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The End of AIDS?

Could universal testing and treatment end the epidemic?

by Liz Highleyman

Three decades into the AIDS epidemic, advances in treatment have been astounding, turning a quick death sentence into a chronic manageable illness for those who have access to modern meds.

The HIV prevention story, however, hasn't been as happy. After a sharp drop in the late 1980s, the number of new infections in the U.S. reached a plateau, and holds steady at around 56,000 per year. Globally, there were an estimated 2.7 million new infections in 2008, and for every two people who start treatment, three more become HIV positive. Once-promising prevention tools such as vaccines and microbicides have seen very slow progress.

But what if HIV treatment itself is the best weapon against new infections? HIV medications dramatically lower the

risk of transmitting the virus, and some experts think that if every person with HIV started treatment, transmission of the virus could finally be halted.

Treatment as Prevention

It is well known that lowering HIV viral load decreases the likelihood of transmission. This is already the standard approach for preventing mother-to-child transmission. Giving drugs like AZT or Viamune – or even better, a combination regimen – to an HIV-positive woman during pregnancy and delivery, and to the newborn immediately after birth, reduces the risk of the baby becoming infected to less than 2%. There's good reason to think a similar strategy would work for HIV transmission via sex or sharing drug injection equipment.

Early in 2008, the Swiss Federal Commission for HIV/AIDS set off a vigorous debate when it issued a report stating that a person taking HIV treatment

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EDITORS IN CHIEF

Daniel Tietz

Sean Cahill

EDITOR

Mark Milano

ASSOCIATE EDITORS

Luis Scaccabarozzi

Nathan Schaefer

Robert Valadéz

MEDICAL EDITOR

Jerome A. Ernst, MD

PUBLICATIONS MANAGER

Mark Milano

PUBLICATIONS ASSOCIATE

Laura Engle

DESIGN

Tom Dolle

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ACRIA Trials in Progress

Pomegranate Juice

People who have not taken HIV meds for at least 90 days will drink pomegranate juice or placebo juice daily for 10 to 18 weeks to study its effect on the heart, quality of life, and HIV viral load.

Crofelemer for Diarrhea

People 18 and older who have persistent diarrhea will take crofelemer (a new anti-diarrhea drug) or placebo tablets for 6 weeks.

Then everyone will take crofelemer for 5 months.

Ibalizumab

People who have taken HIV drugs will receive infusions of ibalizumab (a monoclonal antibody designed to block HIV entry into CD4 cells) twice a month for 24 weeks or longer, along with other HIV drugs.

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

LETTERS TO THE EDITOR

To the Editor:

I read the summer issue of *Achieve* and found the articles to be quite informative. "Women and HIV: A Nuanced Epidemic" really caught my attention. We have known for years that HIV is prevalent in low-income minority women. What we need to find out is: why do the women continue to take such risks? Yes, some experience substance use, domestic violence, and even mental health issues, but what leads them into risky behavior when most of them understand the risk factors? It's hard to get underneath the surface of such an issue.

As a society, we should address the reasons why we continue to put ourselves at risk. We can not sit back and think, "It could never happen to me." We have the facts and we see each and every day that people all over the world are dying from this virus.

Keep the stories and articles flowing.

Yours truly,

Julius B.

To the Editor:

I would like to congratulate you and your great staff for the work you have put into helping my overcome my fear about HIV.

I read your publication and was speechless. Everything I wanted to know about inflammation was in a publication you sent a friend of mine who "went home."

I have read the cover off your publication and it's simply great. A very important tool for those of us living with HIV. It will be of enormous use to me and the other HIV-positive inmates that I share this knowledge with.

Thank you with humility,

Sidney

Louisiana

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with an undetectable viral load for at least six months and no other sexually transmitted diseases essentially cannot transmit HIV through heterosexual contact. The statement did not apply to gay men, who have not been studied as thoroughly as heterosexual couples.

At the 2008 International AIDS Conference in Mexico City, Commission President Pietro Vernazza explained that the statement was intended to aid Swiss physicians in discussing sexual risk with their patients, not as a universal recommendation. But he reaffirmed that unprotected sex with an HIV-positive person with undetectable viral load is as safe as using a condom – not 100%, but within a “comfortable range” most people can live with.

This conclusion was based on several studies showing a very low likelihood of transmission between steady heterosexual partners. A study of nearly 400 mixed-status couples in Spain, for example, saw no new infections due to unprotected sex if the HIV-positive partner was taking treatment. A smaller Brazilian study found that transmission only occurred when the positive partner was not adherent to HIV therapy.

In June, the Partners in Prevention team reported in *The Lancet* that treatment reduced the risk of transmission between heterosexual partners by 92%. This study of more than 3,000 couples in Africa found that the transmission rate was very low (0.37 per 100 person-years). In contrast, 70% of new infections happened when the positive partner was not taking HIV meds and had a viral load over 50,000.

More cautious experts warn that, while HIV transmission may be rare when the positive partner is taking HIV drugs, it is not impossible. In the African study, there was one transmission from a positive partner taking treatment, and some other large surveys have also seen a very small number of similar cases. This may happen because even individuals on effective therapy can have viral load “blips,” or brief increases. And a small proportion of people with an undetectable viral load in their blood can have persistent virus in their semen or vaginal secretions.

A concern is that people who think they cannot transmit HIV because their viral load is undetectable may dispense with safer sex or safer needle-use practices. If enough people do so, new infections could theoretically increase, even with a small risk of transmission.



need treatment this early. Traditionally, explains Wafaa El-Sadr from Columbia University, it was assumed that after people acquire HIV they have “many, many years when they’re infected but they’re actually doing well, or they appear to be doing well.”

The Test-and-Treat Debate

Beyond prevention of individual infections, public health is a key issue underlying a more controversial approach known as “test-and-treat” or testing and linkage to care (TLC). The idea behind this strategy is that increasing the number of people who are taking HIV treatment lowers the “community viral load.”

Viral load typically rises to a high level soon after infection and for the next few months. One study in Quebec found that as many as half of all HIV transmissions may happen during this time. Initial HIV infection often causes no symptoms – or symptoms easily mistaken for the flu – so most people do not know they are infected until they take an HIV test some time later.

Test-and-treat relies on regular HIV testing to catch each infection as soon as possible, followed by immediate treatment to minimize the time viral load is high enough to increase the risk of transmission. But everyone may not

But test-and-treat says don’t wait to start treatment, and not just for public health reasons. While the benefits of early treatment for preventing HIV transmission are obvious, proponents argue that it has other advantages as well. A growing body of evidence shows that HIV causes persistent immune activation and inflammation that can contribute to problems throughout the body – such as cardiovascular disease and brain impairment – long before CD4 cells fall into the danger zone. What’s more, today’s meds are more convenient and more tolerable than earlier drugs and they can keep viral load low enough to stave off resistance.

In late 2009, a panel of HIV experts raised the U.S. guidelines for starting treatment from 350 to 500 CD4 cells; even above this level, half the panel favored treatment and half considered it “optional.” Using a test-and-treat strategy, there would be no upper limit.

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On the other side, people who oppose test-and-treat – or who think it's premature – say we really don't know how well the drugs will work and what kind of toxicities they might cause over the long term.

This poses a potential trade-off between individual and collective benefit. Why should people who do not yet need treatment for their own health take the risk of starting immediately to lower the odds of others becoming infected? HIV therapy is a lifelong commitment, and it may be hard for people to stick to it if they are basically healthy – and less-than-perfect adherence can lead to drug resistance.

Some HIV advocates have additional reservations. Testing HIV positive and taking HIV drugs can lead to stigma, unwanted disclosure, problems with health insurance, legal consequences (especially around criminalization of HIV transmission), and even domestic violence. Further, there is concern about the possibility of mandatory testing or coercive treatment for the sake of public health goals.

Modeling the Math

The first support for test-and-treat as a public health strategy came from mathematical models, which plug different variables into equations to crank out predictions. At the 2006 International AIDS Conference, Julio Montaner and colleagues from the British Columbia Centre for Excellence in HIV/AIDS reported results from a “prevention-centered” model that looked at what would happen if all people with HIV worldwide started treatment, leading to no further infections thereafter.

The model showed that within 45 years, widespread treatment could reduce HIV transmission by 70-fold – from more than 7 cases per 1,000 people to less than 0.1 cases – and reduce the total number of people living with HIV from 38 million to less than 1 million. Assuming a generic regimen costing \$1 per day, the total price tag would be \$338 billion. That's a bargain compared to the \$650 billion cost of the “current uptake” model, which assumed treatment coverage in low- and middle-income countries would reach the current level in wealthy countries.

“Although treating 100% of HIV-infected individuals worldwide might not be feasible or even ethically acceptable at this time, given the state of the pandemic, consideration of this possibility is worthwhile,” the researchers concluded.

Taking financial and ethical barriers into account, Montaner's team devised a new mathematical model focusing on HIV-positive people in British Columbia who need treatment for their own health. If everyone started therapy when their CD4 count reached 350, they calculated that about 2/3 of new infections might be prevented by 2030. If just 75% started therapy, new infections would still decrease by 40%.

Reuben Granich and colleagues from the World Health Organization (WHO) presented another mathematical model in the January 3, 2009 issue of *The Lancet*.

Researchers estimated that a universal test-and-treat strategy could reduce new infections by about 95%. Within 50 years, total HIV prevalence would fall to less than 1% – essentially halting the epidemic.

The researchers asked what would happen if all people age 15 and older in a high-prevalence area were voluntarily tested for HIV each year and if all those found to be positive started HIV treatment regardless of their CD4 count.

Using South Africa as a test case, and assuming that all transmission was via heterosexual sex, they estimated that a universal test-and-treat strategy could reduce new infections by about 95%, from 15-20 cases per 1,000 persons per year, to just one case, within ten years. Within 50 years, total HIV prevalence would fall to less than 1% – essentially halting the epidemic. While the test-and-treat strategy would cost more up front, by 2032 its price tag would equal that of the current approach of limited testing and medically indicated treatment.

“Although other prevention strategies, alone or in combination, could substantially reduce HIV incidence,” the WHO team concluded, “our model suggests that only universal voluntary testing

and immediate initiation of antiretroviral drugs could reduce transmission to the point at which elimination might be feasible by 2020 for a generalized epidemic, such as that in South Africa.”

Living in the Real World

At the 2010 Retrovirus conference, Moupali Das-Douglas from the San Francisco Department of Public Health reported that a 40% decrease in average community viral load between 2004 and 2008 – from about 24,000 to 15,000 copies – was associated with a 50% reduction in new HIV diagnoses (both recent infections and newly diagnosed existing infections).

By 2008, about 80% of newly diagnosed individuals were linked to care, about 90% of them started HIV treatment, and 75% achieved an undetectable viral load. The researchers concluded that

these findings “support the hypothesis that wide-scale early [HIV therapy] can have a preventive effect at a population level.” Community viral load can serve as a “virometer,” or a way to “take the temperature” of a community, Das-Douglas explained. “This helps us see how well treatment is working, but also how well prevention is working, so we can target interventions to those at highest risk.”

Julio Montaner's team has also seen evidence that their mathematical models reflect real-life outcomes in British Columbia, where the epidemic is largely driven by injection drug users in Vancouver's Downtown Eastside district. In 2009 they reported changes in community viral load and new HIV infections in a group of 2,000 injection drug users. The median community viral load declined steadily, from about 55,000 copies in 1996 (when less than 10% were taking treatment) to about 8,000 copies in 1998, to below 1,000 copies in 2000. And community viral load was a stronger predictor



of new HIV infections than homelessness, syringe sharing, or unprotected sex.

Montaner's team later found that between 2004 and 2009 – a period that saw stepped-up efforts to expand HIV treatment for drug users – community viral load decreased and the proportion of HIV-positive people with undetectable virus rose from about 40% to about 75%. During the same period, new HIV diagnoses among injection drug users declined steeply, from 150 in 2004 to 80 in 2009. They reported that between 1996 and 2009, the number of people taking HIV drugs in British Columbia increased by 547%, while new HIV diagnoses fell by 52%. For every 100 additional people who started

treatment, they calculated that new diagnoses fell by 3%.

In the wake of these findings, British Columbia has invested nearly \$50 million in a four-year pilot project called “Seek and Treat” that will try to expand access to HIV treatment for “hard-to-reach” populations including injection drug users, sex workers, and men who have sex with men.

“The more people you put on therapy, the less transmission there is,” said Anthony Fauci, Director of the U.S. National Institute of Allergy and Infectious Diseases (NIAID), which helped fund the study. The decrease in new cases “likely could not be explained by anything else.” He named test-and-treat as one component of a three-part

strategy for controlling the HIV epidemic, along with pre-exposure prevention and finding a functional cure. The National HIV/AIDS Strategy, released this past July, prominently features a TLC approach.

A Little TLC

NIAID has launched a pilot study of TLC in Washington, D.C., and the Bronx, New York – among the highest HIV prevalence cities in the country. Rachel Walensky and the Cost-Effectiveness of Preventing AIDS Complications (CEPAC) team recently reported findings from a mathematical model that estimated that universal testing in Washington, D.C., followed by immediate HIV treatment could increase life expectancy by one to two years and reduce transmission by 15% to 27%. “Test-and-treat will save lives, but it won't stop the HIV epidemic in its tracks all by itself,” Walensky said. “It is only a single new and important page in the HIV-prevention playbook.”

San Francisco has taken a different route with a new city-wide policy, announced this past spring, to offer treatment to everyone with HIV, regardless of CD4 cell count. “Based on accumulated data we believe all HIV-infected people should be treated with antiretroviral therapy unless there is a strong reason not to,” said Department of Public Health Director Mitch Katz. But, he emphasized, “we don't dictate medical practice by policy,” and the ultimate decision will remain with patients and their providers.

Public health officials acknowledge that widespread early treatment will likely drive down community viral load and prevent new infections, but the Positive Health Program doctors at San Francisco General Hospital who spearheaded the change said they were primarily motivated by benefits for individuals.

At a packed forum in April, Steven Deeks, whose team at the University of California San Francisco has pioneered research on HIV and inflammation, explained the rationale behind the policy shift. “We should perhaps think of AIDS as acquired inflammatory disease syndrome,” he suggested. “Five years ago we said drugs are no fun and we should wait, but the consequence of waiting is that people develop irreversible harm to

continued on next page

the immune system. The new paradigm is that while today's drugs are not totally benign, they are less toxic than the virus," he continued. "If I'm wrong, we'll start people [using treatment] a couple years earlier than we otherwise would. But if I'm right and we don't start early, there's no going back."

The policy has generated considerable controversy. San Francisco-based HIV advocacy group Project Inform issued a statement supporting the city's new policy. Other advocacy groups, including New York's Treatment Action Group, decided not to take a position on test-and-treat and earlier therapy until more information is available about long-term risks and benefits.

A recently opened international trial called START – Strategic Timing of Antiretroviral Treatment – is designed to provide such data. HIV-positive people with a CD4 count above 500 will be randomly assigned to either start combination therapy right away or delay treatment until their CD4 count falls to 350. The study will look at outcomes like death, progression to AIDS, and serious non-AIDS conditions. But START is not expected to produce results until around 2015, and some public health officials don't want to wait.

Debate

On the other side, test-and-treat skeptics express concerns about unknown long-term drug toxicities, drug resistance, and of course the added cost of providing treatment for people whose immune systems are still working well. Some have even implied that drug company profits were motivating the push for expanded testing and early treatment.

"The seeming simplicity of preventing new infections through the [test-and-treat] approach is appealing. But that simplicity hides deeply disturbing truths, including that many people coerced into unnecessary treatment will suffer side effects and treatment-induced diseases," POZ magazine founder Sean Strub wrote on his blog. "It is unethical and irresponsible to coerce or encourage people who are not recommended for treatment under

the guidelines to start therapy without fully informing them of the risks."

"It is an experiment based on a mathematical model," he continued. "It is as though a decision has been made to redirect the country's public health response [to] AIDS from proven behavioral interventions, like condoms and prevention education, to the use of antiretroviral medications. Public health officials' focus on treatment as prevention and the pharmaceutical industry's incentive to expand markets are now in dangerously perfect alignment."

"The seeming simplicity of preventing new infections through the [test-and-treat] approach is appealing. But that simplicity hides deeply disturbing truths, including that many people coerced into unnecessary treatment will suffer side effects and treatment-induced diseases." Sean Strub

To address such concerns, Project Inform clarified its statement, emphasizing support for the more comprehensive approach dubbed Testing and Linkage to Care Plus (TLC+). The revised policy urges people to find out if they are HIV positive and if so, to get into care to address all the medical, psychological, and social issues they may face. Only then would they make a decision with their doctors about whether they are ready for and could benefit from HIV treatment.

"TLC+ is firmly rooted in principles of informed choice by HIV-positive people

regarding all aspects of their care, particularly decisions about whether to be tested and when to start HIV treatment," the statement said. "Project Inform views it as ethical and empowering of people with HIV to describe treatment as a possible support for prevention. We believe that most HIV-positive people are altruistic and willing to factor the possible benefits for prevention into their treatment decisions."

The Beginning of the End?

While the debate continues, the idea of treatment as prevention has already been widely embraced by medical experts and public health officials. On a global level, WHO announced last year that scaling up access to HIV therapy is important for both individual clinical benefit and for prevention of new infections.

UNAIDS included treatment as prevention as part of its five-pronged "Treatment 2.0" strategy announced this summer in Vienna. The new approach could prevent up to a million new HIV infections per year if therapy were provided for all people who need it under the latest WHO guidelines, tripling coverage from the current 5 million people to 15 million.

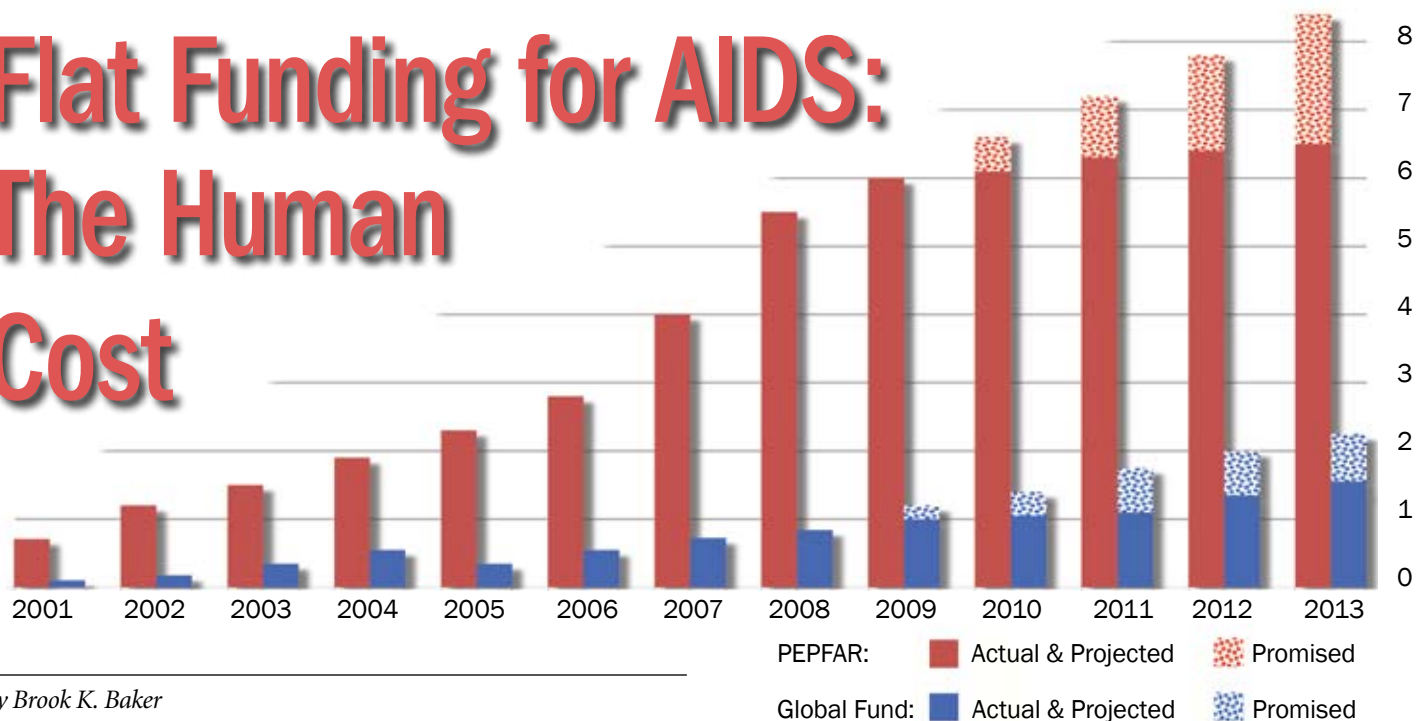
Most experts are hesitant to predict that universal testing and treatment could completely halt the epidemic, but many think it would help bring it under control.

"Both syphilis and tuberculosis were pandemic at the end of the nineteenth century, and both epidemics were controlled by effective diagnosis and treatment," pioneer AIDS researcher William Haseltine wrote in a 2009 essay in *The Atlantic*. "So, too, might the current HIV/AIDS pandemic be slowed until vaccines are someday available."

Over the past 20 years HIV treatment has seen great advances, but much remains to be done, said Montaner. "I hope Vienna will go down in the history of the epidemic as where we concur that treatment is not just good for patients but also for public health, because treatment is prevention." ■

Liz Highleyman is a freelance medical writer and journalist based in San Francisco.

Flat Funding for AIDS: The Human Cost



by Brook K. Baker

Last July, activists lambasted the Obama administration and other rich countries at the International AIDS Conference in Vienna, claiming that the current flat funding of global AIDS programs breaks prior commitments to universal treatment and threatens the lives of millions of people with HIV. The Obama administration has defended its commitment to fight HIV, but close examination shows a flattening of resources just when more people have joined the waiting lists for treatment.

The Facts on Funding

According to UNAIDS, annual funding for AIDS from all sources slowly crept up in the 1990s, from only \$200 million to \$1 billion. In contrast, between 2000 and 2009, AIDS commitments increased dramatically, from \$1.4 billion to nearly \$16 billion a year less than half of which comes from rich country donors. But in 2009, donor commitments plateaued and disbursements actually dropped for the first time.

First, it's important to distinguish between donors' stated commitments and the actual money spent. During the past eight years there has been a \$7.9 billion difference between the two!

	2002	2003	2004	2005	2006	2007	2008	2009
Commitments	1.6	2.0	3.6	4.3	5.6	6.6	8.7	8.7
Disbursements	1.2	1.6	2.8	3.5	3.9	4.9	7.7	7.6

U.S. commitments increased dramatically over the past eleven years, until they too flattened. Using Kaiser Foundation figures that combine funding for HIV prevention, treatment, and care, U.S. funding shows eight years of growth followed by stagnation. U.S. appropriations to the Global Fund to Fight AIDS, Tuberculosis and Malaria during the same time period fluctuated, but show an overall tenfold increase followed by three years of flat funding.

On the campaign trail, Barack Obama, Joe Biden, and Hillary Clinton all pledged \$50 billion for global AIDS over five years.

That would have meant increasing AIDS spending by nearly \$1.5 billion a year for five years. In 2008, the Lantos-Hyde Act reauthorizing PEPFAR (the President's Emergency Fund for AIDS Relief) approved at least \$39 billion for HIV and another \$9 billion for TB and malaria. That would have meant a \$.6 billion increase each year, from \$5.4 billion in 2010 to \$8.4 billion in 2013. Instead, we have had steady-state funding at roughly \$6 billion for three straight years and projections of near flat-funding for the next three years as well.

Funding has increased 5% over a three-year period. But once we take into account inflation, the actual rate is flat or worse.

The above graph includes actual and projected U. S. funding for PEPFAR (minus R&D and TB funding) and the Global Fund, in billions of dollars. (The projections are based on the PEPFAR II authorization of \$39 billion, Obama's campaign pledge of \$50 billion, actual U.S. contributions to the Global Fund, and U.S. contributions required to meet its 1/3 donor fair share of the Global Fund.) About 40% of the Global Fund budget goes to TB and malaria, so U.S. commitments to global HIV alone could be reduced accordingly in the graph.

Based on these data, it is hard to understand how the Obama administration claims that it has not flat-lined global AIDS funding. True, in absolute dollar figures, overall funding has increased \$300 million, or 5%, over a three-year period. But once we take into account inflation, the actual rate of funding is flat or worse.

Activists contrast what is actually being delivered to the promises made during the 2008 Presidential campaign. Then, Obama's

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AIDS platform stated: “He has pledged to provide at least \$50 billion by 2013 for the global fight against HIV/AIDS, including our fair share of the Global Fund, in order to at least double the number of HIV-positive people on treatment and continue to provide treatments to one-third of all those who desperately need them.”

But the Obama administration’s new health policies may cement a funding stranglehold. Earlier this year, President Obama announced his Global Health Initiative (GHI), which plans to expand U.S. funding for maternal and child health, sexual and reproductive health, neglected diseases, and overall health system strengthening. The GHI proposes \$63 billion over six years, including \$51 billion for AIDS, TB, and malaria. This works out to only \$8.5 billion a year for all three diseases, instead of the \$9.6 authorized by the Lantos-Hyde Act. A leaked report from administration sources projected total AIDS spending of only \$37 billion over six years, guaranteeing that flat funding will continue. Fully funding PEPFAR (as opposed to Obama’s flat budgets) would mean:

- 1.3 million more people could receive HIV treatment.
- 3.9 million more women could receive services to prevent mother-to-child transmission.
- 36 million more people could access programs to prevent sexual transmission of HIV.

Ineffectual Excuses

Why is the administration cranking back the fiscal faucet? After all, President Obama has announced a domestic national AIDS policy for the first time, and he is committed to the benign exercise of U.S. global power. Moreover, he has mounted such a vigorous defense of his policy – with reports he is “hurt” by the criticism – that it would appear he does care about global health justice.

The President may have his own misconceptions, but he is also being bombarded with disinformation. He is partially under the sway of neo-orthodox health policy wonks like White House advisor Zeke Emanuel, who espouses investing in lower-cost public health initiatives. Using the deadly tools of cost-efficiency,

Emanuel and other health pundits like Mead Over, Bill Easterly, and Laurie Garrett consistently advise the President that he must avoid escalating investments in treatment and must instead prioritize HIV prevention. They argue that we should shift investments to cheaper child and maternal health programs and overall health system strengthening.

Prevention vs. Treatment

Suggesting a battle between prevention and treatment has been a long-standing mantra from certain public-health advocates, starting with the World Bank in the 1990s. You can’t read an article about global AIDS without quotes from Bill Gates or Dr. Emanuel saying, “We can’t treat our way out of this pandemic.” Certainly, the U.S. needs to increase its investments in evidence-based, comprehensive prevention strategies that address the epidemic’s structural, behavioral, and biological drivers. Certainly it should continue to spend a significant

portion of its resources on comprehensive sex education, male and female condoms, promotion of delayed sexual initiation, partner reduction, circumcision, needle exchange, and new technologies like microbicides. But we must simultaneously continue the scale-up of treatment – saving lives and achieving prevention goals are both important.

But despite new evidence supporting treatment as prevention, the administration continues to assert that it must divert funding from treatment to its “neglected sister,” prevention.

Behavioral changes are linked to people knowing their HIV status and receiving prevention counseling – and the greatest incentive to HIV testing is the availability of treatment. Moreover, growing evidence shows that HIV treatment reduces transmission – one study found that people in treatment were 92% less likely to transmit HIV to their spouses than those who were not. Community reductions in viral load are linked to reduced transmission in those communities. But despite this new evidence supporting treatment as prevention, the administration continues to assert that it must divert funding from treatment to its “neglected sister,” prevention.

Pitting HIV against maternal and child health is equally irrational. AIDS is the leading cause of death of women of reproductive age worldwide and a leading cause of child mortality in Africa. By placing health needs in a cage of mortal combat, the administration is creating a false universe of fixed resources. Instead,

women's access to HIV treatment and prevention of mother-to-child transmission should be linked with maternal health programs. Just as success in combating HIV and TB are linked, so too are public health campaigns that address neglected and noninfectious diseases. Expanding the health care workforce, strengthening health systems, and funding community-based programs will improve health outcomes across the board.

Spending Wisely

The President has also adopted the rhetoric of “country-control” and “sustainability.” When translated, these terms mean that the U.S. should get out of the funding game and focus on technical support – that it should gradually reduce spending so that countries, no matter how poor, will eventually take over the fiscal burdens of prevention, treatment, and care. The President has been sold this canard because of the projected costs of future AIDS entitlements, which some cynically call the “treatment mortgage.” Seeing the long line of people with HIV (34 million and counting) and the escalating costs of new first- and second-line regimens, foreign policy advisors assert that AIDS will eat up the whole health budget and that the President will lose his ability to leverage U.S. influence through carefully managed, carrot-and-stick foreign aid.

President Obama is steadfast in his pursuit of efficiency, due to the 2008 economic meltdown. Admittedly, there has been much inefficiency in U.S. AIDS programming. PEPFAR has had irrational prevention policies that emphasize abstinence-only messaging, require a mandatory anti-prostitution pledge, and ban needle exchange programs. The U.S. at first wasted money on expensive brand-name medicines, on high overhead and fees to consultants and non-governmental organizations, and on repetitive trainings. With new efficiencies, task-shifting in the health workforce, and lower costs for generic drugs, however, the per-person cost of treatment has fallen from more than \$1,000 a year to around \$400. Coupled with increased monies from the countries receiving PEPFAR funding, this allowed an additional 1.2 million people to begin treatment in 2009, despite donors' renegeing on promised funding increases.

The most understandable defense of flat funding is the current fiscal crisis. Government revenues have plummeted and stimulus spending has added to the national debt. At some point, analysts argue, the books must be balanced and tough choices must be made to cut spending. Global AIDS Ambassador Eric Goosby and former President Bill Clinton have argued that some of those cuts will necessarily occur in the funding promised for PEPFAR.

Activists are not arguing that the financial crisis isn't real, but that it is ultimately political – that where there is political

will, there is a way. The U.S. still has a huge economy, a huge government budget, and multiple opportunities to change priorities. If the U.S. can find hundreds of billion of dollars for war efforts in Iraq and Afghanistan, \$85 billion for the auto industry, and over a trillion dollars to bail out the financial industry, surely we can find a few extra billion dollars for global health and HIV.

Waiting in Line to Die

The rate of new HIV infections dropped to 2.7 million a year (a 17% decrease) during the past decade of escalating funding. Worldwide, the number of people on treatment increased from fewer than 200,000 in 2000 (mostly in Latin America) to 5.2 million, with Africa increasing from 20,000 people to 4 million – a whopping 20,000% increase. Similarly, coverage to prevent mother-to-child-transmission increased from essentially zero (except in Thailand and Brazil) to over 53%. And the number of people agreeing to HIV testing has escalated, so that many millions now know their HIV status and can positively plan for their future. But with the continuing threat of flat funding, the question remains: What will be the human cost?



At the Global Fund, the impact is already clear. For the past two funding rounds, it has instituted funding cuts, one called a 10% “efficiency gain,” and the second a potentially reversible 25% “resource-constraint” cut for programs running over two years. But now the coffers of the Global Fund are nearly empty. It presented three options for the next round of funding: a “flat-lined” budget of \$13 billion, a “modest-impact” budget of \$17 billion, or a “scale-up” budget of \$20 billion. Regrettably, the Third Replenishment, which just took place, produced only \$11.69 billion in pledges – less than flat-lined budget option. Although the U.S. pledged \$4 billion over three years (a 38% increase over its last three years of pledges), it still fell 62% short of what was needed. So, just when countries have been asked to make bigger and bolder requests, to seek funding for health

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Tiny Tax, Giant Return

Could a new tax save the lives of millions of people with HIV around the world?

by Asia Russell

In 2005, world leaders promised that all people in poor countries who needed HIV treatment would have it by 2010. But according to a new report by the World Health Organization, only 5.25 million of the 15 million who need it are receiving HIV treatment. Ten million people are still waiting, even though they are at high risk of advanced disease or death.

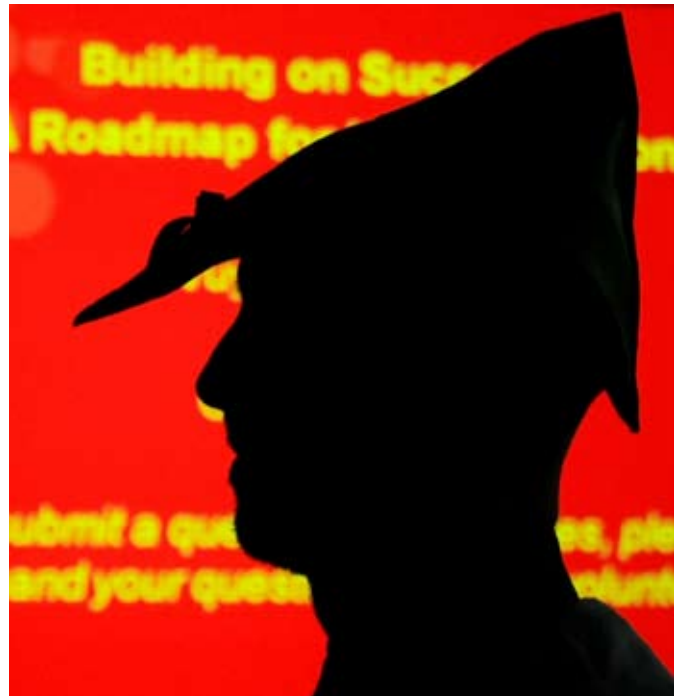
Meanwhile, rich countries are using the global financial crisis as an excuse for not increasing HIV funding. And the economic crisis is severely damaging the developing world in other ways as well. About 46 million more people are living in poverty, global job losses could total 51 million, and health investment in particular is under threat. According to the World Bank, up to 400,000 more infants in poor countries may die as a result of the crisis.

Preserving Progress

The improvements in treatment access and other advances that poor countries have made in the fight against HIV are fragile, and the stakes could not be higher. According to UNAIDS, 22 of the countries most affected by HIV in sub-Saharan Africa have reduced the number of new HIV infections by over 25%. But the broken promises of rich governments could quickly reverse these gains. A slowdown in funding would mean much more expensive health challenges in the future.

UNAIDS estimates that the fight against AIDS requires an additional \$10 billion this year alone. But where will the money come from? Well, public outrage at the financial mess created by reckless banks has helped spark new interest in an old idea: creating a small tax on different types of financial transactions. A “Financial Transactions Tax” (FTT) would generate billions to fight HIV, maternal death, poverty, climate change, and other challenges. At the same time, it would help curb the irresponsible, speculative behavior that led to the economic crisis.

How would it work? An FTT would tax banks for many of the transactions they handle, such as the sale of stocks and bonds



In the U.K., the tax is known as the “Robin Hood Tax,” so in Vienna, activists dressed in Robin Hood-style green hats, chanting “No retreat! Tax and treat!”

or the trading of currency. And the tax would be designed so that the purchase of stocks or bonds by consumers would not be affected.

The Leading Group on Innovative Financing for Development, a U.N. body of 60 countries, is studying FTTs. It estimates that a tax of only 0.05% on all financial transactions could raise \$700 billion a year. And an even smaller tax – 0.005% – on currency transactions of the dollar, pound, euro and yen, could raise \$33 billion each year. This foreign exchange market is the largest in the world, at \$800 trillion a year, and is the only area of the financial sector that is not taxed. It has grown 20% in three years, and now trades \$4 trillion a day. The vast majority of these foreign exchange transactions involve huge financial institutions buying and selling currencies for a quick profit. These transactions do nothing to create jobs or build infrastructure; they simply make wealthy individuals and companies richer.

International Support

Proposals for an FTT have received widespread support from a variety of European, U.S., and African leaders, including Ethiopian Prime Minister Meles Zenawi and U.N. Secretary

General Ban Ki-moon. During the U.N. meeting on the Millennium Development Goals in September, French President Nicholas Sarkozy called for the creation of an FTT, saying the world has “no right to [seek] shelter behind the economic crisis as supposed grounds for doing less. Finance has globalized, so why should we not ask finance to participate in stabilizing the world, by taking a tax on each financial transaction?” He added, “While all developed countries are in deficit, we must find new sources of financing for the struggle against poverty, for education and for the ending of the planet’s big pandemics.” Several other nations have also voiced their support, including Germany, South Korea, Brazil, and Norway.

Economic advisers in the Obama administration have pushed back against the idea. But lack of consensus is not a barrier to action. Wolfgang Schäuble, the Finance Minister of Germany, recently told the German Parliament that an FTT should be explored, whether there was global agreement or not. “If we can get that through on the global level, then good. That would be ideal,” he said. But if that doesn’t work, “then we must look to the European Union. And if we have a problem with Britain, then I think we should try it with the euro zone.”

Despite reluctance from some White House economic advisers, key U.S. lawmakers have expressed their support, including Speaker of the House Nancy Pelosi. Representative Pete Stark, a former banker who chairs the Health Subcommittee of the House Committee on Ways and Means, introduced the Investing In Our Future Act. It would create a 0.005% tax on currency transactions above \$10,000, effectively excluding trades done by ordinary people from the tax. An estimated \$28 billion could be raised over time from just this tiny tax. The bill calls for monies raised by the tax to be invested in domestic and global priorities: fighting HIV, tuberculosis and malaria; reducing the impact of climate change; and providing affordable child care to families in the U.S.

Taking Action

Activists from around the world have intensified their pressure on political leaders. In the U.K., the FTT is known as the “Robin Hood Tax,” so at the 2010 International AIDS Conference in Vienna, activists dressed in Robin Hood-style green hats and interrupted a speech by Bill Gates, chanting “No retreat! Tax and treat!” At a press conference later during the conference, the U.N. Special Envoy on Innovative Finance, Philippe Douste Blazy, called on world leaders to support the FTT.

FTTs have been well tested in several countries: In the U.K. a 0.5% tax on the purchase of stocks raises about \$6 billion annually. In the U.S. a small transactions tax has

already been implemented to fund the Securities and Exchange Commission. In Belgium, an FTT raised 147 million euro in 2005.

The serious consideration being given to an FTT comes at just the right time. The richest 20 countries of the world – the G20 – will meet in November in South Korea, with an FTT high on its list of priorities.

It would create a 0.005% tax on currency transactions above \$10,000. An estimated \$28 billion could be raised over time from just this tiny tax.

People in the U.S. can take action and ask their member of Congress to co-sponsor the Investing In Our Future Act. (For more information about the act, including a current list of co-sponsors, search for H.R.5783 at opencongress.org.) If your Congressperson is not a co-sponsor, call the Congressional



switchboard at (202) 224-3121 and ask to speak with a staffer about the act. Tell him or her that you want your Senator or Representative to co-sponsor the legislation. You can also send an email by searching for “Investing In Our Future” at www.foe.org. ■

Asia Russell campaigns for access to treatment in developing countries as the Director of International Policy for Health GAP.

Fighting for South Africa

by Mpumi Mantangana

I first began hearing about AIDS in 1997. I'd finished my nursing training in 1990 and I was never taught anything about HIV. It was whispered about, but we were told it wouldn't affect us because it was only with gay people and drug users. We thought it was a white disease. But then it came to our doorstep and we started to see our people getting sick. We started to see people who were not gay, people in our community, who were HIV positive. But after testing, they had to go into hiding because there was absolutely nothing we were offering them. We just left them to die.

When my brother died of AIDS in 2002, that made me very angry. I wanted to fight back, not just for my brother alone – there were so many people that were dying. We had funerals day in and day out. We used to have funerals only on Saturdays, but now we had them every day. And the majority of people who were dying were the young stars, the future of the country. And no one was saying anything about that – the government was just quiet about it. The government said AZT was toxic and they would not “poison” their own people.

So I joined Treatment Action Campaign (TAC) in 2000. The first time I went to their offices, there was no one there. The security guard told me they had all left for a picket. I thought, “I wish I was in that picket!” The following day, I went back and met Mandla Majola, one of the founders of TAC. He was from my neighborhood, so I had a warm welcome from him. I said I was feeling so frustrated working in a clinic where I was testing more than ten people every day – and seven of them would test positive! He said, “You came to the right place, because we are fighting for access to medication.”

When my brother died, I told myself, “I need to be vocal. I need to go wherever I'm needed to talk about this. I need to educate the community.” The HIV protests I joined reminded me of the days when we were rebellious against apartheid in the 1970s. At my first protest with TAC, we challenged the pharmaceutical companies because we heard there were antiretrovirals (ARVs) in Swaziland and Botswana, but they were very expensive. HIV was hitting hardest in the poorest of the poor communities – in the townships. They didn't have money to buy food, and the rate of unemployment was very high. How could they buy medication when they weren't even working? So we had a large march, and I felt great because I felt I was doing something.

The next step was to take our government to task. We felt so frustrated because we didn't have anyone in the government to go to. The President, Thabo Mbeki, and the Minister of Health, Manto Tshabalala, they were talking the very same language – that the drugs were poison and that HIV didn't cause AIDS. So we knew we had to really shout, to whoever would listen to us. How could our President say that no one was dying from HIV? That was an insult. And then Nelson Mandela came on board and that's when I first thought, “Yes, we are on the right track – we just have to put on more pressure.” And when the international family joined us, that's when the government started to feel it.

We tracked down the Health Minister when she was going to speak in Cape Town about using garlic and beetroot to fight AIDS. We snuck inside, and as she was going up to the podium, we shouted, “To hell with Manto! To hell with garlic! To hell with beetroot! We want ARVs!” We were shouting at the top of our voices and truly it was chaotic. She couldn't utter a word. She didn't have a way of promoting what wasn't true.

As she was going up to the podium, we shouted, “To hell with Manto! To hell with garlic! To hell with beetroot! We want ARVs!”

We first felt victory when we took our government to court. When the judges ruled in our favor that the government had to supply ARVs, we shouted, “Haaaaa!” in court and sang the national anthem. We felt so great and we marched out into the streets. Justice had been done, but now it was back to the drawing boards – we had to strategize. We had to plan how we were going to monitor the rollout of treatment. And that's when Treatment Literacy was born.

Treatment Literacy is the powerhouse of TAC. A group of educators are trained in HIV: the lifecycle, how to take your medications, the side effects, TB. And they come out very, very confident to teach in the community and the clinics. I've never seen patients who understand their disease like HIV-positive patients. That started to panic the nurses: “What type of patients are these, that they know all this?” So we started going around and teaching nurses, because nobody was trained in HIV. And we told the patients, “When you know more than the nurses, you have to play it down or you won't have anyone to help you.”



I tried to get as many nurses and doctors as possible to attend the workshops. It was crazy to teach doctors and patients in the same room. But the doctors weren't offended to learn with the patients, because we all saw what was happening and we all wanted to help. We had people coming from Zimbabwe and from Cape Town to our trainings, and I still do them.

When we first heard about PEPFAR, we were shocked. But we thought, "If someone from outside our country can come with help, we appreciate that." We knew that South Africa alone could never keep up with providing ARV drugs. Especially with the attitude of the government of the time. Bearing in mind that we had heard so many bad things about George Bush, but we acknowledged for the first time that he was doing a good thing by supporting a misery that he was seeing from far away. The PEPFAR funds have made a great difference, along with the Global Fund. In 2001, our clinic was the first in South Africa to give out ARVs, to 150 people, with no government help. Now, with international funding, we have 5,200 people receiving ARVs at our clinic alone.

We have changed HIV into a chronic disease. It's not a death sentence. People know that there's something you can do. But we still have people out there who are afraid – especially females. We had three cases where TAC activists were raped and killed. One of the women demanded that the rapists use

a condom, and they didn't want to. She said, "But I'm HIV positive," and was killed. The courtroom for the trial was packed, and TAC told the court, "You have to keep the ones who are killing people who disclose their HIV status in jail." And they are still in jail. They were given life sentences, and that was victory for us. We can't allow hooligans out there to spite people who are working very hard

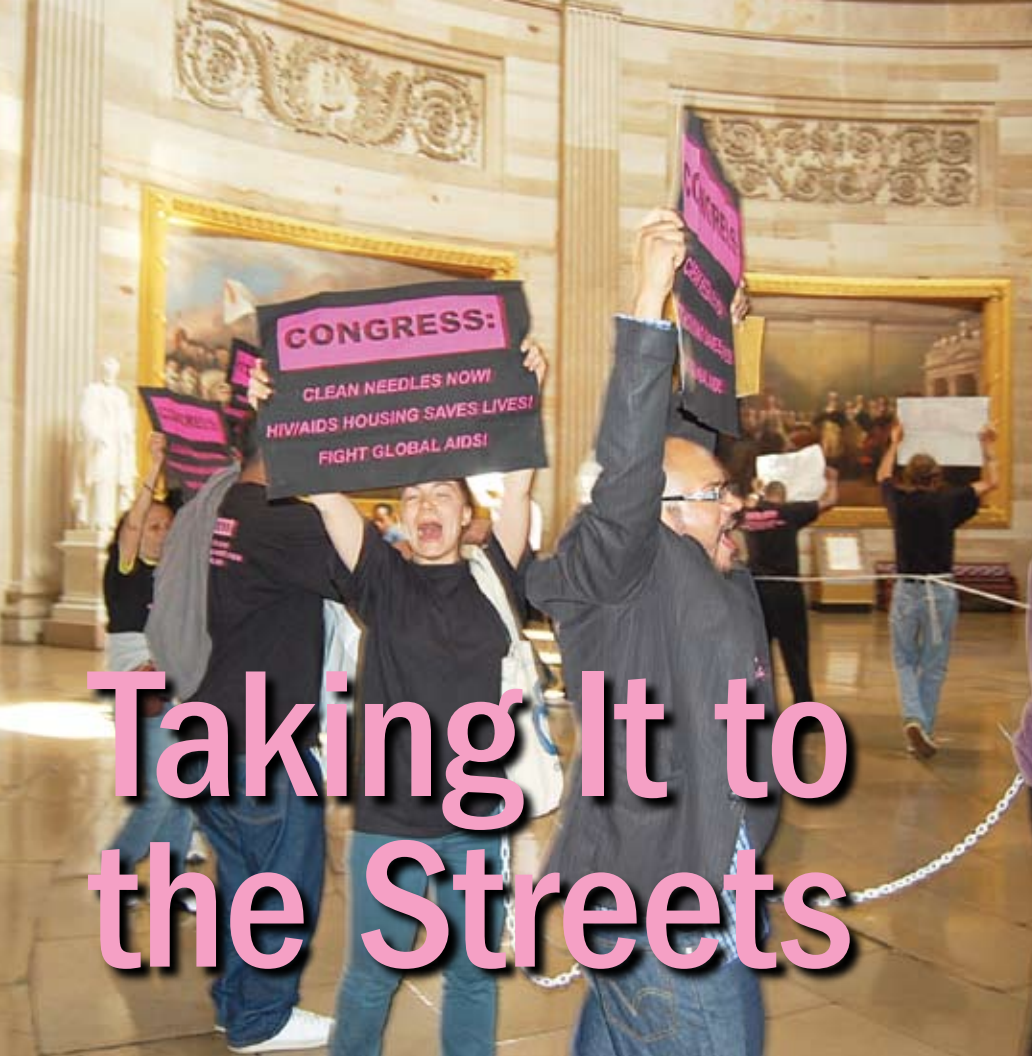
We wear T-shirts that say "HIV Positive." People know that either you are positive or you support people who are positive by wearing that T-shirt. That was a real victory against stigma. When Thabo resigned in 2008, Barbara Hogan became the new Health Minister. And we gave her an "HIV Positive" T-shirt at a rally and demanded she wear it. When she did, we were applauding her because we never had a health minister in South Africa who would do that. She marched with us! That meant a lot to us. Now we can sit at a roundtable and talk to stakeholders about HIV. TAC leadership is invited.

And there are fears because there are patients who are resistant to first and second-line regimens. In South Africa, we have nothing after second-line. It's becoming scary. So we still need the outside world to lobby for South Africa. There are cases where people are failing both lines, so we are going back to square one like in the 1990s. And we really don't want to go back that way again.

Now, because of the recession, donor funding is being cut. There were stockouts in Free State. For about three months they couldn't put people on ARVs and the people that were already on couldn't get them refilled. That made us scared because if one province can have stockouts that means that we all can. We want to plead with the rich countries to keep their promises. They just now bailed out the banks with big money, but they can't find the \$9 billion the Global Fund needs to provide universal treatment?

When I look back, I don't regret shouting and disrupting meetings. I would do it again if we had another stubborn health minister. I'm hopeful – I think the current government AIDS leadership, more especially from the health side, have paved the way and we just hope that the people taking over after the next election won't be derailing what has been done. Because what they are doing now is good.

Two weeks ago, I was reading an article in the *Cape Times* where the funeral parlors were starting to feel the pinch of the ARV programs. They claim that the programs are putting them out of business. When I got to work that day I put the article up on the wall and shouted, "Hallelujah! We all have to come and see!" They were becoming tycoons, benefiting from the misery of other people. But now there are less funerals because people are healthy. Those are the victories that we have to cherish for a long time. We have to go forward, not back. ■



Taking It to the Streets

by Kaytee Riek

In July of 2000, 5,000 people with HIV marched through the streets of Durban, South Africa. Their message was radical: Every person with HIV has a right to treatment. At that time, less than 1% of all people with HIV who needed treatment had access to it. The other 99% were condemned to wait for death, hoping that medications would somehow appear. The march showed that people with HIV around the world would not sit quietly. They would stand up, along with their allies, and demand that everyone have access to treatment.

Since that march, much has changed. The U.S. has led the way in increasing access to HIV treatment, prevention, and care programs in many countries. In January 2003, after a year-long activist campaign, President George W. Bush announced a bold new initiative to invest \$15 billion over five years in global AIDS programs. That program is known as PEPFAR, or the President's Emergency Plan for AIDS Relief.

PEPFAR changed the course of history. Before PEPFAR, convincing people to get tested for HIV was nearly impossible, because a positive test result meant certain death. But once treatment became available, people began to get tested at much higher rates. Those who had access to treatment (about 4 million people)

This is the story of how AIDS activists won historic commitments from President Obama and Congress to continue to fight global AIDS.

were now able to live full lives, working and caring for their children.

If the history of the epidemic were written two years ago, the story would have been one of tremendous success and optimism. Congress had passed a renewal of PEPFAR, and promised \$39 billion over five years for global AIDS. This would have doubled the number of people in treatment, and trained 140,000 new health workers. Organizations around the world

were rapidly scaling up services because of the increased funding promised.

But now, that success is under attack. Governments are using the financial crisis as an excuse to scale back their commitments to fight AIDS. For the first time in ten years, AIDS programs in Africa are facing the possibility of having to create waiting lists for treatment. People are beginning to have to travel long distances to get medicine because it is no longer available where they live.

This is the story of how AIDS activists won historic commitments from President Obama and Congress to continue to fight global AIDS. It's the story of how AIDS programs came under attack from ideologues who felt that treatment is not "cost effective." And, most importantly, it's the story of how people with HIV and their allies continue to mobilize to make the same radical demand made in 2000 – that all people, no matter where they live, have a right to HIV treatment.

Bird-dogging

In 2007, a small handful of activists gathered to discuss how the next president should address AIDS. There was a real opportunity to build upon the success of PEPFAR, and to make it even better. Out of that meeting came a platform for each candidate, and the "08.Stop.AIDS" campaign, with its ten-point platform of specific things the next president must do.

The platform was bold. It called for \$50 billion over five years to be invested in fighting AIDS, an end to abstinence-only sex education, funding for syringe exchange, and support for organizations that worked with sex workers. Activists wanted to see the next president support a new health workforce initiative that would train hundreds of thousands of new doctors and nurses.

We faced an uphill battle. Democratic candidates felt that HIV had already been addressed by President Bush. Republican candidates, catering to a fiscally conservative base, were unwilling to support the call for an increase in AIDS funding.

Even Barack Obama, who had recently traveled to South Africa to meet with AIDS activists and to his father's home in Kenya to take a public HIV test, was resistant. In Orangeburg, South Carolina, I caught up with him in the alley behind the first Democratic debate. I shook his hand, and held on while I asked him if he would be willing to commit to increase funding for global AIDS to \$50 billion over five years. He pulled his hand away, said he wasn't sure, and jumped into his car.

The next day, in Charleston, a group of activists joined the receiving line, to shake the candidate's hand. Each in turn asked him if he would be willing to support \$50 billion over five years. When he got to me, he stopped and said, "I remember you. You asked me a question yesterday." But he moved on without answering the question.

For six months, activists continued to go to town halls, rallies, and volunteer appreciation nights, in a tactic known as "bird-dogging." They tried to speak with all of the candidates, one of whom might become our president. And one candidate after another agreed to support the \$50 billion request. But Obama held out. Every time someone asked him about it, whether it was in Iowa or New Hampshire, he would refuse to answer.

Activists increased the pressure. A handful of candidates supported the funding increase, but several, including Obama, hadn't agreed. And no candidate had agreed to the entire platform. So a broad coalition, including ACT UP Philadelphia, ACT UP/NY, Health GAP, the New York City AIDS Housing Network, the Student Global AIDS Campaign, and the American Medical Student Association, organized a march to the Democratic debate in Philadelphia. Since it was just a few days before Halloween, they dubbed the march "Trick or Treat-ment."

On that day, every Democratic candidate, including Obama, released a promise to provide \$50 billion over five years for

global AIDS. But the coalition wanted full plans to fight AIDS from each candidate. And by World AIDS Day 2007, each democratic candidate had released a comprehensive plan. Obama's plan pledged "to provide at least \$50 billion by 2013 for the global fight against HIV/AIDS, including our fair share of the Global Fund, in order to at least double the number of HIV-positive people on treatment and continue to provide treatments to one-third of all those who desperately need them." While no Republicans had joined in supporting the platform, we deemed the campaign a success, and moved on to the next stage.



The Final Push

By January 2008, it was clear that Barack Obama had a good shot at being the democratic nominee for President. His events had gotten much larger – now, instead of 100-person town halls, there were 10,000-person rallies. Activists continued to shake his hand in rope lines and to tell him why he needed to talk about AIDS. Even though he had released his AIDS plan, he was not talking about it. We felt that HIV, a disease that kills two million a year and infects three million a year, warranted more attention on the campaign trail.

Congress was beginning to debate legislation that would reauthorize PEPFAR for another five years. The bill, based largely on the candidates' platforms, promised \$48 billion over five years,

doubling the number of people in HIV treatment, training 140,000 new health workers, and contributing \$2 billion a year to the Global Fund. When seven Senators put a hold on the bill, activists asked Obama and McCain to be cosponsors. Both did so. After another demonstration, the hold was lifted and the bill passed a week later, overwhelmingly.

Activists were elated. But the legislation just authorized the money; it didn't actually spend it. That had to be approved every year, in a separate process. So, while activists had won a historic victory, we couldn't just pack up and go home.

Barack Obama became the first person elected to the presidency with a plan to fight AIDS. He hired Rahm Emmanuel as Chief of Staff, and installed his brother, Dr. Ezekiel Emanuel, as a senior advisor on health policy, with direct control over global health funding. Dr. Emmanuel had recently published an article in the *Journal of the American Medical Association* arguing that global AIDS money could be better spent on other health challenges. In the wake of that article, a thousand AIDS activists, many with HIV, took to the streets to congratulate Obama and show him that he had their support to enact his AIDS plan. They marched to the office of Obama's transition team and spoke with them about why the president-elect must keep his promise.

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Broken Promises

It seemed destined to happen - we all feared it would. So we captured screenshots of Obama's campaign website. And sure enough, shortly after the inauguration, the promise to invest \$50 billion over five years disappeared from the White House website. A few weeks later, the President's first budget came out. Instead of the promised increase in funding for PEPFAR and the Global Fund of \$1 billion a year as, there was an insignificant \$150 million increase in funding - barely enough to keep pace with inflation.

In April, at a briefing on the President's Global Health Initiative, the President's advisors discussed the details of this new proposal. But during the entire presentation, not a single detail was mentioned about what level of funding it would receive. All they said was that President Obama was committed to ending AIDS, and that the U.S. would broaden the scope of its global health efforts to include maternal and child health, reproductive health, and neglected tropical diseases. Half the questions from the audience were variations of "This all sounds good, but will you be increasing overall funding for global health to cover this, or will it be taken out

of PEPFAR's budget?" The advisors said that was still being worked out.

Not two minutes after the meeting, everyone attending got an email with the funding details - making it impossible to question them directly. But some quick analysis showed that the Global Fund and PEPFAR would not receive anywhere near the level of funding Obama had promised. What the GHI amounted to was repackaging old programs, and scaling back on commitments to fund AIDS. Put another way, the "global health pie" was the size Obama promised, but now it was cut into more slices, making the biggest slice (AIDS programs) dramatically smaller.

Between the financial crisis, pressure to rein in spending, and Dr. Emmanuel saying that we should invest in less expensive health interventions, rather than HIV treatment, activists had to respond.

Protests Continue

On July 7, 2009, 35 activists chained themselves together in the Capitol Rotunda and unfurled a giant banner demanding that Congress fund global AIDS, syringe exchange, and AIDS housing. They chanted loud enough that Senate Majority Leader Harry Reid and Speaker of the

House Nancy Pelosi could hear them in their offices, and were arrested. On World AIDS Day, hundreds of AIDS activists held a funeral in front of the White House to mourn the loss of life due to Obama's broken promises. They released a report card on the administration's progress on fighting global AIDS. The grade: D+.

In early 2010, Obama proposed to freeze all non-military spending, so activists brought 600 pounds of ice to the White House, a reminder that a frozen budget leaves people with AIDS out in the cold. When the President's budget came out, global AIDS programs received an insignificant 2% increase not even enough to keep pace with inflation. But worst of all, Obama proposed to cut funding for the Global Fund. Every year since 2002, the Global Fund had received an increase. This was a huge blow, especially since the Global Fund was facing a financial shortfall so severe that existing grants might be cut.

There had always been suspicions around the administration's claims that these tiny funding increases were having no effect on the ground. But soon after the budget was released, activists found a smoking gun - a memo from the CDC to organizations implementing U.S.-funded AIDS programs in Uganda. It read:

The U.S. Government recognizes that in the coming years, the number of patients in need of antiretroviral treatment will increase dramatically. While the U.S. Government is committed to continuing treatment for those individuals already enrolled on antiretroviral treatment, funding for HIV programs is not expected to increase in the near future. As a result, PEPFAR Uganda cannot continue to support scale up of antiretroviral treatment without a plan for the Government of Uganda on how the patients will be sustained.

This needed to become public. We took it to the *New York Times*, which ran a front-page story. It told of one Uganda clinic turning away 800 people a month because there was no funding for new AIDS treatment. Worst of all, these were mostly people who had been tested for HIV with U.S. money and promised medication when they got sick.

On May 13, 2010, as President Obama attended a fundraiser in New York City, 500 people marched through the streets carrying signs reading, “Obama to People with AIDS: Wait to die.” Nearly a dozen were arrested trying to enter the fundraiser. On June 17, 2,000 people marched to the U.S. Embassy in Johannesburg, South Africa. They delivered a letter calling on the U.S. to increase funding for PEPFAR and the Global Fund to the levels Congress had authorized.

Vienna

In July, over a thousand activists from every corner of the globe marched through the halls of the International AIDS Conference in Vienna and staged a “die-in” in front of the opening session. Chanting “Broken promises kill,” they took the stage, making sure that everyone in the room knew that governments around the world – not just the U.S. – were failing to keep their commitments to fund AIDS programs.

Soon after the budget was released, activists found a smoking gun – a memo from the CDC to organizations implementing U.S.-funded AIDS programs in Uganda.

The Obama administration could no longer ignore us. Eric Goosby, the U.S. Global AIDS Coordinator, used the conference to claim that the U.S. was not breaking its promise. Dr. Emanuel blogged that the U.S. was not retreating from AIDS funding promises. National Security Council Member Gayle Smith wrote a piece for the White House website detailing the administration’s commitment to fighting AIDS. But at every turn, there were activists demanding that the U.S. increase funding.

The activism continued at a U.N. summit on poverty in September, where President Obama spoke about the U.S. commitment to fighting AIDS. But activists in New York and Philadelphia marched in long, single-file lines, visually demonstrating the consequences of broken promises. A handful of activists disrupted Obama at a fundraiser in Manhattan, and later in Philadelphia and Boston, garnering national attention.

U.K. are already in favor of it. But will the U.S. support it?

This campaign has been a success in that people took to the streets and demanded that the president keep his promise. But we haven’t won yet. There are still ten million people in need of HIV treatment. Programs are continuing to turn people away due to lack of drugs.

There’s a real chance to win this campaign and ensure that every person has access to lifesaving treatment. We can



Where Are We Now?

Fall is the time when the administration takes stock and begins to plan the next year’s budget. Obama could reverse course and dramatically increase funding for global AIDS to the levels promised. He could propose \$8.25 billion for PEPFAR and another \$2.25 billion for the Global Fund, which would be on par with what Congress authorized. He could speak out in favor of the Financial Transaction Tax (see article on page 10) – a tiny tax on the trading of currencies by banks. Economists estimate that it could raise \$33 billion a year. France and the

demand that our Congresspeople push Obama to increase global AIDS funding. We can write letters to local papers. We can join protests, especially on World AIDS Day, to demand that the President keep the promise he made three years ago to fully fund global AIDS. You can learn more about the campaign at www.TakeANumber.org. I can’t wait to see you on the streets! ■

Kaytee Riek is a member of ACT UP Philadelphia and Director of Organizing for Health GAP.

EUROPE!



A global campaign to stop the attack on affordable medicines

by Sheila Shettle and Alexandra Lee

In their bid to protect pharmaceutical company profits, the European Commission is pushing policies that could cut the lifeline for millions of people in developing countries who rely on affordable generic medicines to stay alive. “Europe! Hands Off Our Medicine!” is Doctors Without Borders’ campaign to push Europe to back down.

Doctors Without Borders (Médecins Sans Frontières, or MSF) and other health care organizations rely on affordable, quality-assured generic medicines to provide treatment to some of the poorest people across the globe. Most of these generic medicines are produced in India. In fact, 80% of the HIV medicines MSF uses to treat more than 160,000 people with HIV are made in India.

India: Pharmacy of the Developing World

Until recently, patents on actual medicines did not exist in India, only on the process to make them, which allowed the country to become an important source of affordable medicines. A patent is a right granted to a company or institution that allows it to prevent anyone else from selling a product (for example a medicine), usually for twenty years. This means that for twenty years, the company holding the patent has a monopoly on the medicine and is free to charge any price it wants, even if this means pricing it out of reach of those most in need. Patents have often stood in the way of being able to provide people with the treatment they need.

When drug patents did not exist in India, nothing was stopping many manufacturers from making generic versions

of drugs that were patented in other countries. As generic companies competed for the market, prices came down dramatically, and drugs produced in India became some of the most affordable in the world. India became a key source of essential medicines, including medicines to treat HIV. Because of this fierce competition, the price of a standard HIV drug regimen dropped by over 99% over the past decade, from more than \$10,000 per person per year in 2000 to under \$70 today.

Indian generic medicines have played a critical role in getting more than five million people in developing countries on HIV treatment today. A recent study published in the *Journal of the International AIDS Society* reported that Indian generic manufacturers were the source of 87% of AIDS medicines purchased for developing countries by donors like PEPFAR and the Global Fund in 2008. But because of international trade rules and policies being promoted by the European Commission, the “pharmacy of the developing world” is at risk of being shut down.

Tightening the Screw

India is a member of the World Trade Organization (WTO), the institution that sets and oversees international trade rules. As a WTO member, India had to agree to create a patent law that would cover medicines beginning in 2005. This move had a big impact on the ability of Indian generic manufacturers to produce affordable medicines in the future.

“Europe wants to shut down generic production and send us back in time – when we watched helplessly as our colleagues, friends, and families struggled with ill health and death because some big company and its government decided to put profits before people.”

Loon Gangte - DNP+, India

Starting in 2005, when a patent was granted on a medicine in India, local manufacturers could be prevented from producing cheaper generic versions. This affected not only India’s domestic supply of affordable medicines, but also those of other countries that relied on importing medicines from India.

But when the Indian government designed its patent law, it made sure to include certain safeguards in the interest of public health. The law says that only drugs that can show an improved therapeutic effect over existing medicines deserve a patent. This means that companies cannot simply make minor changes to existing drugs (like combining two different drugs into one pill) and obtain a patent on the “new” drug. The law also allows anyone to challenge or oppose a patent by showing that the drug does not deserve a patent according to the law. In addition, no drug invented before 1995 can be patented in India. This means that generic production of older medicines is secured, but the situation is quite different for newer medicines.

The Treatment Timebomb

Despite these important protections built into the Indian patent law, the future of generic production in India looks bleak, especially when it comes to newer medicines. This is particularly important for people living with HIV. People require continuous access to newer medicines if side effects or drug resistance develops. Further, the last several years have brought new types of HIV medicines, providing people with HIV in wealthy countries many more treatment options. But their counterparts in developing countries will likely have a long wait before benefiting from these new drugs.

Most if not all of these newer medicines will likely be patented in India, blocking the production of affordable generic versions. In fact, some new medicines, such as Isentress and Intelence have already been patented in India, blocking the generic competition that led to deep price drops for the first HIV drugs. The most affordable second-line HIV regimen costs seven times more than the most affordable first-line regimen. And a possible third-line regimen could cost nearly 50 times as much. This means that treatment will once again be priced out of reach for the millions of people who will need newer medicines to stay alive. With growing numbers of people in urgent need of treatment, this is a time bomb waiting to explode.

Europe Attacks Access

Just as the outlook for affordable medicines in developing countries was becoming dismal due to India's patent law, the European Union stepped in to deal several more blows. Europe's attack is taking a variety of forms, targeting essentially every aspect of medicine supply. It could affect production, registration, sale of and trade in generic medicines and will disrupt patients' ability to receive affordable treatment for HIV and other diseases.

To give one example: Europe is negotiating for India to introduce "data exclusivity", which allows pharmaceutical companies to keep private, for a certain amount of time, the clinical trial data for medicines that they had originally developed. This would be the policy whether the drug is patented or not. It would mean that generic manufacturers could not register their medicines simply by proving that they have the same therapeutic effect as the brand-name product; they would be forced to provide their own clinical trial data for their generic versions of the drugs, because the original data would not be public. Clinical trials are not only very expensive, but redoing trials for already proven medicines is not ethical, as it means withholding effective medicines from some people in the trial. Data exclusivity would effectively delay or even block generic medicines, reserving the market for the large pharmaceutical companies that keep prices high.

Another way European governments have been attacking access is by detaining shipments of legitimate generics that are travelling through Europe from India on their way to patients in developing countries. European custom officials have staged more than a dozen such raids at airports, and some shipments have even been sent back to India. Europe claims this is done to protect the public in an effort to crack down on counterfeit medicines. But this has nothing to do with fakes. Delaying

these shipments has resulted in people having had their treatment interrupted. For people with HIV who need to take their medicines on schedule, delays can be very dangerous.

Europe has been launching these attacks against the backdrop of millions of people who do not have access to the essential medicines they need to stay alive. These actions are incredibly destructive at a time when tight budgets are already drying up the money needed to put people on treatment – the largest treatment providers such as the Global Fund and PEPFAR are facing severe funding shortfalls. Pushing policies that keep drug prices high when funds for treatment are short will deepen the health inequalities between patients in rich and poor countries, and lead to more unnecessary deaths.



Fighting Back

The European Commission must be stopped before it is too late and people in poor countries have to pay the price. Protests have already been organized across the developing world, including India, Indonesia, Brazil, Nepal, and Thailand by networks of people with HIV demanding that Europe stop its campaign against their lifeline to affordable medicines.

We ask that everyone, everywhere, help us in this fight by sending a message to Europe to keep its hands off our medicine. Please visit action.msf.org to sign and send an email to the European Trade Commissioner Karel De Gucht, calling on him to put a halt to Europe's destructive policies. For more information on this and other issues surrounding essential medicines, visit MSF's Campaign for Access to Essential Medicines online at msfaccess.org. ■

Médecins Sans Frontières is an international medical humanitarian organization that provides aid in nearly 60 countries to people whose survival is threatened by violence, neglect, or catastrophe. The MSF Access Campaign works to improve access to existing medical tools and to stimulate the development of urgently needed improved tools.



by Kristin Goodwin

On January 12, 2010, Haitians living with HIV, their advocates, and service providers sat in a room in Port-au-Prince with tough decisions to make about Haiti's AIDS funding. In the last few years, it had become clear that the Haitian government and the organization that administered funds from PEPFAR were not getting resources to the people who needed them most. It was time for a new direction, and for the funds to go toward more services on the ground.

The air in the room was heavy. The conversation was an important one – changes needed to be made about how this funding was being used. At the time, 55% of Haiti's PEPFAR funding was taken off the top for “administrative costs.” And although Haiti did provide HIV medications, the system had serious problems that prevented people's needs from being met. A lack of housing and supportive services made providing comprehensive treatment and care very difficult. Haitians with HIV also suffered intense stigma that prevented them from obtaining services.

But something else happened that day that prevented these problems from being addressed – an earthquake that changed everything. As the walls of the meeting room began to shake, and then to collapse, the people ran into the streets and saw the entire city of Port-au-Prince literally fall down around them. In seconds, the city's already precarious infrastructure collapsed into chaos.

Before the Earthquake

Haiti had once had the highest HIV prevalence in the Western Hemisphere: over 6% of its people had HIV. But significant progress had been made in slowing the epidemic, and HIV prevalence had dropped to 2.2% (lower than Washington D.C.'s rate of 3%).

Over 40% of Haitians who were receiving HIV treatment and care before the earthquake are no longer receiving it, and haven't been for almost a year.

Thanks in part to PEPFAR, Haiti had been able to provide 68 sites where people could get HIV treatment, and the country did extensive tracking of patients using an electronic system. The government regularly surveyed HIV and other health issues, and had launched an HIV testing campaign. Most importantly, Haiti had developed strong networks of people with HIV and of AIDS organizations that advocated and fought for prevention, care, and access to services.

After the Earthquake

As the immediate panic subsided, people searched the rubble for those lost and did

what they could to find safety. As days and weeks passed, it became clear that the earthquake, which killed almost 300,000 people and displaced over a million, threatened to undermine completely all of the progress that Haiti had made on HIV. Hundreds of thousands of people lost their homes, and hundreds of crude encampments sprung up in the hardest-hit areas in Port-au-Prince and surrounding areas. But as that temporary solution became more permanent, the encampments became increasingly dangerous. Orphaned children were at high risk of exploitation. Physical and sexual violence – especially against women, children, and transgendered people – escalated, placing people at risk for HIV. Open sex work and exchanging sex for food and shelter became common practices, further increasing the HIV risk.

In the months since the earthquake, the situation in Haiti has not improved. Although the international community responded with significant contributions to help overall recovery efforts, much of that funding has still not hit the ground, and very little of it was HIV-specific. Over 40% of Haitians who were receiving HIV treatment and care before the earthquake are no longer receiving it, and haven't been for almost a year.

HIV-positive Haitians had been told repeatedly that an emergency plan to address the situation was in the works but that plan, once drafted, showed no real change in the way that AIDS services would be provided after the earthquake. Most egregiously, people with HIV were not consulted during its creation, and most have never seen a final version.

Activism in Vienna

As the 2010 International AIDS Conference in Vienna approached, activists in New York and Haiti began to strategize about the messages that needed to be sent during the conference. Advocacy efforts in Haiti had not made much headway, and it was time to take the issue to the international stage.

Six of the delegates who traveled with New York's Housing Works to Vienna had come with PHAP+, a grassroots Haitian coalition of people with HIV and their service providers. They wanted the message to be clear: Haiti needed a post-disaster

AIDS plan that included treatment, housing, food, shelter, and jobs. And Haitians with HIV needed to be involved in the process of deciding how to meet these needs.

Before the keynote speech by former President Bill Clinton (the U.N. special envoy to Haiti), a group of Housing Works and Haitian delegates placed themselves in the middle of the VIP section, directly in front of where he would be speaking. They were armed with banners, chants, and noisemakers, and were prepared to interrupt his speech to make their concerns known. Conference staff acted before the meeting even started, but the activists refused to leave the VIP area. The end result was a conversation between Haitian AIDS activist Esther Boucicault and President Bill Clinton in which he promised to address her con-



cerns. Later that afternoon, Esther was able to meet with Clinton's staff to schedule a meeting, and Clinton himself agreed to visit one of her organization's clinics this fall.

The following day, PHAP+ and Housing Works organized a march. The group chanted their demands for treatment, housing, food, and jobs in English and Haitian Kreyol, making its way into the main session room, stopping the program. As the Haitian delegates made their way onto the stage, the conference speakers stepped aside and allowed Esther to take the microphone. She eloquently and boldly called for an emergency AIDS plan for Haiti. She informed the international HIV community that its donations had not been utilized but sat in banks

across the world while people in Haiti were living in tents without clean water, food, or medical care. As her words were translated, the surprise in the room was unmistakable. Many in the audience clapped and cheered as the activists marched off the stage. Their demands had been heard.

After Vienna

Yet, more than nine months after the earthquake, and another two months since Vienna, Haiti is still without an organized emergency AIDS response. U.N. and USAID officials have promised an action plan, but that "plan" that was written was simply to appease critics, not to set anything real in motion. Haiti's two major health care entities are competing over the reconstruction

of the health care system, and neither of them is talking with HIV-positive people or grassroots providers and advocates. The city sits on piles of rubble. Thousands of people are still living in the camps, with the threat of imminent eviction. Some HIV medication is being distributed, but treatment is still not reaching those who need it. HIV prevention is not being done in the encampments, leaving their inhabitants at risk for HIV. And now, cholera has reared its head, which will claim more lives as aid organizations rush to respond.

Moving Forward

The need for immediate action couldn't be clearer, but both national and international

efforts have come up short. It is the activists in Haiti who will get this done by refusing to stand and watch their country fall apart.

Unfortunately, grassroots organizations are being overlooked as allies, and large amounts of aid funding is going to large internationally based charity organizations that have parked themselves in Haiti. But the grassroots organizations have been able to most effectively reach people, especially people with HIV. Despite the fact that they are not being included in the response to this tragedy, people are moving forward, and – even without government cooperation – many small community-based services are being provided.

With the total destruction of Haiti's health care system, Haitian activists involved in the coalition PHAP+ and other grassroots organizations have partnered with Housing Works to organize clinics in places where the needs are greatest. In the initial days after the earthquake, these clinics triaged injuries and provided people a safe space. Now, they continue ensure that there are places people can go to receive HIV medications and comprehensive health care.

PHAP+ has also continued to bring light to the lack of prevention and care for people who are HIV-positive and those who are at risk in the encampments. In the months following the earthquake, they organized widespread condom distribution, sending volunteers and coalition members into the largest camps in Port-au-Prince to talk with people about HIV and how to stay safe. These actions have been tied to public criticism of the government's response and a demand for a community-supported Haitian National AIDS Strategy to rebuild its system of care for those who are HIV-positive.

Haitian activists with HIV have been more and more public about their status, which has allowed them to be clear about their needs as a community. Stigma has hampered housing provision, jobs and health care for people with HIV for years, and the earthquake has only amplified those needs. But their willingness to speak out and to demand that the government and the international community respond will be the key to Haiti's recovery. ■

Kristin Goodwin is the Director of NYC Policy and Organizing at Housing Works.

system strengthening, and to create new programs for vulnerable populations, the Global Fund faces a profound funding crisis.

Similarly, the capping of PEPFAR funding led to directives in Uganda and elsewhere that “a flat-lined budget for treatment ... should not be exceeded” and that the few treatment slots available from losses to follow-up or death should be given to “the sickest patients.” In the wake of this directive, thousands of people who tested HIV positive, often in late stages of immune deficiency, were told to wait in line – in essence to die. Those who were untested would now wonder, “Why should I get an HIV test? There’s nothing for me but a death sentence.” For those who do test, profound ethical quandaries arose. Those who arrived in wheelbarrows, on the brink of death, would die unless they were rushed to the front of the line, postponing treatment for others whose prognosis is greatly enhanced if they start treatment while their immune systems are still functioning. Pregnant women wondered, “Should I begin treatment to reduce the risk of transmission to my baby or should I give my place in line to a baby with HIV who will otherwise die within two years?” Should husbands and wives and brothers and sisters flip coins? Or will the czars of rationing reserve scarce treatment slots for health workers, many of whom have HIV and all of whom are needed to provide desperately needed health care?

The position of AIDS activists is clear: If there is enough money for war and enough to bail out bankers, there’s enough to save the millions of lives that will be lost if flat funding continues.

International outrage at the stark reality of these death queues, and coordinated advocacy campaigns in Africa and the U.S. led by Health GAP and its allies, resulted in an eventual reversal of the U.S. policy, at least in Uganda. A recent statement from the U.S. Ambassador to Uganda stated, “To address Uganda’s short-term needs, the American people will add new HIV funding above and beyond our current annual budget of \$280 million. These new funds, invested over a two-year period, will increase enrolment of new patients by at least 36,000 this year, with an additional 36,000 patients next year.”

Fighting for Funding

Creating false conflicts, engaging in wishful thinking about efficiency, and praying for people to get well will not stop the crash



The Global Fund

of the people’s immune systems. Untreated, people with HIV will die, often in the prime of life, leaving vulnerable children, grieving partners and parents, and depopulated communities. The position of AIDS activists is clear: If there is enough money for war and enough to bail out bankers, there’s enough to save the millions of lives that will be lost if flat funding continues.

The U.S. accounts for a quarter of the global economy and a third of donor-country economies. UNAIDS estimates that the global AIDS funding need for 2010 is \$26.7 billion, with more needed if we are to start treatment earlier with the better treatment regimens recommended under the new WHO treatment guidelines. Funding needs will continue to rise over the next five years to reach universal access.

If the U.S. decides to provide its fair share (about \$9-\$14 billion a year from 2010 to 2015), it will offer leadership for other countries to follow. Even if 2011 appropriations only reach \$7.25 billion (and grow by \$1 billion a year after that) and the U.S. directs \$6 billion of that funding to the Global Fund over the next three years, we would be substantially closer to achieving the goal of universal access by 2015. If money is short, as the U.S. claims, the U.S. can join the international effort to make the financial sector pay a financial transaction tax that would fund global health investments (see article on page 10).

But informed outrage alone will not put the U.S. back on track to providing its fair share of funding. Activists need to continue shrewd campaigns aimed at Congress and the White House. The consequences of inaction will be all too real for the millions who are diagnosed with dangerously low CD4 counts, for mothers hoping to prevent transmission during childbirth, and for the community at large, which would see dramatically lower transmission rates if universal access to treatment were achieved. ■

Brook Baker is a professor at the Northeastern University School of Law and a Policy Analyst for Health GAP.

Creating Opportunity from Challenge

In May of 2009, President Barack Obama proposed a new Global Health Initiative to combat AIDS in some of the world's poorest countries. The plan proposed spending \$51 billion on PEPFAR, the government global AIDS program. This is \$5 billion less than what was promised in the 2008 Lantos-Hyde Act, disappointing many activists. Despite the drop in funding, however, there are still ways to work efficiently and provide AIDS services.

One way to do more with less funding is to redirect current prevention funds to areas in greater need, and to programs that are proven to work. In one promising example, the 2008 reauthorization of PEPFAR greatly relaxed restrictions on sexual education. Under President Bush, although one-third of prevention funds could be used on "condoms and related activities," any program that received PEPFAR funding was required to promote abstinence until marriage. Under this administration's new guidelines, if over half of an organization's programs teach about condoms, that organization can file a request for approval with an explanation. These requests, however, can sometimes be denied.

On the positive side, the reauthorization also proposed funding for the prevention of HIV among men who have sex with men and commercial sex workers, two groups disproportionately affected by HIV but largely ignored in the first few years of PEPFAR. This will enable organizations to spend money on two historically ignored high-risk groups, making the fight against HIV much more effective. PEPFAR funding can also now be used on needle exchange programs. Research has proven that clean needles drastically lower rates of both HIV and drug use.

One of the best ways to reduce spending on HIV treatment is to purchase generic medications. Although these were not widely available in the early years of AIDS, the landscape has changed dramatically in the past decade. Due to competition between generic manufacturers, HIV medications are now available for much lower prices. Nevertheless, even these reduced prices are still too high for many people in developing countries. The Global Fund and PEPFAR can help lower these costs even more by negotiating directly with manufacturers. In recent years, the Clinton Health Access Initiative has had success in negotiating with Pfizer to cut their prices for AIDS medications by 60%.



Organizations on the ground can also reduce their costs. By shifting tasks to local centers, the costs of medication delivery and overhead can be cut. Fewer trips to conferences and thoughtful use of technical assistance to improve the quality and efficiency of services can redirect valuable funds to direct care for patients. Informative studies and reports should be sent only to organizations that will use them (since printing and mailing costs can be high), and agencies should not overproduce these materials. New funders should be discouraged from creating "new" organizations from scratch – they should instead donate to existing efforts.

Other measures that cost little or no money can make AIDS spending much more efficient. Male circumcision, which

reduces transmission of HIV by over 50%, can be encouraged. Health care providers can also investigate maternal care and birthing practices to make sure that precautions are used, such as washing hands, using gloves, and using a birthing assistant. This is crucial to ensuring that mothers and children are kept safe from HIV and receive proper HIV treatment when needed. With needle exchange now eligible for funding, organizations should make sure that patients are made aware of these programs and helped to take advantage of them.

One of the most important ways to cut costs for HIV care, and keep patients healthy, is to have testing readily available.

When HIV is caught early, treatment can be less expensive and more likely to keep people healthy longer. Organizations should make sure that HIV testing is available, for both children and adults, at routine doctors' visits.

Treatment programs are also one of the best ways to prevent transmission, since people who are on HIV treatment are 92% less likely to transmit HIV to their partner. Educating patients about the importance of family support, and implementing programs that reduce gay stigma and HIV stigma, are vital. When lesbian, gay, bisexual and transgender people feel supported by family and peers, they are less likely to engage in behavior that puts them at risk of HIV. People living with HIV are significantly more likely to stay on treatment and to practice self-care if they feel they are supported.

Above all, it is important to think creatively about bringing limited resources to those who need them most. A drop in funding is never great news, but with the right planning and restructuring, it can be an opportunity to refocus our efforts in the fight against AIDS. ■

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Support DASH!

A CALL TO ACTION

Your voice is urgently needed to secure funding for the Division of Adolescent and School Health (DASH) at the CDC. For over two decades, DASH has effectively worked with schools across the country to build the infrastructure necessary to provide a coordinated approach to health issues, including much of the HIV, STD, and pregnancy prevention education that is provided in public schools.

When the Senate Appropriations Committee passed the Labor, Health and Human Services, and Education appropriations bill, it consolidated items from five areas within the CDC, including federal funds usually allocated to DASH. This would effectively eliminate the only dedicated funding for coordinated school health, and cut \$40 million in HIV prevention education for youth. Congress should continue to act in the best interest of young people by investing in school health funding through DASH at the highest level possible.

We urge you to call your members of Congress at 202-224-3121 and tell them to support student health and academic success by maintaining funding for DASH!