Michigan HIV News

SPRING-SUMMER 2004

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Gospel Against AIDS Goes Global

You don't need to be religious to see the benefit of Gospel Against AIDS in the war on AIDS. Especially in communities of color, the church is a key gatekeeper to social influence on acceptance vs. discrimination for those living with HIV. It also provides an unequaled venue for educational opportunities that can affect those most at-risk for HIV infection.

Gospel Against AIDS (GAA) offers tools to religious leaders to enable them to confront the epidemic head on. GAA was the brainchild of a woman who realized that just knocking on the door wasn't going to get you in – and decided to do something about it. Rosalind Andrews-Worthy developed an interdenominational training program to help Black clergy deal with the difficult issues they face when confronting HIV. With this training, Worthy and her colleagues at GAA have worked miracles within the religious community.

Rosalind Andrews-Worthy

The organization has grown exponentially from its grassroots beginnings in Detroit in 1995 to form the Global Research, Education and Training Networks (GREATNES). With a team of physicians and public health administrators from Africa and Asia, the GAA/GREATNES curriculum has been translated into French, Spanish, Vietnamese, Ibo and Hindi.

Worthy traveled to Ghana this spring as the honored guest of the Board of the new GAA-Ghana.

See this feature story on page 8.

A New Fidelity

As prevention grant funding gets fine-tuned, providing technical assistance and capacity development assistance to agencies around the state becomes more important. That's the job of Amy Peterson, who has been honing her own skills since she started in the HIV/AIDS field 12 years ago at a CBO in Chicago. She earned a Master of Public Health degree in 2002, which added to her arsenal of program management and training skills that she brings to her current position with the HAPIS Prevention Community Partnerships Unit.

My job "becomes more important because there have been so many changes," said Peterson. Agencies are experiencing change because change has been happening from the top down, beginning with the CDC's Advancing HIV Prevention Initiative and the new requirements mandated for state health departments. "Around the same time, CDC became much more invested in using proven interventions," she said.

Continued on page 3

"Retooling to Maximize the Power of Prevention"

Several HAPIS/DHAS staff, as well as a number of community partners, attended the HIV Prevention Leadership Summit sponsored by the Centers for Disease Control and Prevention held in Atlanta June 17-19. Following are a few of the Michigan delegates' highlights.

Implementation of Partner Counseling & Referral Services - PCRS serves as a key program in the Advancing HIV Prevention (AHP) initiative. One of the goals of AHP is to identify the 25% of people in the U.S. who are infected with HIV and are unaware of their infection. PCRS not only informs partners of potential HIV exposure but also links individuals to testing and prevention, medical and support programs.

Building Agency Capacity to Prepare for PEMS - This workshop presented by CDC was intended to assist grantees and state health departments on the requirements of the Program Evaluation and Monitoring System (PEMS). CDC is still unsure of a release date for this system or when data collection variables will be final.

Integrating Hep C into HIV Prevention Community Planning - The New Mexico HIV Community Planning Group presented a workshop on New Mexico's 1997 Harm Reduction Act. Hepatitis prevention is integrated into the harm reduction/syringe exchange program while targeting injecting drug users at high risk for both HIV and hepatitis. By integrating HCV, Community Planning Groups are not limited to HIV prevention and can offer "one stop shopping."

Implementing the 2002 STD Treatment Guidelines Recommendations for MSM: Integrating Programs to Improve Services - Magnet, an innovative gay men's health center in San Francisco, was developed in response to rising rates of HIV & syphilis among gay men. After a two-year planning process, Magnet opened to provide culturally competent, gay-specific services. They offer Hepatitis vaccinations, HIV testing, STD testing and treatment, mental health and substance use counseling, acupuncture and massage. They also host community events such as art exhibits, book readings, town hall forums, performances, and social events. Some events are purely social, while others may center around health/social issues (e.g., Tina's Café, open mike night themed around discussion of crystal meth). Find out more about this model program at: magnetsf.org.

Access to Services by African American Men and Women

In 2003, the Michigan HIV/AIDS service system funded through the Ryan White CARE Act (RWCA) continued to ensure access to HIV services for African American men and women. According to the client-level data reported by all RWCA-funded programs in Michigan, including ADAP, a total of 6,952 HIV-positive individuals were served during the 2003 calendar year. Of these clients, 4,216 (60.6%) were African American (including 35 who also reported themselves as Hispanic, and 193 who reported more than one race), a percentage that exceeds the proportion of African Americans reported to be living with HIV or AIDS in Michigan's HIV/AIDS Surveillance System (57.9% as of January 1, 2004).

The proportion of African American clients served statewide by Title II-funded programs alone (55.8%) is slightly less than reported in overall statewide surveillance data, however most African Americans (as well as most of PLWH/As) reside in the Detroit EMA, which is served primarily by Title I resources, rather than Title II.

Targeting Prevention

Statewide Update Conference – This year's STD & HIV Conference will be held December 2-3 at the Ypsilanti Marriott. A multicultural track has been added this year, addressing four major racial/ethnic groups in Michigan: African American, Latino/a, Native American, and Arab/ Chaldean.

Trainings and Capacity Development – A Positive Perspective – The Michigan AIDS Fund and DHAS/HAPIS trainers conducted a PLWH/A speakers' training in May. The training was filled to capacity before it was advertised, so MAF will be offering an additional training in the fall.

The Midwest AIDS Prevention Project and DHAS/HAPIS collaborated in capacity development workshops on both the individual-level counseling and the group-level components of the Prevention for Positives (POP) Intervention in March. Ten organizations sent participants to the trainings.

Community Health Awareness Group (CHAG) conducted the pilot Comprehensive Outreach Resources and Education (CORE) training – the MDCH certified outreach worker training – in Detroit in March. The first certification training was held in June.

HIV Prevention Funding – CDC has not yet released guidance for application. Liisa Randall will again take lead responsibility for developing the application due in Sept. or Oct., a delay of several months compared with prior years. HAPIS has created a new Curriculum Template, an outline of what is expected from prevention contracted agencies, now available to ensure quality interventions, as well as a sample curriculum to provide agencies with the level of detail that is expected. For additional information, contact Robin Orsborn at HAPIS.

DHAS Prevention News continued on pg 3; See page 14 for more Care News

Rapid Testing *Special Events* - National Test Day in Michigan . All of the agencies who are approved rapid test sites planned to use OraQuick for National Test Day activities held from June 21st through July 2nd. Also, this summer, Michigan will participate in a CDC-supported project to implement rapid HIV testing as part of community events targeted to African American MSM. Through a collaboration between CHAG, Detroit Health Department and Visiting Nurse Association, rapid HIV testing will be offered at the Black gay pride event "Hotter than July", held July 28 – August 1st. CDC will be on site to administer surveys to aid them in identifying perceptions about HIV testing, history of HIV testing and key barriers and facilitators associated with African American MSM seeking HIV testing.

Counselor training - Eighteen new counselors were certified in the use of OraQuick and rapid testing at a Detroit training in May. Two new sites begin rapid testing this summer. Detroit Community Health Connection will provide rapid testing at four of their locations and Henry Ford Health System will provide rapid testing in their emergency room and

A New Fidelity - Process Evaluation con't

"Because of so many changes…my role really became to bring agencies along, not only philosophically, but also with acquiring the knowledge and skills to be able to implement these new interventions."

Where previously HAPIS recommended that the agencies have protocols in place to receive funding, "We now *require* protocols," said Peterson, " these protocols outline step by step how they will do an intervention" with predetermined materials, curriculum and sites. "Agencies need to be consistent in their interventions and adherence to the protocols," and maintain their "fidelity" when implementing the intervention.

Writing the protocols was a challenge for some of the HAPIS funded agencies. "We had heard from the agencies that they weren't sure how to do that," said Peterson and so HAPIS developed a protocols workshop, held in May, which provided assistance to those who needed it.

What's totally new is the concept of monitoring the process. "Are you doing the program as it was intended?" said Peterson. "We want a more thoughtful process of to whom and why are you providing the program…and then do that same intervention consistently."

The HIV Event System, an Internet-based data reporting system that HAPIS initiated three years ago with its prevention grant-funded agencies, is an integral part of the process monitoring process. This sounds redundant and bureaucratic, but it's actually a very effective way to assess what services are being provided, to whom, and where.

Process monitoring and evaluation maintain the science in science-based prevention. Science means having controls. Controls in behavioral science mean consistency in program delivery and "fidelity" or being true to the original plan and protocols.

> "Agencies need to be consistent in their interventions and adherence to the protocols," and maintain their "fidelity" when implementing the intervention.

Gone are the days of the "wild-wild west" of HIV prevention, when everyone had great ideas and programs would shoot from the hip. Today CDC wants to fund "interventions which are tried and true science-based prevention programs." HAPIS provided a presentation to Michigan agencies, on the eight or nine "interventions in-a-box" in April 2003, prior to their applications for the 2004-2007 prevention funding cycle.

But just like a cake mix, if you don't follow the directions (protocols), you won't get that picture on the box. You can't skip the eggs and have it taste the same.

So monitoring program fidelity is new for HAPIS this year, said Peterson. And again, this is measured through process monitoring and process evaluation. This is not to be confused with outcome or impact evaluation.

All of this does get confusing, so Peterson coordinated a workshop to explain the role of process evaluation and distinguish among the different types of evaluation. In April HAPIS sponsored "Using Process Evaluation to Improve HIV Prevention Interventions" presented in Ann Arbor by Peterson and David Napp, who has worked as a consultant for CDC to develop trainings in response to CDC's ongoing interest in developing evaluation capacity nationally. (You may view an abbreviated PowerPoint presentation from that workshop on-line soon at www.mihivnews.com/fidelity.pdf)

The second change for HAPIS in this funding cycle was "acknowledging that our agencies by and large did not have the training or know-how to conduct outcome monitoring," said Peterson. So they tried to simplify the application by requesting "what types of changes you expect to see, what direction and what type of change you are expecting with this intervention." HAPIS technical assistance will then help these agencies develop tools for outcome monitoring.

So, how's it going so far? At the 90-day assessment, even the "high-functioning, long standing" agencies were having a problem with curricula and protocol development. "There was a disconnect between what HAPIS thought agency capacity was in these areas, and the reality. So we have created tools and training to bridge the gap...," said Peterson. The training in May was to focus on quality assurance and protocol development. "It has been a time of great change and learning for both HAPIS and our contract agencies, but the quality of HIV prevention services depends on us figuring it out together."

'Show me the Money'

In one speech, delivered with policital acuity in Philidephia on June 23, President Bush addressed the care issues most on our minds, emergency relief for ADAP and CARE Act reauthorization and release of global AIDS funding dollars. He even mentioned the "C" word. (However, the week prior without fanfare, the CDC slipped into the Federal Registry proposed prevention mandates that caused a wake of media response. See Federal Prevention Guidelines and Grants on page 15.)*

Not to be confused with *the* Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR) – unilateral funding to 12 African nations and Haiti and Guyana in the Caribbean – just added Vietnam, said Bush. According to a White House release, some analysts predict the increase there would be greater than predicted increases in India, Russia or China, which are "three of the countries that have been referred to as the 'next wave' countries," according to the senior officials. And the President announced an immediate release of $500 million to the now 15 target countries for his five-year, $15 billion PEPFAR.

USA Today reported the president also said he would take $20 million from other programs to provide drugs to American HIV/AIDS patients unable to afford them and waiting for help (emergency supplemental for ADAP). And he called on Congress to renew the Ryan White CARE Act, which expires next year.

The Kaisernetwork reported that the same day the US House Foreign Operations Appropriations Subcommittee approved a $19.4 billion draft foreign aid spending bill for fiscal year 2005, including $2.2 billion for global AIDS, TB and malaria programs (less than Bush's proposed FY 2005 budget, but it doubled the amount Bush would contribute to the Global fund providing less for PEPFAR). Combined with an anticipated $600 million in funding from the Labor-HHS-Education appropriations bill, this would bring overall global AIDS, TB and malaria spending to $2.8 billion for FY 2005.

National News continued on page 15

*ADAPs (AIDS Drug Assistance Programs) serve as "payer of last resort" for prescription medications to people with HIV/AIDS and each year, approximately 136,000 people receive services from ADAPs, representing about 30% of people estimated to be living with HIV/AIDS in care in the U.S.

world news briefs

15th International AIDS Conference
Bangkok July 11 - 16

Seventeen thousand delegates from 160 countries attended the opening ceremonies of the XV International AIDS Conference in Bangkok, Thailand. The theme this year was "Access for All."

***See reports of the conference at*:**
www.mihivnews.com/in_the_news.htm

Peter Piot, UNAIDS executive director, cautioned that the downward revisions of the estimates (38 million worldwide with HIV at the end of 2003 down 13% from previous estimate) in the UN biennial report released July 6 do not mean the epidemic is slowing. Rather, he said, AIDS is continuing to expand, reaching alarming heights in Asia and Eastern Europe. *Boston Globe* (7.07.04)

· G8 leaders announced the formation of the Global HIV Vaccine Enterprise to speed the development of an HIV/AIDS vaccine. *Kaisernetwork* (6.14.04)

· The World Health Organization pulled two Cipla-produced generic antiretrovirals (3TC and AZT) from its list of approved HIV drugs and said the Indian drug firm had not proven that these generics were biologically equivalent to patented drugs. *NY Times* (6.16.04) Three out of 27 Asian antiretroviral rug manufacturers meet WHO quality standards, study says. *NY Times* (7.08.04)

· The Global Fund to Fight AIDS, TB and Malaria needs $3.5 billion for 2005 projects, but donors have so far pledged only $900 million. *New York Times* (07.17.04)

· Brazil provides free AIDS drugs to about 125,000. Since 1996, when it pioneered free distribution, AIDS mortality has fallen from 70 percent to 40 percent. Latin American politicians and scientists are examining ways to assure the long-term viability of free antiretrovirals. *Nature* (6.03.04)

· US Food and Drug Administration will fast-track its review process for generic combination drugs for AIDS patients in developing nations. *AP* (5.18.04)

· Uganda joined Botswana to become the second African country to distribute free generic drugs, and plans to treat all of the country's 100,000 people living with AIDS. *AP* (6.14.04)

· Botswana, with the world's highest HIV prevalence rate (nearly 40% of the adult population), has adopted a routine HIV testing policy; testing is strongly encouraged at all visits to the national health care system. *Washington Times* (5.10.04)

· Russia has the world's fastest rate of HIV infection, with an estimated 1-1.5 million Russians infected with HIV. *Seattle Times* (6.17.04)

MICHIGAN: Taking Control

In June, 50 CBOs, health departments and medical centers observed National Testing Day in Michigan, sponsored by the Michigan Department of Community Health. The national campaign helps reach millions of Americans at risk for HIV. This year's messages encouraged them to "Take the Test, Take Control."

The CDC estimates that between 850,000 and 950,000 Americans are living with HIV, and yet nearly 180,000 to 280,000 are unaware of their HIV infection.

Four Michigan CBOs Receive Direct CDC Grants

Michigan agencies targeting specific at-risk audiences with prevention were three of the 142 CBOs nationwide that were to receive awards averaging approximately $345,000 on July 1, according the the CDC press release, May 21. The Arab Community Center for Economic & Social Services (ACCESS) in Dearborn will target the Arab-American MSM Community; Community Health Awareness Group (CHAG) will provide prevention for Injection Drug Users in Detroit; and the Detroit Hispanic Development Corporation (DHDC) will reach out to Hispanic MSM.

Community Health Outreach Workers, Inc.(CHOW) in Detroit received one of 12 national awards for "Strengthening Community Access to and Utilization of HIV Prevention Services," from the CDC program announcement 04019 targeting prevention capacity building for services to racial/ethnic minority populations announced in April.

"Granholm Signs Bills to Teach Abstinence in Sex Ed Classes"

Michigan Gov. Jennifer Granholm signed legislation in June (further) requiring school districts to teach abstinence with respect to HIV/AIDS issues and emphasize marriage when teaching about sexual intercourse. The two-bill package revising what is taught in sex education classes includes the establishment of a complaint process for people who think schools are not in compliance with the new requirements, with schools facing up to a 1 percent loss of their state aid if the complaint process does not result in compliance. The new laws require that instruction include adoption as an option for teens who become pregnant and lay out the criminal consequences of having sex with a person under age 16. They also direct that parents must comprise at least half the members of local sex education advisory boards. *AP* (06.24.04) CDC summary

Vaccine Awareness Day

The Midwest AIDS Prevention Project recognized Vaccine Awareness Day this year by hosting an educational forum in Ferndale with a guest speaker, Gail B. Broder, MHS from the HIV Vaccine Trials Network (HVTN). Michigan HIV News interviewed Broder prior to the forum. *See the interview on page 13.*

The NAMES Project Foundation Michigan Chapter

The second semester AIDS Memorial Quilt has arrived in Michigan. These 20 Blocks of Quilt will be available for view and/or displays, through the end of the year. The Michigan Chapter will be receiving up to 20 more blocks in October. To view the Blocks visiting the Michigan Chapter please go to the web site: www.namesproject-michigan.org/quiltinmichigan.html. Please contact them via the site to organize a display of 1 or more blocks of the Quilt or have a section of the Quilt at your event. *Thursday Morning Fax* (6.03.04)

In Remembrance

Schawne Anthony Parker departed this life June 26 suddenly from an aneurism. Parker was born January 7, 1967 in Detroit, Michigan. At an early age he knew that his life's work would be helping others. In 1993, Parker became the President of Men Of Color Motivational Group where he helped establish an organization which provides services for African American Men with HIV/AIDS. In 1995, he became a patient advocate at the Detroit Medical Center. Parker also worked for the City of Detroit Health Department. In 1997 Parker helped start Gospel Against AIDS with Rosalind Worthy. He became Executive Director of Community Health Outreach Workers, Inc. in Detroit in 1998. From this base he helped lead the fight to decrease the epidemic. He served on the Michigan HIV/AIDS Council until December 2003 and was Community Co-Chair May 2000 through December 2002. He also began the African American Workgroup, for which he was Chair from 2000-2002.

Steve Pollock passed on June 15 following a long struggle with cancer. He was 57 years old. Pollock was an active member of the HIV/STDs and Adolescents Networking Committee and was the former Executive Director of the Michigan Network for Youth and Families (MNYF). Pollock was instrumental in bringing the first national Training-of-Trainers (TOT) of the "Street Smart" HIV/AIDS and STD Program for Runaway and Homeless Youth to Michigan. He was recognized for his work helping sexual minority youth in Michigan.

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Midwest AIDS Prevention Project
429 Livernois
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(248) 545-1435 (tel)
(248) 545-3313 (fax)
www.aidsprevention.org

Michigan HIV News
Editorial Board
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Bwood@mihivnews.com

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429 Livernois
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Statewide Training

Schedules and/or contacts for training provided by MAPP, the MATC Michigan AIDS Education and Training Center and MDCH are provided on the website (www.mihivnews.com/train.htm). Note: Community Health Awareness Group is now providing HAPIS sponsored outreach worker training.

MAPP Training

The Midwest AIDS Prevention Project offers training from peer ed to GLTB sensitivity for medical professionals statewide. **Contact:** MAPP at (248) 545-1435.

MDCH Training

You will find on the website the complete DHAS training schedule, also the MDCH Office of Drug Control Policy, Substance Abuse Prevention, HIV/AIDS Regional Training Centers Training Schedule. Following its the Revised July - December Training Calendar.

HAPIS HIV Prevention/Test Counselor Related Training

Module trainings scheduled through Dec. For more information, registration deadlines and application forms to download, see the website (www.mihivnews.com/dhas_train.htm).

Module 1: Basic Knowledge Training

Dates	Location
Aug. 5-6	Lansing
~~Aug. 19-20~~	~~Detroit~~ cancelled
Sept. 21-22	Traverse City
Oct. 5-6	Detroit new
Oct. 28-29	Lansing
Dec. 7-8	Detroit

Module 2: HIV Prevention Specialist Certification Training

Dates	Location
Jul. 8-9	Detroit
~~Jul. 20-21~~	~~Lansing~~ cancelled
Sept. 14-15	Lansing
Sept. 23-24	Traverse City
Oct. 7-8	Detroit
Oct. 14-15	Detroit
Nov. 2-3	Detroit
Nov. 16-17	Lansing
Dec. 9-10	Detroit

Module 3: HIV Test Counselor Certification Training

Dates	Location
Jul. 22-23	Lansing
Sept. 16-17	Lansing
Oct. 21-22	Detroit
Nov. 4-5	Detroit
Nov. 18-19	Lansing

Note: There is a $40 fee for non-MDCH designated sites to attend Modules 1-3.

One-Day Prevention Specialist/Test Counselor Update Training

For additional options, see the website page: www.mihivnews.com/dhas_train.htm; for further information contact the Training Unit secretary (517) 241-5903.

Dates	Location
Aug. 24	Lansing
African American Heterosexual Men	
Sept. 30	Lansing
PCRS Training for Community Based Organizations	
Oct. 18	Detroit
Addressing the Issues of Transgendered Clients	

Assuring the Quality of HIV Counseling, Testing, and Referral

Dates	Location
Oct. 4-5	Lansing

HIV Prevention Counseling: Addressing the Issues of Clients Who Test Positive

Date	Location
Aug. 30-31	Detroit

To register for Prevention/Test Counselor Trainings, contact the (ETRD) Unit Secretary, Julie Babb, at (517) 241-5903.

HIV/AIDS Case Management Certification Training

Participants must have the prerequisite HIV Prevention/Test Counselor certification. It is necessary to attend the en-

tire training session and satisfactorily complete the certification examination to become a MDCH-certified HIV/AIDS case manager. More information on these trainings and recertification options is available on the website. **Contact:** Bear Press: (517) 241-5929.

Date	Location
Oct. 25-29	Detroit

Partner Counseling and Referral Services Training

For more information on the PCRS trainings, **Contact** Audrea Woodruff at (313) 456-4421.

PCRS Certification Training for Local Public Health

Date	Location
August 18-19	Traverse City

PCRS Supervisory Training

Date	Location
August 4-5	Kalamazoo

PCRS Certification Update

Date	Location
July 8	Sault Ste. Marie

A discussion on how the Internet can be used in conducting PCRS. Also, examine the non compliant client, and what strategies can be used to delivery PCRS.

Sept. 14 Lansing

A special panel of professionals from the following systems (Mental Health, Substance Abuse, and the Courts) will discuss the issues of clients who are served in one or more of these systems and who are in need of PCRS. Representatives from these systems will present a scope of their services, while offering guidance for referring clients into their systems.

Sexually Transmitted Diseases Training Courses

Contact: Deana Hurlburt at (517) 241-5921.

Date	Location
Aug. 17	Detroit

Advanced Interviewing for Gonorrhea and Chlamydia. This is a 9 am - noon class.

Special Training

MI-Poz Legislative Training

Date	Location
August 16	Okemos

Sponsored by MAF, this advocacy training is for positive individuals. Space is limited, call Mark Peterson (248) 545-1435. Hotel and meals will be covered.

Statewide Meetings

Community Health Outreach Workers

CHOW POWer Set Coalition meets the first Monday of every month at a differen lo:ation around the state. (313) 963-335.

HIV/STD and Adolescents Networking Committee

The meeting scheduled for July 14 in Lansing was cancelled. This statewide committee provides an opportunity to network with professionals in youth serving agencies. A subcommittee plans the annual Teen Peer Education Conference. **Contact:** MDE (517) 241-4292.

MHAC

The next meeting on September 1 will be held at the Sheraton Lansing Hotel. The Michigan HIV/AIDS Council is the statewide planning group for prevention and care. **Contact:** Belinda Chandler (517) 241-5926.

PWA Infected and Affected Advisory Group

This advisory group to DHAS/HAPIS for the purpose of planning and implementing needs assessment and related activities is open to any person living with or affected by HIV/AIDS in Michigan. **Contact:** Belinda Chandler (517) 241-5926.

Save the Date

Dec. 2-3 Ypsilanti
DHAS Statewide STD & HIV Conference
Marriott Conference Center
More conference listings on the web site
.

WHERE TO CALL

HOTLINES

National AIDS & STD Hotline:
(800) 342-2437
Hours: 24 hours daily
Spanish: (800) 344-7432
Hours: 8 a.m. to 2 a.m. daily
TTY: (800) 243-7889
Hours: 10 a.m. to 10 p.m. weekdays

Michigan AIDS Hotline:
(800) 872-AIDS (2437)
Hours: 9 a.m. to 5 p.m. weekdays

Teen Hotline (Red Cross):
(800) 440-TEEN (8336)
Hours: 6 p.m. to midnight Fri.-Sat.

Hotline for Women:
(800) 554-4876
Hours: 2 p.m. to 9 p.m. Monday, Wednesday, Friday

National HIV/AIDS Treatment Hotline:
(800) 822-7422
Hours: 9 a.m. to 5 p.m. weekdays, 1 p.m. to 7 p.m. Saturday
Confidential treatment information by phone call provided by Project Inform. Volunteer operators (most are PLWH/As) can answer questions on HIV treatments and related diseases.

INFORMATION

National Prevention Information Network: (800) 458-5231
Expanded resource center, contracted by CDC, includes STDs and TB.

Clinical consultation:
(800) 933-3413
The Health Resources and Services Administration provides consultation for health care professionals.

Clinical trials:
(800) TRIALS-A (874-2572)

Gospel Against AIDS - GHANA

In April, Rosalind Andrews-Worthy, Founder and Executive Director of Gospel Against AIDS (GAA), traveled to Ghana for the Inauguration and Launch of GAA-Ghana. This was less than a year from the time that the founding pastor, Reverend Adjei, visited Michigan in August 2003 with fellow Ghanaian, Reverend Amoani. "The Reverends came and sat through a (GAA) presentation and even before the program was over Rev. Adjei said, 'We need this program in our country,'" said Worthy. "They knew – as the state of Michigan and the (CDC) now recognize – the power of outreach of religious leaders."

Reverend Adjei is a man of his word. As President of the Christian Friends for Democracy (Ghana) he started the ball rolling for GAA Ghana upon his return home. According to Worthy, Rev. Adjei began working to form GAA Ghana with the Ghana Ministry of Health and the Ghanaian AIDS Commission as well as some 2000 churches under the umbrella of the Christian Friends for Democracy.

"I didn't know any of this," said Worthy. "In February or March I received an invitation from Rev. Adjei to attend the Launch of GAA in Ghana on April 21st! I knew nothing of the extent to which the planning had proceeded. He had put together the program, designated officers for Gospel Against AIDS Ghana, and had begun an entire action plan and outreach for the villages around Aburi."

Upon Worthy's arrival in Ghana the huge welcoming events in Aburi also were a complete surprise to her. "He had all of the local television and radio stations present!" People from all of the neighboring villages had walked "huge distances" to come into Aburi to attend the brass band procession through the streets that welcomed Worthy to Ghana. A day long list of events for the Inauguration of GAA-Ghana followed, including an address by the Regional AIDS Co-Coordinator, and the official Launching by the Deputy Minister of Health.

Ghana, a small democratic country wedged between the Ivory Coast and Togo on the tropical Atlantic "Gold" Coast of sub-Saharan Africa, has strong ties with African-Americans as its primary export in the 16-18th Centuries was slaves. Today agricultural crops form the base of Ghana's economy; the country has been stripped of much of its gold and other natural resources and, with a failing economy, the average citizen is poor.

According to Reuters (1.26.04), of the 19 million people in Ghana, 3.4% are HIV-positive, and 200 people become infected daily.

For the week of her stay in Ghana, Worthy was followed by a video camera documenting her visit. And this was not a leisurely tourist trip. One of the GAA-Ghana Board members took a week off his work to escort Worthy and her husband to the many scheduled training events and activities that included side trips to the neighboring villages of Aburi, one of the regions of highest AIDS prevalence, via roads traveled more by foot than vehicle.

GAA ACTIVITIES IN GHANA

Rosalind Andrew-Worthy and the GAA Ghana leadership spent hours in training in each of the villages they visited around Aburi. They covered all the ABCs "underlining the role that religious leaders have to play – the capacity development for religious leaders. That's the (same) training that we offer here statewide," said Worthy.

GAA provides the much needed training for religious leaders to be able to deal with the education of their congregations. While she was in Ghana, Worthy also performed two worship services which showed the religious leaders exactly how to show compassion for those living with HIV. Even though they covered how to do this in the capacity development class, "there's a difference between doing it in a classroom – having people teach back to you among other religious leaders – and doing it before a congregation," said Worthy.

"What's demonstrated was, of course, scriptural references and how a sermon can be written, but more the hands on approach

Continued on page 9

– the touch that takes place in a healing service, the one-on-one prayer partners," she said. "People do not understand this, the need for healing service or worship service as part of our program. Some people don't understand the importance of the religious community as a power. The church has been the apex of many societies."

CHALLENGES TO PREVENTION IN GHANA

During the capacity development training, which gathered religious leaders from a variety of faiths, Worthy said that when she called the pastors to come and form a prayer line – demonstrating how to receive the individuals from the congregation one on one – "they didn't want to do it because they feared the other participants might be infected."

"They believed that HIV is transmitted through perspiration. So I had to stand up and show them; if I was willing to do it then they had to be willing to do it."

This is just one example of the lack of basic knowledge of HIV and AIDS that has plagued the rural areas and outlying villages of Ghana. Worthy did not spend her visit in the cities. There the Ghana AIDS Commission has effectively been operating a prevention education campaign since the beginning of 2002.

Religious leaders have a role to play not just in reducing discrimination based on fear and misinformation but in prevention education to dispel myths and change social mores of risk behavior. According to the 2000 government census, approximately 69 percent of the country's population is Christian, 16 percent is Muslim, and 9 percent adhere to traditional indigenous religions or other religions.

Polygamy is still practiced in Ghana, and the myth that having sex with a virgin will cure you of AIDS increases the risk to young women in Ghana, according to Worthy.

GAA Ghana had the support of an interdenominational group of religious leaders and the sensitive issue of polygamy was discussed. The people realize that "their house is burning," said Worthy and they were willing to tackle the difficult issues.

"We were even granted an audience with the chief of the region. Tradition has it that no business can be done without the chief's blessing. He came to extend his support to people who were coming to save the lives of his people." So GAA had full support from all of those who had an influence over the Ghanaian people.

In Ghana, HIV is primarily transmitted heterosexually. Commercial sex workers returning from other countries may have accounted for the earliest infections. By 2000, the Ministry of Health reported 2/3 of AIDS cases were among females.

The documentary made of Worthy's visit shows a line of females who wait just to receive a warm hug from her at the Inauguration. During the actual services the congregants would form long lines "because they realized they could share with me in their language and I wouldn't understand." They could disclose their HIV status without fear of stigma. "All they wanted was somebody to pray for them."

GAA Ghana Launch

GAA Ghana Launch parade through Aburi (left), Rev. Adjei (lower left), GAA leadership, Treasurer, Vice President and Pastor (below)

Continued on page 16

*TABLE 1: Characteristics of Michigan Residents Living with HIV or AIDS

	Estimate of HIV Prevalence[1]	Estimated Prevalence Rate[2]	Reported Living with AIDS[3]		Reported Living with HIV not AIDS[3]	
			Number	Percent[4]	Number	Percent[4]
MICHIGAN TOTAL	**16,200**	163	5,513	100%	5,778	100%
SEX						
Male	**12,520**	257	4,399	80%	4,328	75%
Female	**3,680**	73	1,114	20%	1,450	25%
BEHAVIOR						
Male-Male Sex	**7,490**	N/A	2,745	58%	2,476	54%
Injecting Drug Use[5]	**0**	N/A	897	19%	788	17%
IDU w/ heterosexual	***1,140***	*N/A*	*425*	*9%*	*372*	*8%*
IDU w/o heterosexual	***1,270***	*N/A*	*472*	*10%*	*416*	*9%*
Male-Male Sex/IDU	**830**	N/A	291	6%	285	6%
Blood Products	**180**	N/A	77	2%	50	1%
Heterosexual[6]	**2,250**	N/A	706	15%	859	19%
Partner IDU	***690***	*N/A*	*216*	*5%*	*265*	*6%*
Partner Bisexual	***110***	*N/A*	*34*	*1%*	*44*	*1%*
Partner Rec'd Bld	***50***	*N/A*	*16*	*0%*	*22*	*0%*
Partner HIV +	***1,390***	*N/A*	*440*	*9%*	*528*	*12%*
Perinatal	**200**	N/A	35	1%	103	2%
Undetermined/Other[4]	Not Applicable	N/A	762	(14%)	1,217	(21%)
Presumed Hetersexual[7]	*Not Applicable*	*N/A*	*613*	*(11%)*	*822*	*(14%)*
Other[8]	*Not Applicable*	*N/A*	*149*	*(3%)*	*395*	*(7%)*
AGE AT DIAGNOSIS						
0 -12 years	**220**	12	35	1%	118	2%
13 -19 years	**360**	36	51	1%	200	3%
20 -24 years	**1,460**	227	255	5%	764	13%
25 -29 years	**2,510**	383	666	12%	1,085	19%
30 -34 years	**3,290**	465	1,144	21%	1,146	20%
35 -39 years	**3,270**	415	1,230	22%	1,052	18%
40 -44 years	**2,360**	291	964	17%	682	12%
45 -49 years	**1,380**	188	589	11%	370	6%
50 -54 years	**780**	123	340	6%	207	4%
55 -59 years	**340**	70	138	3%	96	2%
60 -64 years	**140**	37	64	1%	37	1%
65 years and over	**80**	7	37	1%	21	0%
RACE / ETHNICITY						
White, Non-Hisp.	**5,920**	76	2,108	38%	2,015	36%
Black, Non-Hisp.	**9,360**	668	3,134	57%	3,387	60%
Hispanic	**600**	185	226	4%	189	3%
Asian	**60**	34	26	0%	17	0%
American Indian	**50**	94	13	0%	24	0%
Unspecified/Other[4]	Not Applicable	N/A	6	(0%)	146	(3%)

Footnotes for Table 1

1. This estimate includes all persons living in Michigan at diagnosis of HIV or AIDS, including those not reported or not yet diagnosed. All estimates are rounded to the nearest ten, and the minimum estimate given is 10. See below for explanation of this estimate.
2. Rates are calculated per 100,000 population in 2000.
3. Includes reports that contain patient name or are otherwise unduplicated.
4. Age, sex, race, and behavior percentages are calculated excluding missing data. The percentages of total cases missing this demographic information are given in parentheses.
5. The IDU risk category is further subdivided to indicate the number and percentage of persons who also had a sexual partner who is considered to be a "high risk" heterosexual, (i.e., partner is an IDU, a bisexual male (for females), a recipient of HIV infected blood or blood products or a person who is known to be infected with HIV).
6. The heterosexual category includes only those persons with "high risk" heterosexual partners as defined in footnote 5.
7. This subset of undetermined includes persons who had heterosexual sex but their partner(s') risk is unknown. This includes unconfirmed occupational exposures (1).
8. Includes persons with confirmed exposure in the health care setting in the U.S. (2) or other countries (1), and pediatric cases with probable sexual mode of transmission (2).

Statistics, provided by the MDCH HIV/AIDS Surveillance Section, are from *HIV/AIDS Quarterly Analysis.*

Pending Lab-Based Reporting of HIV

Just passed by the Michigan Senate and on to the House is a bill to amend the "Public Health Code" regarding HIV reporting in the State. Passage of Senate Bill No. 1129 would add to the completeness of reporting of both HIV and AIDS.

It would do this by requiring licensed clinical labs to report positive HIV tests, and also "test results ordered for the management and surveillance of the infection" (CD4 test results under 200 and viral load test results) which would indicate an AIDS diagnosis. Under the present law, Michigan has name-based reporting of HIV positive tests to local public health departments by physicians and testing sites for testing that is not requested to be done anonymously. Medical providers are also required by law to report AIDS diagnosis.

Michigan was actually ahead of the national game for requiring HIV name-based reporting. It was written into the public health code as part of a package of HIV laws passed back in 1988. Now Michigan is the only name-based HIV reporting state that does not require the clinical laboratory to report HIV according to Eve Mokotoff, HIV/AIDS Epidemiology Manager for MDCH.

"An integrated, clinically-based HIV/AIDS surveillance system worked well in the late 1980's and early 1990's," stated Mokotoff in a presentation. (However), as medical care became more decentralized, the system's dependence on conducting surveillance with a manageable number of key physicians became less reliable."

"An integrated, clinically-based HIV/AIDS surveillance system worked well in the late 1980's and early 1990's. (However), as medical care became more decentralized, the system's dependence on conducting surveillance with a manageable number of key physicians became less reliable."

If this bill is passed by the House, it will not affect a person's ability to be tested anonymously in Michigan, which has been unique in allowing anonymous reporting from the non-anonymous care setting (i.e., physician's offices) according to Mokotoff. "We are not interested in, and have no plans for, changing the availability of anonymous reporting in Michigan."

See the PowerPoint presentation by Eve Mokotoff, which explains the ramifications of the bill on surveillance and the possible impact on future Ryan White funding at www.mihivnews.com/HIV_Reporting.htm

TABLE 3: Michigan Residents Reported Living with HIV or AIDS: Sex by Race by Behavior as of 4/1/04

MALES:	White		Black		Hispanic		Other or Unknown		TOTAL	
Male-Male Sex	2,700	75%	2,303	49%	152	47%	66	39%	5,221	60%
Injecting Drug Use	175	5%	773	17%	58	18%	8	5%	1,014	12%
Male-Male Sex/IDU	223	6%	332	7%	14	4%	7	4%	576	7%
Blood Recipient	80	2%	23	0%	1	0%	2	1%	106	1%
Heterosexual	89	2%	325	7%	34	11%	6	4%	454	5%
Perinatal	12	0%	57	1%	2	1%	2	1%	73	1%
Undetermined/Other	302	8%	841	18%	60	19%	80	47%	1,283	15%
Presumed Heterosexual	*190*	*5%*	*609*	*13%*	*49*	*15%*	*24*	*14%*	*872*	*10%*
Other	*112*	*3%*	*232*	*5%*	*11*	*3%*	*56*	*33%*	*411*	*5%*
MALE TOTAL	3,581	(41%)	4,654	(53%)	321	(4%)	171	(2%)	8,727	100%
FEMALES:	**White**		**Black**		**Hispanic**		**Other or Unknown**		**TOTAL**	
Injecting Drug Use	123	23%	525	28%	16	17%	7	11%	671	26%
Blood Recipient	11	2%	10	1%	0	0%	0	0%	21	1%
Heterosexual	283	52%	754	40%	54	57%	20	33%	1111	43%
Perinatal	12	2%	47	3%	5	5%	1	2%	65	3%
Undetermined/Other	113	21%	531	28%	19	20%	33	54%	696	27%
Presumed Heterosexual	*96*	*18%*	*436*	*23%*	*17*	*18%*	*14*	*23%*	*563*	*22%*
Other	*17*	*3%*	*95*	*5%*	*2*	*2%*	*19*	*31%*	*133*	*5%*
FEMALE TOTAL	542	(21%)	1,867	(73%)	94	(4%)	61	(2%)	2564	100%
GRAND TOTAL	4,123	37%	6,521	58%	415	4%	232	2%	11,291	100%

An Ounce of Prevention; And Saving Pound of Cure

A Kaiser Family Foundation survey found that among all U.S. adults, almost half (48%) report having ever been tested for HIV, including 20% in the last year. However, among all those who say they have been tested for HIV, nearly a quarter (23%) had the impression the test was done as a routine part of an exam.

These new findings are part of Kaiser's national "Survey of Americans on HIV/AIDS," conducted this spring. A more in-depth report on Americans' views and experiences with HIV will be released in August with a focus on differences between and among key subgroups of the population. *www.kaisernetwork.org*

Voluntary HIV Testing as Part of Routine Medical Care — Massachusetts, 2002

On the basis of patient volume and existing HIV primary care services, four hospital-associated urgent care centers in 15 cities in Massachusetts with the highest HIV prevalence were selected for the program, "Think HIV." It was designed to assist centers in routine HIV counseling and testing, facilitate patient follow-up for test results, and promote strategies for linkage to care. Patient privacy and the availability of adequate, expedient HIV care for those who tested positive were essential components of the program. Among the 3,068 patients tested, the program identified an HIV seroprevalence of 2.0%. *MMWR* Vol 53, No 24;523 (06.25.2004)

New class of Drug Shows Promise in Trials

New research presented today at the 15th International AIDS Conference in Bangkok shows promise for a novel Pfizer drug, a tablet that blocks HIV from using the CCR5 pathway to enter human cells. *Reuters* (07.13.04)

Studies indicate Young People Taking Risks, Some They are Unaware of

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults including tobacco, alcohol and other drug use and sexual behaviors. This report summarizes results from the national school-based survey conducted by CDC, 32 state surveys, and 18 local surveys conducted among students in grades 9—12 during February—December 2003.

Results: during the 30 days preceding the survey, 44.9% had drunk alcohol; and 22.4% had used marijuana. In addition, during the 12 months preceding the survey, 8.5% had attempted suicide. In 2003, 46.7% of high school students had ever had sexual intercourse; 37% of sexually active students had not used a condom at last sexual intercourse; and 3.2% had ever injected an illegal drug. *MMWR* Vol 53, No SS02;1 (05.21.2004)

An online study of 1,155 people ages 18-35 indicated about 84% believed they adequately protected themselves against STDs, but nearly half engage in unprotected sex. Approximately 47% of the respondents never used protection for vaginal sex, 82% never used protection for oral sex, and 64% never used protection for anal sex, according to the study conducted by the American Social Health Association.

Young people believe neither they nor their partners are at risk for STDs, noted Dr. James Allen, ASHA president and a former assistant US surgeon general. "They don't talk with their partner about ...risk. So they're simply making assumptions." *AP* (04.06.04) CDCSummaries

Testing for Drug Resistance Before Treatment

In 1997-2001, drug-naive persons diagnosed with HIV during the previous 12 months who did not have AIDS were enrolled in a national study. The patients came from 39 clinics and testing sites in 10 U.S. cities. The researchers conducted genotyping from HIV-amplification products by automated sequencing. The scientists conducted phenotypic testing on specimens identified as having mutations previously associated with reduced antiretroviral-drug susceptibility.

"Although the proportion of HIV-infected persons with mutations associated with reduced antiretroviral drug susceptibility did not vary significantly by age group, city, site of enrollment, CD4+ cell count, or recency of infection," the authors found, "persons with these mutations were more likely to be white, to be MSM, and/or to have a partner taking antiretroviral medications." And "while not statistically significant when all mutations are considered, some mutations, particularly those that could be confirmed phenotypically, are more likely to be found in recently infected persons."

"In summary," the scientists concluded, "HIV genotypic testing prior to the initiation of therapy in patients with newly diagnosed HIV infections and without AIDS would identify a substantial number of persons with virus with mutations associated with reduced antiretroviral-drug susceptibility." *The Epidemiology of Antiretroviral Drug Resistance Among Drug-Naive HIV-1-Infected Persons in 10 U.S. Cities*, Journal of Infectious Diseases, 06.15.04; Vol. 189; No. 12: P. 2174-2180 Edited from *The Body* summary. (6.08.04)

Note: Garald A. Goza, Manager HIV/AIDS Surveillance Section, MDCH was one of the authors of this journal article.

Vaccine Research Education

Vaccine Awareness Day started in Baltimore seven years ago with a speech by President Clinton stating that an AIDS vaccine would be available within 10 years. Since then, May 18th has become an annual opportunity to educate the public, "to help people understand what a vaccine could mean for the future and to dispel myths about them," said Gail B. Broder, MHS, of the HIV Vaccine Trials Network (HVTN).

Why the education? Has it been difficult to find participants for clinical trials? "To date the trials have all been able to find the necessary *numbers* of people," said Broder. However, there is a recognized need to have the participants be more representative of the general population – and especially those affected by the epidemic in the U.S. The trials need to include more women and more people of color.

It is important to have women and minorities in the trials to learn how the drugs affect them and how dosing may need to be different. And the number of participants must be large enough to allow for statistically significant sub-group analysis. The controversy over disparate results for the small sampling of Black participants in the unsuccessful AIDSVAX in the VaxGen US trial brought this need to the public's attention.

Young people also need to be included. "We know that infections are growing (among the under-20 age group) but federal guidelines only allow us to include those over 18...We can certainly do a better job recruiting the 18-25 age group," said Broder.

"We have to give VaxGen a lot of credit," said Broder. "Nobody wants to be first. And they pointed out some really important lessons for the rest of us to benefit from."

That is the point of the three-tiered approach to clinical trials generally. Each stage reaps important lessons. "A successful *trial*," said Broder, "may not necessarily produce successful vaccines because there is so much to learn just from the trial process. And from that standpoint the AIDSVAX trial was successful."

> "Vaccines are being created for HIV negative people – to keep them that way. Throughout participation in the trial they are encouraged to practice safer sex, to continue to use clean needles if that's an issue, to limit the number of partners – at every clinic people are being counseled about staying safe."

What is a successful *vaccine*? Depending on where the GPS (global positioning system) places you on this planet, your definition of 'successful vaccine' may vary widely. Those who advocate for the developing world see partial protection as successful and worthy of production and distribution. In fact, VaxGen was shooting for a 30% success rate.

"Even something that prevented 30% of infections would have a *tremendous* impact on world health," said Broder. And researchers have to understand who the 30% are likely to be (gender and race specific) "in order to administer the vaccine correctly."

There is "lots of excitement" about potential vaccines coming down the pipeline according to Broder. But vaccine development and the three-stage trial process is not a speedy process. Promising products now in Phase I clinical trials could take "in the ballpark of 8-10 years" to become eligible for licensure, according to Broder.

There are currently 11 products in Phase I safety studies and a couple in Phase II – which looks for 'immunogenicity' data, i.e. "does it create an immune response and is it the kind of response we are going to need to prevent infection?"

If these prove to be safe for human use in Phase I and provide good immune data in Phase II, then they will move on to Phase III trials. At the present time HVTN has no vaccines in Phase III trials. The Department of Defense is currently conducting a Phase III trial in Thailand using two vaccines together.

Broder said that the hot topic in vaccine research now is looking at a "prime-boost" regimen. The first shot– while it may not have a protective immune response in itself – is used to wake-up the immune system, so when a second 'boost' vaccine is administered, the combination of both may have a synergistic effect. "And that's what a lot of the studies are now looking into." Broder works with eleven US research sites on her job.

But again this is a slow process. Phase I trials take 1-2 years; Phase II are 2-3 years; and then, Phase III will take 3-5 years. Part of the education on vaccines is helping people to understand the process. "To have realistic expectations about the process is really important," said Broder. "Vaccine research started back in 1988...and we're still working at it."

"What's really exciting", she said, "is that now there are a lot of products coming down the pipeline and so the need is going to be there for an educated public to get involved, to volunteer for the trials."

And this is not just true for "at-risk" populations. "In the Phase I studies the only profile you need is to be in good health – and be HIV negative." Depending on the specifics of the product, these trials may be open for those aged 18 to 40 or 50. Phase I trials look strictly at the safety and tolerability of the drug. In this phase, the question of whether the product is creating an immune response is only secondary.

Continued on page 16

Continuum of Care Services Funded FY04/05

DHAS-HAPIS issued this "Continuum of Care Services Request for Proposals" on January 5, 2004. The RFP is for the period of 10.01.04 - 9.30.07 and includes Ryan White Title II resources, as well as Michigan Health Initiative funds for services outside the Detroit EMA. Applicants are funded annually during this three-year period, based on performance, availability of funds and changing needs of the epidemic. Funded agencies:

Bay Area Social Intervention Services (BASIS)
Community AIDS Resource and Education Services (CARES)
District Health Department #10
Grand Rapids Area Center for Ecumenism (GRACE)
Hackley Hospital
Spectrum Health
HIV/AIDS Network and Direct Services (HANDS)
HIV/AIDS Resource Center (HARC)
Health Delivery, Inc.
Marquette County Health Department
St. Mary's McAuley Health Center
Thomas Judd Care Center/Munson Medical Center
Wellness AIDS Services, Inc.
Westminster Presbyterian Church
Lansing Area AIDS Network (LAAN)

Michigan Care Assistance

While many states now struggle to provide needed assistance to their PLWH/As – Michigan's Drug Assistance Program is still solvent. Over 1300 clients are eligible for the current fiscal year which began April 1.

The Michigan Dental Program has recently had to make changes. As a result of the State of Michigan's altered Medicaid adult dental benefit, MDP experienced a significant increase in the number of clients enrolled in the program and as of April 1, there is now a waiting list. Also, those clients who were enrolled but have not accessed dental services in the first 90 days of eligibility are being taken off the MDP, per MDP policy. Those clients may reapply to be placed on the waiting list. For any questions regarding ADAP or MDP contact Merry Gastambide or Chris Hanson at 888.826.6565.

Using Client Level Data for Evaluation Activities

Electronic client-level data files are collected statewide in Michigan from all RWCA-funded providers on a quarterly basis. The client records are unduplicated across all providers, and data are then analyzed to measure the extent of service utilization by underserved minority and other hard-to-reach populations. Client-level data are also used to measure program goals and objectives.

Every year HIV-positive clients served (as reported in the URS) are compared to the living HIV/AIDS cases reported in the state through the HIV/AIDS surveillance system. This is done to verify that the population receiving services is representative of the PLWH/A population in the state or a specific region of the state. This comparison also identifies areas where there is a significant discrepancy between the number of living cases and the number of clients accessing services. These areas can then be targeted for intensive outreach activities in order to bring more PLWH/A into the care system. (This was done in the Benton Harbor area and the Bay City/Flint/Saginaw areas with CBC/MAI and Title II base resources, respectively).

The adjacent table shows the percentage of each population group served in the entire out-state area (the main Title II service area) in CY2003 and compares this to the percentage of living cases for the same population groups in the same area (as of January 1, 2004). These service data include clients who received ADAP services.

By comparing the two columns it is clear that the clients served are very similar to the living cases in the region. In this part of the state, the only noticeable differences between clients served and cases reported is that those being served represent a somewhat younger subset of the PLWH/A population, and Black males are slightly under-represented in the service data when compared to the living cases.

Comparing Out-state Population Groups	Service Clients	Living Cases
Males	77%	78%
Females	23%	22%
White	58%	59%
Black	30%	32%
Hispanic	7%	7%
Other Minorities	3%	1%
Unknown Race	1%	1%
White Males	49%	50%
Black Males	19%	22%
Hispanic Males	6%	5%
Other Minority Males	2%	1%
Unknown Race Males	1%	1%
White Females	10%	9%
Black Females	10%	11%
Hispanic Females	2%	2%
Other Minority Females	1%	<1%
Unknown Race Females	<1%	<1%
0-12 Years*	1%	1%
13-19 Years*	1%	1%
20-24 Years*	3%	2%
25-44 Years*	63%	60%
45+ Years*	32%	36%
Infants: 0-1 Years*	<1%	<1%
Children: 2-12 Years*	1%	1%
Youth: 12-24 Years*	4%	3%
Women: 25 Years*+	21%	20%
Total HIV Infected	2,282	3,606

ADAP: *Keeping Drug Assistance Programs Afloat*

Despite a nine percent increase in the overall ADAP budget between FY 2002 and 2003, an increasing number of people living longer with HIV/AIDS, the rising costs of HIV medications, and continuing fiscal pressures at the Federal and state levels have led some state AIDS Drug Assistance Programs (ADAPs) to implement cost-saving measures such as capping enrollment and reducing the number of HIV-medications offered.

The number of people on waiting lists for enrollment in ADAPs has increased nationwide from 1,263 in April to 1,629 in June, according to a NASTAD report

The eighth annual National ADAP Monitoring Report reveals wide variation in the eligibility criteria and drugs offered by ADAPs in the (US). The report was prepared by the Kaiser Family Foundation, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the AIDS Treatment Data Network (ATDN).

"ADAPs continue to be in a difficult situation with the need for HIV/AIDS medications exceeding available resources," said Jennifer Kates, M.A., M.P.A, Director of HIV Policy, Kaiser Family Foundation. As of April 2004, 13 ADAPs had cost containment measures in place. Eligibility criteria for ADAPs ranges from 125% of the Federal Poverty Level (FPL) in North Carolina (this is approximately $11,000 in annual income for a single person) to 500% FPL or higher. Sixteen states do not cover all FDA-approved antiretroviral medications, including one state (South Dakota) that does not provide any protease inhibitors.

ADAPs are a discretionary grant program funded through the Ryan White (CARE) Act. In addition to federal funding, ADAPs may also receive state general revenue support and other funding, but these other sources are highly variable. Although federal budget increases have generally helped states to serve more people and spend more on drugs over time, five states have had overall budget decreases and the demand for medications still exceeds the resources available in many states.

The survey is sent to states on an annual basis. Fifty-four of 57 ADAPs responded to the current survey. Edited from *Kaiser Release* (5.19.04)

US Defensive in Bangkok

At the 15th International AIDS Conference in Bangkok, the United States fought back against attacks on its AIDS policy and rejected a plea from UN Secretary-General Kofi Annan that it give $1 billion a year to the Global Fund to Fight AIDS, TB and Malaria.

US Global AIDS Coordinator Randall Tobias said the $1 billion donation is "not going to happen," and he called President Bush's request for $200 million for the fund next year "more than adequate…"

Earlier, about 50 protesters shouting "Bush lies, millions die" delayed Tobias' speech defending the administration's AIDS policies. "This year, America is spending nearly twice as much to fight global AIDS as the rest of the world's donor governments combined," Tobias said. ...Critics say (Bush's) bilateral approach undermines the Global Fund, to which the United States is the biggest donor. "The American money going to 15 countries is not leadership on AIDS," said Stephen Lewis, UN special envoy on AIDS in Africa. Annan urged the United States to show the same commitment to fighting AIDS as to the battle against terrorism... *Reuters* (07.14.04) CDC Summary

Federal Prevention Guidelines and Grants

The Centers for Disease Control and Prevention issued proposed changes to the guidelines for giving federal money to AIDS-prevention programs. The new rules would require approval of educational materials before they are posted on the Internet, increase accountability for grant recipients, and ensure recipients' compliance with a federal law requiring that the materials "contain medically accurate information" about the effectiveness of condoms in preventing STDs. *Washington Times* (06.18.04)

In its first round of annual funding since last year's launch of an initiative aimed at keeping people with HIV from infecting others, CDC announced $49 million in HIV prevention grants to 142 community organizations. About 82% of grant-receiving organizations target minorities; 41% of the money goes to programs for gay men. Part of the effort seeks to make testing more available, chiefly using a new rapid HIV test, so people who have HIV can learn their status and reduce their risk of transmitting the virus to others.

After dropping dramatically in the 1990s, AIDS rates have stabilized, while HIV infections - especially among gay men - appear to be on the rise, CDC says, leading public health officials to focus more on encouraging safe sex for those with HIV. *Atlanta Journal-Constitution* (05.22.04) CDC Summary

Researchers reported at the 15th International AIDS Conference in Bangkok that increased risky sexual behavior among MSM is evidenced by a CDC study showing a 17% jump in newly HIV-positive gay and bisexual US men from 1999 through 2002. *Atlanta Journal-Constitution* (07.13.04)

GAA - Ghana

Continued from page 9

More than 100 languages and dialects are spoken in Ghana. As a result of the country's colonial past, English has become Ghana's official language. It is used for all government affairs, large-scale business transactions, educational instruction, and in national radio and television broadcasts. So, while Worthy presented all of her training in English she was accompanied by a translator, since in these rural areas not everyone speaks English.

This has posed communication challenges for prevention messages in a poor country with isolated rural villages where most people don't have even have radios. Worthy said Ghanaians didn't realize that they were not the only ones in the world suffering from AIDS.

For the most part prevention messages must be by word-of-mouth. Worthy did leave information there that could be translated. And before leaving the country she visited a radio station where hours of the GAA training were taped for later broadcast in English. "While there were hundreds who came to the Launch and probably hundreds more who attended the trainings and services, we outreached to thousands because this will be broadcast throughout the country," she said.

TA TO GHANA AND PLANS TO EXPAND GAA IN AFRICA

Worthy is hoping to return to Ghana in the very near future. In the meantime, GAA is collaborating with an on-line career-coaching curriculum company in Michigan to provide on-line technical assistance to GAA Ghana.

Career Coaching Connections, Inc. works with people in business and education, and they have donated their services to allow GAA to provide on-line TA and live chats via the Internet. The GAA infectious disease specialists and trainers will host the live chats here in Michigan and will be accessible for those GAA leaders who have Internet access in Ghana.

Under the guidance of Reverend Samuel Adjei, GAA - Ghana's Board of Directors created and has begun implementing a strategic plan that targets specific villages where HIV/AIDS prevalence is believed to be serious.

Rev. Adjei, as well as wearing the hats of President for both GAA Ghana and Christian Friends for Democracy, is also a peace-keeping mediator for Ghana. "He is already making plans to take GAA to neighboring countries, the Ivory Coast and Burkina Faso," said Worthy.

Worthy's fluent command of French came in handy on the trip. While in Ghana, she had the opportunity to speak with the ambassador of Côte d'Ivoire and discuss how GAA works and how successful a program it is. She sees the possibility of expanding GAA to other countries as well.

This trip to Ghana disproves a couple of myths, according to Worthy. First, that a lot of money is needed to be involved; and second, that the church is not involved. This trip was made possible through contributions by churches in Detroit that came together to support the efforts of GAA.

"There are churches that are very active in supporting prevention efforts and capacity development efforts, locally and internationally – we're the proof of that."

Contact GAA at 313.341.5989.

Vaccine Research Education

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In Phase II "again we are primarily looking at safety, but in a much broader group of people… and we also start looking at questions of dosage, scheduling and timing." Products successful in Phase II trials move on to the Phase III efficacy study, to find out if they work in humans.

Both funding and interest in research for vaccines has increased in recent years. One of the HVTN collaborating groups, International AIDS Vaccine Initiative (IAVI), has received substantial funding from the Bill and Melinda Gates Foundation, for example. But "funding is never enough," said Broder.

"We look at vaccines as being one piece in the pie" that includes prevention and treatment.

A couple of key messages from Broder: "AIDS hasn't gone away…there are 40,000 new infections each year in the US alone. Vaccines are being created for HIV negative people – to keep them that way. Throughout participation in the trial they are encouraged to practice safer sex, to continue to use clean needles if that's an issue, to limit the number of partners – at every clinic people are being counseled about staying safe. Another thing to point out is there is not presently a vaccine."

Much of the job of education about vaccines is to dispel the myths. For example, people need to be convinced that there is no government conspiracy to keep a vaccine away from certain populations or that HIV vaccine trials are not Tuskegee revisited.

"We need to start educating, start laying the ground work now," said Broder, so when HVTN is ready to do a large efficacy study (Phase III trial) "there will be a public that is familiar with our work and wants to participate. Or when that vaccine is found and licensed, there will be people ready to come in to their public health department or practitioner and get vaccinated."

For more on Vaccine Research: http://www.nastad.org/documents/public/pub_prevention/200461June2004HVBulletin.pdf