm, which is 25 percent.

Under an agreement with the state prison system begun three years ago, UTMB provides managed health care to about 70 units in South and East Texas for a maximum of $406 million. The prison units in West Texas are cared for by the Texas Tech University Health Science Center for a maximum of $65 million.

The UTMB system was the subject of a January article by *The News*, which reported the system had hired at least eight doctors to treat prisoners, although the doctors were under licensing restrictions because of professional misconduct, according to the Texas Board of Medical Examiners.

At the time, Allan Polunsky, chairman of the board of criminal justice that oversees the prison system, requested an audit of the health care system. That audit is scheduled to be completed in September.

Mr. Polunsky said he was not made aware of the dialysis center inspection.

"The department won't tolerate inferior medical services, and if that is found to be the case here or any other place, I would expect corrective action would be initiated immediately," he said.

Mr. Polunsky said that overall, he believes UTMB and Texas Tech are providing "a good quality of care for inmates. That's not to say there aren't areas that need improvement."

Linda Reaves, founder of Texas Inmates Family Association, said she has not received complaints specific to the dialysis unit, but she hears constantly about other health delivery problems.

"The inmates are incarcerated for the crimes they did and to serve out their punishment. And during that time, I expect taxpayers to get the kind of health care they've paid for," Ms. Reaves said.

She said inmates know that if their ailments are misdiagnosed or poorly treated, there are no second opinions. And the concern is especially high for such procedures as dialysis, she said.

"The alternative is to die. There is no other," she said.

State health department inspection of dialysis clinics began in September 1996, mandated by the Legislature following an outbreak of hepatitis B at a Houston center.

The state has 246 clinics that perform dialysis used for those with kidney failure. A patient is hooked up to a machine that performs the kidney's function of cleansing and filtering impurities from the blood. Each treatment takes four hours and is performed three times a week.

Thus far, about 200 of the clinics have been inspected, and only nine have been deemed to require Level 3 corrective plans, said Derek Jakovich, an enforcement coordinator for the state's Health Facility Compliance and Licensing division.

Level 3 represents "deficiencies that are a serious risk to patient health and safety," according to the health department assessment.

Mr. Jakovich said Level 3 is considered potentially life-threatening and involves a specific improvement plan that must be achieved within six months. An outside monitor must be hired to oversee the changes, he said.

Problems cited in the inspection included:

- Four patients unobserved and left unattended while undergoing dialysis. Caregivers were observed "sitting at a table together chatting" for about 30 minutes.
- The three emergency backup dialysis machines were out of commission, awaiting repairs.
- A peritoneal dialysis patient had his "exchanges in a room designed and equipped as a 'soiled utility room.' " Caregivers were using a piece of physical therapy equipment to warm his dialysis fluid.
- The cleaning process for the dialyzers "would allow cross-contamination." Dr. Safirstein said a monitor from outside the state already has been hired and will begin work at the prison unit next day.

All compliance requirements should be met within two years and he also said he has received permission to renovate the clinic area to provide better care and observation of patients. That construction work will take about a month to complete, he said.

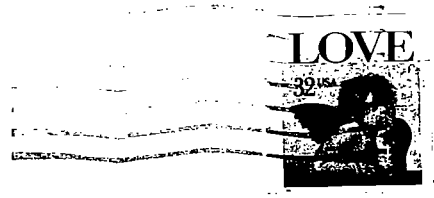
Of the eight other clinics cited needing Level 3 correction, at least three have recently changed management and already have been or soon will be in complete compliance, according to company officers. Those three are Golden Triangle Dialysis of Beaumont, Dialysis Center of Galveston and Brazoria Kidney Center Inc. of Jackson.

A spokeswoman for Biotronik Kidney Center, also of Beaumont, said the clinic has been brought into compliance and is still being monitored.

In Dallas, Elmbrook Kidney Center was cited by the health department. Dr. Jeffrey Thompson declined comment, saying he was concerned that anything he said he don't believe will be reported accurately."

Officials for the other three clinics did not return phone calls. They are Odessa Kidney Dialysis Center, Vivra Renal Care of Northeast Houston and Angleton Dialysis Clinic in Angleton.

Pam Colvin
P.O. Box 183
Denison, Texas
75020



The White House
Sandra F. Thurman
Director
Office of National Aids Policy
Washington, D.C.
20500

SCIENTISTS SAY THEY HAVE TRACED ORIGIN OF AIDS VIRUS

(Discovery may eventually lead to AIDS vaccine)

By Anita Santos

USIA Staff Writer

WASHINGTON -- A team of international scientists have announced they have traced the origin of the AIDS virus to a closely related virus in a subspecies of chimpanzee in Africa.

The scientists, who reported their findings January 31 at the Conference on Retroviruses and Opportunistic Infections, being held in Chicago, said that research will now focus on why the human immunodeficiency virus (HIV) that causes AIDS is lethal for humans while the related virus causes apparently no illness in the chimpanzees, even though humans and chimpanzees are 98 percent genetically similar.

Although scientific researchers have long suspected that HIV-1, the type of AIDS virus that has caused the overwhelming majority of cases in the world, came from chimpanzees, scientists have not been able to identify the precise subspecies until now. The chimpanzee virus is known as SIVcpz, or "simian immunodeficiency virus chimpanzee."

"The chimpanzee, which has served as the source of HIV-1, also quite possibly holds the clues to its successful control," the head of the research team, Dr. Beatrice Hahn of the University of Alabama at Birmingham, said in an interview.

Hahn, whose paper will be published in this week's issue of the journal Nature, said despite the enthusiasm with the discovery, her team is worried about the fact that the subspecies in which SIVcpz was found is at "the brink of extinction" in its natural habitat in West and Central Africa. Hahn believes the chimpanzee's extinction represents a danger to science because much more needs to be learned about the infection in chimpanzees in the wild.

Hahn's team has confirmed the origin of the AIDS virus by analyzing frozen tissue from Marilyn, a chimpanzee who died in 1984 at the age of 26. The researchers have been able to perform various kinds of genetic analysis that were unavailable at the time Marilyn died. The chimpanzee subspecies lives in the African region where AIDS is thought to have started.

HIV presently infects about 35 million people worldwide, with the first infection probably having occurred 50 years ago, scientists have reported. Hahn and her colleagues said that they have conclusive evidence that the HIV virus has spread on at least three distinct occasions. Hahn believes in the theory that humans have been infected from chimpanzees in Africa through exposure to their blood in hunting and when dressing meat. However, why the epidemic came when it did is not known precisely.

Dr. Anthony Fauci, head of the National Institute of Allergy and Infectious Diseases, said in an interview that his federal institute would finance substantial research on the simian virus. He said one focus of the research will be on whether the different outcomes of infection in humans and chimpanzees result from small changes in the genetic makeup of the virus or the host.

The latest findings might lead to new tests to discover viruses in nature that could cause human disease. "No one wants to miss detecting the next HIV epidemic," said Dr. Harold Jaffe, a leading AIDS researcher at the Center for Disease Control and Prevention in Atlanta, Georgia.

Because the chimpanzees are able to live with HIV without developing the illness, scientists hope their discovery will be helpful in improving therapies and eventually developing a vaccine against the AIDS virus.

THE SOURCE OF AIDS
(New York Times 02/02/99 editorial)

(FOLLOWING FS MATERIAL NOT FOR PUBLICATION)

Scientists have believed for some time that H.I.V.-1, the AIDS virus that has infected 30 million humans worldwide, originated in a primate species somewhere in Africa. Now a team of researchers led by Dr. Beatrice Hahn from the University of Alabama has confirmed that the source of H.I.V.-1 is almost certainly a subspecies of chimpanzee called Pan troglodytes troglodytes. This central African subspecies carries a simian version of H.I.V.-1, which was probably transmitted to humans who butchered hunted chimpanzees or handled their meat. Chimpanzees carry the simian version, called S.I.V.cpz, without falling ill. It may be possible to discover in their adaptation to this virus a means of blocking the further spread of H.I.V.-1.

The story of this discovery has a corollary. Pan troglodytes troglodytes is still being hunted, and with a rapacity that will guarantee its extinction before long. Chimpanzee meat, gathered by commercial hunters, feeds loggers in central Africa and even makes its way into urban restaurants. The issue is not just the danger of further cross-species transmission of the retrovirus, tragic as that would be. It is the destruction of a vital genetic reservoir -- the potential source of major innovations in AIDS research -- before research can really get under way. Before the significance of this new discovery can be assessed, it has to be studied among populations of free-living chimpanzees belonging to this subspecies. That will not be possible if they have been hunted to extinction.

There could be no clearer demonstration of the immediate human value of preserving biodiversity. The health of our species depends directly on the breadth of the global genetic pool to which we belong. The cure for disease, as scientists have often demonstrated, can come from the same source as the disease itself. But as always, recognizing the human value of biodiversity -- the utility of these chimpanzees to us -- carries with it a sense of profound sadness, an awareness of how hard it is to value biodiversity for itself. There is still a chance to save these animals, and with luck this new discovery will make their survival more likely.

(PRECEDING FS MATERIAL NOT FOR PUBLICATION)

BY RAY LUSTIG—THE WASHINGTON POST

Reno on Counsel Statute

Attorney General Janet Reno told a Senate panel the independent counsel statute is fatally flawed. But senators expressed doubts about Reno overseeing misconduct probes. Story, Page A2.

Post 5, 1999

U.S. Panel Sees Potential For Medical Marijuana

More Research Urged; Smoking Discouraged

By David Brown
Washington Post Staff Writer

The active substances in marijuana may be "moderately" useful for treating such problems as pain, nausea and appetite loss, but smoked marijuana has little future as a medicine, a panel of experts advising the federal government said yesterday.

The long-awaited review comes after several states have legalized marijuana for medical use, and was immediately seized upon by marijuana's advocates as an endorsement of their position.

"We are very pleased with this report, which clearly shows there is scientific evidence that marijuana has bona fide therapeutic effects for some patients," said Chuck Thomas, the director of the Washington-based Marijuana Policy Project. "Patients already using marijuana should be given the benefit of the doubt, and should not be arrested."

The report, prepared by 11 scientists convened by the National Academy of Sciences' Institute of Medicine, specifically warned against smoked marijuana because of risks of lung damage. Therapeutic marijuana smoking should be permitted only in a few short clinical trials designed to assess claims for marijuana's usefulness as a pharmaceutical.

White House drug control policy director Barry R. McCaffrey, who requested the report, said he

See MARIJUANA, *A9, Col. 1*

Panel Sees Potential for Medical Marijuana

MARIJUANA, *From A1*

endorsed it "thoroughly" and called it a "significant contribution to discussing the issue from a scientific and medical viewpoint." He said he would not oppose limited studies of smoked marijuana until a less harmful way of inhaling the substance's active ingredients is found.

"I would note, however, that the report says 'smoked marijuana has little future as an approved medication,' " McCaffrey said. "You should not expect to go into an ICU [intensive care unit] in 15 years and find someone with prostate cancer with a 'blunt' stuck in his face as a pain management tool."

The 250-page report was prepared over the last year at a cost of $896,000. The panel reviewed published medical studies on marijuana's physiological effects and possible clinical benefits, and took testimony from researchers and patients.

The claims for marijuana are very broad. People have used it as treatment for nausea caused by chemotherapy, appetite loss arising from AIDS, the painful spasms of multiple sclerosis, the pain of migraine headache, the sight-threatening condition known as glaucoma and the memory loss of Alzheimer's disease.

Reliable data on the drug's benefits, however, have been hard to get. The Drug Enforcement Administration places marijuana—along with heroin and several other addictive drugs—in the category reserved for substances with "a high abuse potential." This has made research on patients unusually difficult. Many of the claims for marijuana are based on small, poorly designed studies, or on "clinical anecdotes," the recounted experiences of individuals.

The body produces a marijuana-like substance naturally—its evolutionary purpose is uncertain—which stimulates specific receptors on nerve cells distributed widely in the brain. Marijuana contains about 30 active ingredients, collectively known as "cannabinoids," that also activate these receptors. One cannabinoid drug, dronabinol, is licensed in the United States for use in appetite stimulation in AIDS patients, and to prevent nausea and vomiting caused by chemotherapy.

"There is remarkable consensus about the science—the science suggests the potential of cannabinoid drugs for medical use," said John A. Benson Jr., the former dean of the Oregon Health Sciences University School of Medicine, who was one of the two heads of the panel. "There is far less convincing data about actual medical benefits."

Most studies suggest there are existing drugs that do what marijuana is reputed to do, but better. This was especially true in the case of glaucoma treatment and nausea prevention, the panel found. Nevertheless, a few patients who do not respond to those pharmaceuticals are helped by marijuana.

The panel advocated research aimed at isolating marijuana's ingredients and testing them in randomized controlled trials. An inhalation device is a high priority because it will allow patients to take in the drug as quickly as when it's smoked, without delivering tar and other unwanted substances. In the meantime, studies of smoked marijuana are warranted, the panel said. They should last six months or less, and enroll patients, such as those with terminal cancer, for whom the long-term risks of smoking are relatively unimportant.

The panel found no evidence that closely controlled medical marijuana use would be a "gateway" to illicit drug use, either in ill patients or in society at large.

In the last three years, seven states have passed referenda allowing the medical use of marijuana. Several, however, have run into legal problems, and the statutes have not taken effect.

In the District, a marijuana legalization measure appeared on the ballot in November. Ballots were counted, but the results were not released because Congress prohibited the spending of public money on the legalization effort. The matter is now in federal court.

NAPWA NOTES

A quarterly publication for survivors, friends, donors and members of NAPWA's Health Partners Network.

Fighting for Our Lives

CFC

Support PWA Advocacy

Name

Organization (if applicable)

Street Address

City / State / Zip

Phone

FAX

Email

How can we better serve you?

- ○ I want to support the important health education and advocacy work of NAPWA. Enclosed is my tax-deductible contribution.
  Please check enclosed amount
  ○ $25 ○ $50 ○ $100 ○ $250
  ○ $500 ○ Other _____
- ○ Please send me information on how to join NAPWA's Health Partners Network.
- ○ Please send me more information on how I can contribute to NAPWA's Leadership Circle for tax-deductible gifts of $1,000 or more.

Please detach and mail to:

National Association of People with AIDS
1413 K Street NW
Washington DC 20005-3442
202.898.0414 • 202.898.0435 FAX

www.napwa.org
friends@napwa.org

New Tool for Cutting Through Medicaid Managed Care Jungle

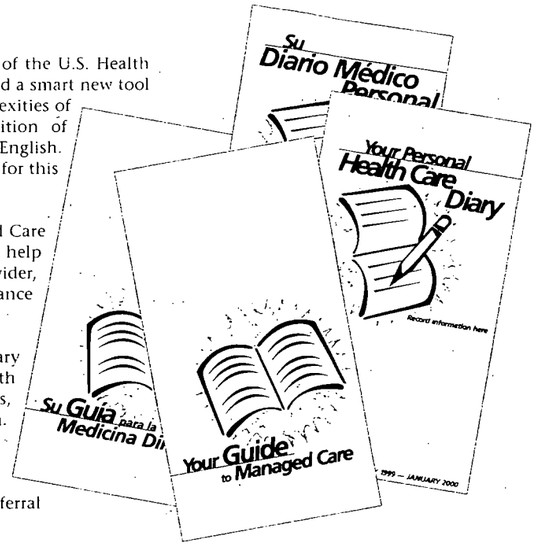
Does dealing with managed care make you want to scream?

NAPWA, in partnership with the HIV/AIDS Bureau of the U.S. Health Resources and Services Administration, has developed a smart new tool to help people living with HIV deal with the complexities of Medicaid managed care programs. A limited edition of NAPWA's "Health Care Passport" is now available in English. A Spanish version will be out in early April. Funding for this project has also been provided by Ortho Biotech.

The passport includes a Guide to Medicaid Managed Care which provides answers to common questions, can help you select a health plan and primary care provider, explains member services and how to file a grievance when you're not getting the right care.

The passport also includes a Personal Health Care Diary which is just perfect for keeping personal health information, keeping track of prescriptions, appointments and all contacts with your health plan.

The Passport is your free guide to better health care. For a copy, fax your name and address to NAPWA Passport at 202.898.0435 or call Information and Referral at 202.898.0414, ext: 115.



National CMV Initiative: Keeping Sight of What's Important

The success of combination therapy has dramatically reduced the number of deaths caused by HIV and the deadly opportunistic infections that strike people living with AIDS.

For the past two years, NAPWA has helped more than 4,000 people living with HIV and their health care providers confront the challenge of cytomegalovirus, a deadly virus which can cause lost of eyesight or other complications if left untreated, through the National CMV Hotline. The hotline provides essential information about CMV for those at risk and offers updates in treatment and research for those living with HIV who have CMV.

After receiving so many calls, NAPWA's education staff seized the initiative and offered free CMV screenings to people living with HIV attending the Poz Life Expos in Los Angeles, San Francisco, and New York City. Several hundred people received information and screening. The screenings were made possible through a partnership with Roche Laboratories.

The good news: no active cases of CMV. The other good news: four individuals were diagnosed with serious ocular complications for which they are now receiving care.

In September 1999, NAPWA will be hosting Seeing Victory: A Roundtable on the Prevention and Treatment of CMV Disease with some of the nation's leading community health advocates, peer educators, treatment activist, physicians, scientist and epidemiologist. This forum, coordinated by Charles Nelson, NAPWA's Associate Director for Health Education, on the eve of the annual Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), will help us chart the next steps in our efforts to stop this deadly virus in its tracks.

For more information call the NAPWA's National CMV Hotline at 1.800.838.9990.

PARTICIPANT RECEIVES AN EYE EXAM AT THE NEW YORK POZ LIFE EXPO CMV SCREENING.

the National Association of People with AIDS

NAPWA NOTES

Winter 1999

Cable Positive, HRSA Join National HIV Testing Campaign Sandy Thurman to Kick Off 1999 Initiative

Cable Positive and the U.S. Health Resources and Services Administration (HRSA) have both signed on as major partners in NAPWA's annual National HIV Testing Day campaign.

The new partnership with Cable Positive, supported by a $100,000 grant, will include the development of public service announcements promoting the message of National HIV Testing Day, "Take the Test, Take Control." Cable Positive will also work with cable operators, programmers and other industry sources to increase awareness of HIV testing and garner industry support for National HIV Testing Day. Building on its previous efforts to promote World AIDS Day, Cable Positive is sure to send a powerful message about the importance of HIV testing.

A $75,000 grant from HRSA will allow NAPWA to specifically tailor new testing efforts to African-American and Latino communities where HIV continues to spread rapidly. HRSA and NAPWA will work together to encourage people from these communities to seek the benefits of early testing and treatment.

White House AIDS Policy Director Sandy Thurman will give the keynote address at this year's Life Awards Luncheon which recognizes leaders who have made a significant contribution to HIV testing and health care services. The luncheon, held each June, serves as the annual kick-off to National HIV Testing Day initiatives nationwide.

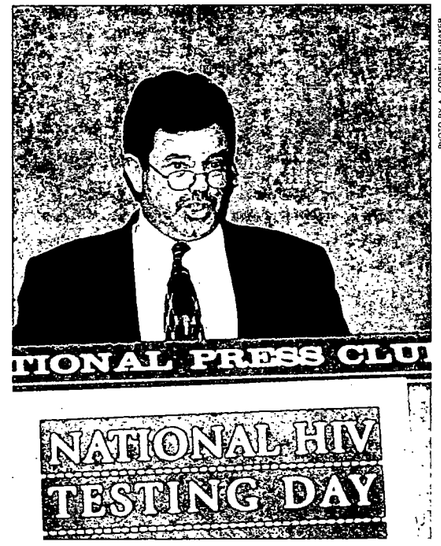


PHOTO BY A. CORNELIUS RAKER

JOE O'NEILL, HRSA ASSOCIATE ADMINISTRATOR FOR AIDS AT THE 1998 LIFE AWARDS LUNCHEON

National HIV Testing Day was started in 1994 by NAPWA in partnership with the National Alliance State and Territorial AIDS Directors (NASTAD) and the National Lesbian and Gay Health Association.

For more information, contact Tony Farmer, Director of Education at 202.898.0414, ext. 147.

Important Upcoming Dates!

Call NAPWA for more information on these and other upcoming events at 202.898.0414.

February 13-15
Ryan White National Youth Conference on HIV/AIDS
Danvers, Massachusetts
Contact: ***Sara Leedom***, ext. 126

March 25
National Testing Day Captain's Training at the HIV Prevention Community Planning Summit
Pittsburgh, Pennsylvania
Contact: ***Tony Farmer***, ext. 143

April 29-May 1
Staying Alive: The National HIV Survival Training
Bethesda, Maryland.
Contact: ***Charles Debnam***, ext. 127

May 2-4
AIDSWatch '99
Washington, DC
Contact: ***Jean-Michele Brevelle***, Ext. 103

June 24
Community Planning Training Conference
Washington, DC
Contact: ***Beri Hull***, ext. 121

From the Executive Director

Charting the road ahead is a challenging–but vital–task, for any organization.

In December 1997, the NAPWA board of directors met in Chicago for a two-day retreat to review NAPWA's mission, and to consider other important organizational issues. This dialogue provided the framework for our current strategic planning initiative. The board met again in January 1998 for its Annual Meeting, at which time the Strategic Planning Working Group was created with a mandate to establish priorities that would guide the agency from 1999 through 2001.

The working group met several times in 1998 to review the progress made under NAPWA's prior strategic plan for the years 1994-1997, to consider the current state of the epidemic and develop new goals and priorities. The working group conducted surveys and focus groups with policy makers, health officials and people living with HIV across the country.

PHOTO BY BARBARA KINNEY

A. CORNELIUS BAKER, EXECUTIVE DIRECTOR

In March 1998, the NAPWA staff held a retreat at the Coolfont Conference Center in West Virginia. This retreat was designed to address administrative and managerial issues at NAPWA and to evaluate the internal structure of the agency as a component of the strategic planning process. At this retreat a number of suggestions were made to improve the agency's management, efficiency and effectiveness. Several initiatives have been implemented to address concerns raised at the retreat, including the establishment of a Staff Advisory Committee to the Executive Director on Workplace Issues, increased emphasis on training for all staff, and an agency-wide workshop to improve team dynamics and cross-cultural, cross-gender and cross-rank communication.

During the Fall of 1998, NAPWA's Policy and Planning Group (PPG) comprised of program directors and senior management met to consider desired outcomes, indicators, targets and implementation strategies for the priorities established by the board. At a day long staff meeting in November, all staff participated in offering creative ideas, solutions and mechanisms for accomplishing those goals

The development of NAPWA's new strategic plan has been an important process. We are grateful for the support given to NAPWA's strategic planning and organizational development activities from the Council of Fashion Designers of America / New York Community Trust. We also deeply appreciate the many people with HIV and our health partners across the country who generously shared their valuable perspectives with us.

With determination and a clear vision of our future we go forward in the fight for our lives.

NAPWA Study Evaluates Services Attention to Client Satisfaction

People with AIDS have never been known as the silent types. That's because speaking up has earned us better health care and life saving treatments.

In September 1996, HRSA funded NAPWA to gather information about the type of client level evaluation activities the Ryan White CARE Act grantees were conducting, and how the providers, in response to clients' needs and concerns, improve delivery systems. A nationwide survey was conducted to gather preliminary information from CARE Act grantees about client level evaluation activities, and to compliment the survey efforts, qualitative in-depth case studies were conducted among six sites in the U.S.

In *Feedback: A Review and Synthesis of Client-Level Evaluation Activities Among Ryan White CARE Act Grantees*, NAPWA presents our assessment of responses to the survey and provides in-depth descriptions of the case studies. The report identifies the range of local client satisfaction assessment activities conducted and the subsequent changes implemented in programs. *Feedback* also sheds light on how providers who assess client satisfaction respond to clients' needs overcome barriers to accessing HIV services, as well as why some grantees do not assess client satisfaction. The report concludes with a series recommendations for policymakers at the local, state and federal level.

NAPWA applauds the work of our research and evaluation team, led by Elona Finkelstein, formerly our Senior Research Associate, with the assistance of Jan Carl Park, a person living with AIDS who served as a health policy consultant on the project. In addition to HRSA funding for this project was provided by the AT&T Foundation.

Contributors

NAPWA recognizes the following grants and donations in support of our work for which we are extremely grateful (September 1 - December 31, 1998):

Public Grants
U.S. Centers for Disease Control and Prevention (CDC)
U.S. Department of Education
U.S. Health Resources and Services Administration (HRSA)

Corporate Leader
Bristol-Myers Squibb Company

Presidents (≥$25,000)
Hoffman-LaRoche Pharmaceuticals
Philip Morris Companies Inc.
The Whitman-Walker Clinic

Advocate (≥$10,000)
Broadway Cares/Equity Fights AIDS
Mathilde Krim

Senators (≥$5,000)
Abbott Laboratories
DuPont Pharmaceuticals
Curtis and Prinz, Inc.

Life Givers (≥$1,000)
Marvin Christian
Howard University Hospital
The Metropolis Fund of Washington D.C.
Tom Viola

Health Partners Network
AIDS Survival Project, Atlanta
County of Los Angeles
Gilead Sciences
Carol Schwartz
Frank Stiebel
Outer Cape Health Services

Survivors and Friends Circle
Abundant Life Clinic
Advanced Therametrix Research
AIDS Services of Dallas
Richard Alther
Arkansas Dept of Health
Asian Pacific Health Care Venture Inc.
Patti Bays
Lee Berry
Donald Bille
Joan Bosch
Jean-Michelle Brevelle
Morris Cherrey
Richard Cutter
Alda Irene Douglas-Proctor
Joan K. Ferguson
Allan Freeman
Centro Hispano De Chelsea
Funds for Life
Charlynne Galousin
Desert AIDS Project
Ebsco Industries
East Boston Neighborhood Health Center
Joshua Goldberg
Donald Fishbein
Susie Fletcher
Glaxo Wellcome
George Heerman
Celeste Hicks
Tandy Hill
HIV Community Coalition
James Holmes
Harrison Howe
Deborah Karllin
Jeffrey Kassel
John Kinyon
Lisa Klopfer
Robert Kohman
Laura Kroger
Irvin Kupper
Garrett Lanzy
Adam Lebowitz
Scott Lundie
Natalie Masliyah
Scott Mayers
Metrolina AIDS Project
Sally A. Michael
Monessen Valley AIDS Task Force
Augustus Nasmith
National Viatical Representatives
New Orleans Center for the Living
Richard Otis
Tyler Percle
Lester Pettibone
JP Polete
Polaroid Foundation
PROCEED Inc.
PWA Coalition of Blue Ridge
Albert Rosen
Jon Schlissel
Robert Schuppert
Richard Sisk
Oscar Smith
Barry Stover
Dan Tietz
The Travel Group
Kevin Trapp
Vision Research
Anthony Volponi
Washington County HIV Clinic
Richard Zaparan
Richard Zwiebel
80th Ave Dental Associates

Board Nomination Period Opens

We're looking for a few good leaders. The Governance Committee has launched NAPWA's first open nomination period for membership on the board of director's.

Directors are required to make an annual financial contribution, attend four meetings of the board of directors, and serve on at least one committee (finance, development, policy, programs or governance).

The Governance Committee reviews all nominations and recommends candidates to the board of directors. The board plans to elect five new members this year. NAPWA is committed to having a board of directors that is reflective of the epidemic in its many levels of diversity.

If you have an interest in serving on the board, please send a letter of interest with your qualifications to Governance Committee/Board of Directors, NAPWA, 1413 K Street, NW, Washington, DC 20005. The nomination period is from February 15 to March 31, 1999.

Mission Statement

The National Association of People with AIDS (NAPWA) advocates on behalf of all people living with HIV and AIDS in order to end the pandemic and the human suffering caused by HIV/AIDS.

Board of Directors

A. Cornelius Baker
Executive Director

the National Association of People with AIDS