

Michigan HIV News

A PUBLICATION OF THE MIDWEST AIDS PREVENTION PROJECT

SPRING 2003

INSIDE

The 10th Conference on Retroviruses and OIs, a convergence of the world's frontrunners in HIV/AIDS research, provided a wealth of information. Read highlights from the conference.

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Linking prevention for older African Americans

The 15th National HIV/AIDS Update Conference held in Miami this spring addressed, among other issues, the increase of HIV infection among older adults. Many physicians “overlook” HIV symptoms in older patients and

do not question them about their sexual behaviors, according to Dr. Mervyn Silverman, chair of the conference. “It’s not on their radar screen and it needs to be. Rarely will the patient bring it up,” Silverman said to the *Miami Herald* (3/29).

African Americans age 50 and older in Detroit and Wayne County will now be reached with a unique prevention program for both HIV and substance abuse. Adult Well-Being Services, funded by a three-year service grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is developing and implementing the program. This service grant follows a one-year planning grant from SAMHSA that allowed for “The Older Adult Interagency Collaborative HIV Prevention and Substance Abuse Prevention Planning Initiative,” which as the name implies is a collaboration with local agencies.

The first year involved extensive needs assessment including 30 area agencies and organizations, development of a Service Delivery Plan and its rollout in the well-attended “Call to Action” in December 2002.

In the United States, (stats available through 12/02) 12% of black (not Hispanic) males diagnosed with AIDS were over 50; and 8% of Black (not Hispanic) females diagnosed with AIDS were over 50. 8% of black (not Hispanic) males diagnosed with HIV were over 50; and 6% of Black (not Hispanic) females diagnosed with HIV were over 50. Note: these are only the reported cases and part of the problem is that HIV goes undiagnosed in this age group until late in the course of infection.

Substance abuse is also a problem for Americans over 50. An estimated 17% of those 50 and older and 37% of baby boomers have a substance abuse problem. Older adult substance abuse, particularly with alcohol and prescription drugs, is one of the country’s fastest growing health problems, according to Adult Well-Being Services.

Adult Well-Being Services in Detroit has been providing health promotion, which incorporates substance abuse prevention, since 1985.

It was the idea of AWBS Executive Director Karen Schrock, formerly the Chief of Substance Abuse Services for Michigan, to go for the grant. She recruited Thea Simmons to develop and write the grant proposal for a program that would combine HIV and substance abuse prevention for older African-Americans in Detroit and Wayne County.

The Center for Substance Abuse Prevention (CSAP) under SAMHSA said they were looking for programs targeting youth and underserved

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**Thea Simmons, Director
Community Health Promotion
for Adult Well-Being Services**

Funding the global war on AIDS

around the world

President Bush signed into law a \$15 billion program intended to help prevent and treat AIDS in poor countries of Africa and the Caribbean.

The program, first introduced by the White House four months ago, is designed to triple the United States' investment in international AIDS assistance during the next five years. It requires that a substantial part of the prevention subsidies be used to encourage sexual abstinence outside marriage — an approach favored by conservatives but viewed as largely ineffective by public health specialists.

The law is meant to expand efforts to curb the spread of the disease, pay for medicine and the training of health workers, build

clinics, expand HIV testing, and provide help to orphans whose parents have died in the epidemic. *Washington Post* (05.28.03)

The European Union approved a \$468 million program to fight poverty-related diseases, such as AIDS, tuberculosis and malaria, and promote reproductive health in developing countries. *Agence France-Presse* (05.20.03)

The world's seven wealthiest nations and Russia are expected to renew their support for the Global Fund to Fight AIDS, Tuberculosis and Malaria at the G-8 meeting in June, a move fundraisers say will spur governments to plug a budget gap of \$1.3 billion for vital new projects. *Associated Press* (05.20.03)

Just the science, please

Besides the congressional democratic opposition to religious politics qualifying the U.S. global AIDS spending, there have been other recent outcries of religious roadblocks to prevention.

The International Federation of Red Cross and Red Crescent Societies warned in a statement made in May that "faith-based or other prominent organizations" that single out high-risk groups for "blame and discrimination" or condemn the use of condoms obstruct the fight against HIV/AIDS. Bernard Gardiner, of the Federation's HIV/AIDS program, said that while many religious figures were in the forefront of constructive community action, "faith-based messages get in the way of science." "What we need are clear messages for people and

one is that condoms work. This message should not be muddied," explained Gardiner. *Agence France Presse* (05.08.03)

Also in May, at the Second International Muslim Leaders' Consultation on HIV/AIDS, Amina Wadud, associate professor of Islamic studies at the Commonwealth University in Virginia, said "a traditional Islamic theological response can never cure AIDS." She said Muslim women are bound by Islam to comply with their husband's desire for sex, and can be punished if they do not. This included women who know their husbands are HIV-positive. About 20 delegates walked out; some accused Wadud of blasphemy and demanded she be expelled from the conference for her comments. *Associated Press* (05.21.03)

■ Only one in five of those at the greatest risk for HIV infection know how to protect themselves because less than half of what is needed is being spent on prevention, according to a report issued in May by the Global HIV Prevention Working Group.

■ Dr. Jong-wook Lee, 58, South Korea's TB expert, was elected in May to head the World Health Organization. Lee replaces former Norwegian Prime Minister Gro Harlem Brundtland, stepping down in July.

■ WHO will draft a five-year anti-retroviral treatment strategy plan modeled on Brazil's national AIDS treatment program particularly the integration of prevention, treatment and human rights.

■ "Pandemic: Facing AIDS," a new five-part documentary series narrated by Elton John, focuses on people living with AIDS in Thailand, Uganda, Russia, Brazil and India. The series was produced by Rory Kennedy, daughter of the late Sen. Robert F. Kennedy, and can be seen in June on HBO.

■ A division of Bayer sold millions of dollars worth of a medicine that carried a high risk of giving HIV to customers with hemophilia in Latin America and Asia, while selling a new, safer product in the European and US markets, reported the *New York Times*.

■ At least a half-million Russians now are infected with HIV and the true number could range as high as 1.5 million, or more than 1 percent of the overall population.

■ "In Africa, 60% of women infected with AIDS are in monogamous marriages — or so they thought," said Stephen Lewis, UN special envoy on HIV/AIDS in Africa, opening an international HIV/AIDS researchers conference in Halifax, Nova Scotia, in April.

■ In South Africa, HIV/AIDS was responsible for about 39% of premature deaths in 2000; and without intervention premature deaths in South Africa could double by 2010.

Homeland insecurity

Several AIDS activists said they are delighted by the new global AIDS law but suggested that the administration's commitment to easing the epidemic within this country is shaky.

They said that the White House has recommended cuts in funding for the Ryan White CARE Act, a major source of payment for HIV/AIDS services, and that federal aid to state programs that subsidize AIDS therapies has not kept pace with the demand.

Jose M. Zuniga, president of the International Association of Physicians in AIDS Care, said yesterday was a "good day," but added: "I would hope the president would equally deal with the domestic issues." *Washington Post* (05.28.03)

DHAS Update

Defining our mission

Many of you know that the Division of HIV/AIDS-STD (DHAS) has been involved in a year long strategic planning process. One of the strategic issues identified by this process was to expand the ways in which we communicate with our community partners about activities of the DHAS. A column in the Michigan HIV News was suggested.

As we thought strategically about the DHAS goals and objectives for the upcoming years, we felt strongly that we should have a combined mission statement that truly reflects our commitment to both HIV and STD. After careful review of all input, including feedback from the key audiences for the Division's services, we are pleased to present our mission statement:

"The Mission of the Division of HIV/AIDS-STD is to promote the public health and provide leadership to:

- Prevent the spread of HIV and STD's
- Provide care to those infected and affected by these diseases
- Utilize science-based strategies with proven effectiveness
- Deliver quality prevention and care initiatives with highly skilled and culturally competent staff

Of course the mission statement is only one part of the strategic work that we have been engaged in. We believe that the guiding principles and program objectives that were developed during this process will position us to be responsive in a changing environment. Copies of the Strategic Plan will be

mailed to our community partners and will be available on the *Michigan HIV News* website.

In addition to the many internal changes, there have also been external changes that we believe will lead to a more efficient and effective way of doing business. Our process for both prevention and care planning and care contracting was restructured earlier this year from a regional approach to a centralized approach. This restructuring has resulted in an additional \$337,425 that has been contracted out for direct care services and an additional \$150,000 for direct prevention services. DHAS continuum of care staff has met with local providers to facilitate a smooth transition to centralized contracts with our division.

The Michigan HIV/AIDS Council is now more representative of those living with HIV/AIDS in Michigan, a key requirement of the community planning process mandated by the Centers for Disease Control and Prevention. DHAS will be working closely with the MHAC Needs Assessment Committee and proposed PWA Workgroup, as well as an Advisory Group to assure that we achieve a highly inclusive needs assessment process at the local level.

The staff of the Division of HIV/AIDS-STD would like to thank you for your partnership, commitment and tireless efforts on behalf of the citizens of Michigan. I look forward to the opportunity to share more information with you in upcoming issues.



Loretta Davis-Satterla, DHAS Director, is also now serving as chair of NASTAD, the National Alliance of State and Territorial AIDS Directors.

DHAS conducts Statewide Needs Assessment

The Division of HIV/AIDS-STD (DHAS), HIV/AIDS Prevention and Intervention Section (HAPIS) is currently collaborating with the Michigan HIV/AIDS Council (MHAC) Needs Assessment Committee on developing and implementing comprehensive needs assessment activities for HIV/AIDS care services in the State of Michigan in a process that began in May and will continue through September 2003. These activities will seek to identify service needs, gaps and barriers for persons living with HIV/AIDS (PWAs).

The primary goal of this needs assessment is to ensure that the continuum of care services funded by MDCH/DHAS/HAPIS reflect the current needs of PWAs in all areas of the state. To determine the extent to which this goal has been met DHAS will answer the following questions statewide and with respect to geographical area, race/ethnicity, gender, age, risk factor, sexual orientation and HIV, etc.:

- Why types of services are being utilized?
- What services are needed, but are not available?
- What services are needed, but not able to be accessed by clients?
- What available services are not being utilized by clients?
- What barriers are PWAs experiencing when accessing services?
- How can services be improved?
- Why are some PWAs not in medical care?
- How can providers engage in successful outreach to bring people into medical care?
- To what extent does a continuum of care exist?
- Why are people leaving care?
- What other non-RW-funded organi-

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Michigan HIV News

www.mihivnews.com

A publication of the Midwest
AIDS Prevention Project

MAPP
429 Livernois
Ferndale, MI 48220
(248) 545-1435 (tel)
(248) 545-3313 (fax)
www.aidsprevention.org

Michigan HIV News

Editorial Board

Paul Benson, D.O., Chair
Mary Dillinger, M.S., R.N., A.C.R.N.
Leon Golson
Selvy Hall-Kinnard
Sammye Stamper

Editor

Barb Wood
Bwood@mihivnews.com

Designer

Sue Chevalier
SueChev@aol.com

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To receive a printed copy via U.S. Post office, please send \$10 for a 1 year subscription (4 issues), with name and address to:

MI HIV News
MAPP
429 Livernois
Ferndale, MI 48220

E-mail: To be notified when the next issue is available to download from the website, send message "subscribe" to: info@mihivnews.com

Statewide Training

Schedules and/or contacts for training provided by the American Red Cross, Community Health Outreach Workers, MAPP and MDCH are provided on the website at www.mihivnews.com/train.htm.

MAPP Training

The Midwest AIDS Prevention Project offers training (also for trainers) for a variety of programs from peer ed to GTLB sensitivity for medical professionals statewide. **Contact:** MAPP at (248) 545-1435.

MDCH Training

On the website you will find the complete DHAS training schedules for HIV/AIDS and STD Sections, also the MDCH Office of Drug Control Policy, Substance Abuse Prevention, HIV/AIDS Regional Training Centers Training Schedule.

Case Management Training

Participants must have already completed the five-day HIV Prevention/Test Counselor Certification training. It is necessary to attend the entire 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 Pross: (517) 241-5929.

Case Management Certification

October 27-31 *Detroit*

HAPIS HIV Prevention/Test Counselor Related Training

For more information or to register for Prevention/Test Counselor Trainings, contact the Education, Training and Resource Development (ETRD) Unit Secretary, Julie Babb, at (517) 241-5903.

Option 1:

Five-Day HIV Prevention/Test Counselor Training (Parts I and II)

June 16-20 *Sault Ste. Marie*
December 8-12 *Detroit*

Option 2:

Part I Two-Day HIV/AIDS Basic Knowledge Training (HIV Prevention/Test Counselor Training, Part I)

June 26-27 *Detroit*
July 17-18 *Lansing*
August 7-8 *Lansing*
August 21-22 *Gaylord*
September 18-19 *Detroit*
October 2-3 *Detroit*
October 30-31 *Detroit*

Part II Three-Day HIV Prevention/Test Counselor Training

July 9-11 *Detroit*
July 23-25 *Detroit*
September 10-12 *Lansing*
September 24-26 *Gaylord*
October 8-10 *Lansing*
October 15-17 *Detroit*
November 5-7 *Detroit*
November 12-14 *Detroit*

One-Day HIV/Test Counselor Update Training

Counselors who work in HAPIS funded/designated test sites are required to be updated every two years. For other options to meet update requirement, call Francisco Michel at (517) 241-5916.

HIV Testing and Care: HIV Infection in People Over 50

July 29 *Detroit*
October 14 *Lansing*

Supervisors Training: Assuring the Quality of HIV Prevention Counseling

This workshop is only open to supervisors of HIV prevention/test counselor staff. It is designed to help supervisors assure the quality of HIV counseling, testing, and referral services. **Contact:** Amy Peterson at (313) 456-4425.

October 22-23 *Detroit*

PCRS Training**Two-Day PCRS Certification for LPH**

The Counseling & Referral Services (PCRS) Certification Trainings for local health departments (LHD) familiarize staff with strategies and techniques to control the spread of HIV and other STDs. HIV prevention/test counselor certification is a prerequisite, and this course is required of all LHD counselors employed to conduct PCRS activities. **Contact:** Audrea Woodruff (313) 456-4421.

August 20-21 Traverse City

PCRS Recertification for LPA

August 6 Lansing
August 18 Sault Ste. Marie

One-Day PCRS Certification for CBOs

The ETRD Unit has assumed responsibility for conducting the PCRS for CBOs training. Please contact Francisco Michel, (517) 241-5916, if you have any questions.
September 16 Detroit

STDs & Special Trainings

For more information on the STD trainings, contact Deana Hurlbert at (517) 241-5921.

Clients Who Test Positive

August 27-28 Detroit

STDs for DIS

July 15 Detroit

HPV and Herpes

September 9 Lansing

Statewide Meetings**CHOW**

Community Health Outreach Workers (CHOW) provides training statewide on HIV, STD and other community health information related to outreach prevention and intervention strategies. CHOW meets the second Monday of each month at 1 p.m. in locations around the state. **Contact:** (313) 963-3352.

HIV/STD and Adolescents Networking Committee

This statewide committee provides an opportunity to network with professionals in youth serving agencies. A subcommittee plans the annual Teen Peer Education Conference. The next meeting will be 11:30 a.m.-2:30 p.m. Aug. 27. Location TBA. **Contact:** Kim Kovalchik at MDE (517) 241-4292.

MHAC

The Michigan HIV/AIDS Council is a merger of the Statewide planning groups for prevention and care. The next meeting will be Sept. 4. **Contact:** Belinda Chandler (517) 241-5926.

Michigan Conferences & Events**HIV and Substance Abuse**

June 23-24 Dearborn
At the Ford Conference & Event Center. Registration \$125, on-site or call DHD (313) 876-0981.

On the Front Lines

July 8-9 Novi
Conference at Novi Hilton for HIV p-test counselors, case managers, and PCRS staff. Call HAPIS (517) 241-0966.

2003 STD & HIV Conference

November 20-21 Grand Rapids

National Conferences & Events**National HIV Testing Day**

June 27
Contact HAPIS (517) 241-5940.

National HIV Prevention Conference

July 27-30 Atlanta, GA
www.2003hivprevconf.org

US Conference on AIDS (USCA)

September 18-21 New Orleans, LA
www.nmac.org/conferences/usca2003

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)

www.mihivnews.com/calendar: Please visit our website for a more extensive listing of conferences and events, meetings and trainings.

Linking prevention for older African Americans

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populations of color. Schrock saw African Americans over 50 as an underserved population and this grant as an opportunity to target the dual need of HIV and SA prevention.

“We did exploration nationally,” said Simmons, now the director of Community Health Promotion for Adult Well-Being Services. No formal curricula for HIV and substance abuse (SA) prevention exist for this age group. “We thought it was really stellar that CSAP decided to put (HIV and SA) together. And we are really on the cutting edge in putting that together for older adults.

“In 2001, we proposed to devise an HIV and substance abuse prevention planning initiative for older African Americans in Detroit and Wayne County.”

Adult Well-Being Services received the SAMHSA one-year planning grant. The planning initiative began by bringing to-

anything in bed besides sleep...and substance abuse?! Not Granddaddy!!” They found that people (older adults and service providers) simply did not realize older adults’ very real vulnerability to HIV and substance abuse *or* make the connection between SA and HIV risk.

“This is a cutting-edge issue. The rate of AIDS in older adults is growing faster than for those in their 20s or 30s. That’s indisputable. And we’re estimating 17% to 37% of older adults are abusing substances. Everything is underidentified, underreported, underestimated and of course, older adults are an underserved population.”

The culmination of the planning grant was a ‘Call to Action’ inviting service providers for the aging, public health and mental health providers, along with faith-based organizations and the target population to talk about the realities of HIV and substance abuse.

enhance their services and use that tool to get additional funding,” said Simmons.

Now with the three-year service delivery grant from SAMHSA, the time has come to develop the curricula and deliver the prevention services. Adult Well-Being Services is developing community education for African Americans age 50 and over and will also provide professional development for multidisciplinary service providers who work with older African Americans.

Since none currently exists, AWBS will be developing the curricula for skill building and empowerment with the two specified target audiences. As an example, many who participated in the needs assessment felt women were at greater risk for HIV but did not have the interrelationship power to reduce their risk. “We’re talking about negotiation and power issues,” said Simmons.

“The problem is there are so many issues that compete for older adults attention. People are worrying about diabetes; or about being diagnosed with X, Y, and Z. We talk about ageism. We know older people are not as valued in our society. If you look at almost any prevention pamphlet or brochure those faces are probably no older than 28,” said Simmons. One of the first things ABWS did was to update a fact sheet for HIV/AIDS and adults over 50.

Part of the grant program will be offering 8 hours of professional development, so there will have to be a curriculum developed especially for that. “Some of our partners, DHD (Detroit Health Department) and MDCH (Michigan Department of Community Health) and the Bureau of Substance Abuse already have wonderful training. We will just have to make it age and culture specific,” said Simmons.

The program will divide the targeted audience into two age groups, those aged 50-64 and 65 and over. For the first group they will be working with churches, fraternity groups, and service groups.

“We are going to have to make some inroads with these ‘younger’ older folks,”

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“This is a cutting-edge issue. The rate of AIDS in older adults is growing faster than for those in their 20s or 30s. That’s indisputable. And we’re estimating 17% to 37% of older adults are abusing substances.

Everything is underidentified, underreported, underestimated and of course, older adults are an underserved population.”

gether a collaborative of 30 area agencies, organizations and gatekeeper consultants. A needs assessment was conceptualized and assessment methodologies were developed which used both focus groups and written surveys. Two groups were involved in the assessment; the multidisciplinary professionals who serve the target population in every conceivable service arena and African-Americans aged 50 and older.

AWBS learned a lot from the needs assessment. “It’s so interesting to me, the denial that we have experienced – the denial and the acceptance – but primarily the denial, by providers and lay people,” said Simmons. She continued, “Many have a hard time imagining that older folks do

The Call to Action was held in December at UD-Mercy in Detroit. A panel of elders discussed the truth about behaviors. “Older people don’t just knit and jiggle their grandchildren on their knees,” said Simmons. The risks are there for older adults; surprising things go on in retirement homes. They are still having sex and using drugs, all kinds of drugs.

The Call to Action also covered the findings from the survey and focus groups and the recommendations from the needs assessment, and rolled out the Service Delivery Plan.

The purpose of publishing the service delivery plan was to share it with the larger interdisciplinary community “so they can

Linking prevention for older African Americans

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said Simmons. "With them we are going to do just straight out HIV and SA prevention. From our experience, observations and literature review. ... This age group is amenable to straight on education without candy-coating it."

For the 65 and over group AWBS will offer a four-part health promotion series. Two of the sessions will cover HIV/AIDS and substance abuse. The additional two will cover health topics such as aging successfully, cardiovascular health, or diabetes care, which Adult Well Being Services has been doing for years.

In the third year of funding the Initiative will be putting together a physician's tool kit "because it's time to get physicians involved in this," said Simmons. "Older adults are very responsive to interventions. Especially with substance abuse, if a doctor intervenes early on ... there is a much higher recovery rate. But there generally is a reluctance, with physicians, to avoid addressing issues related to both substance abuse and HIV."

Simmons brought quite a broad public and mental health background to her position with Adult Well-Being Services and at one time actually trained clinicians on how to give a patient-sensitive gynecological exam.

Simmons also has a long history with HIV prevention. She worked at United Community Services when it was the planning body for the United Way in Detroit. At that time they had a Venereal Disease Action Coalition, where she worked with many of the "elders" of HIV prevention in the metro area – "a handful of people who came together and got funding to do lay, professional and clinical education on (STDs)." They used the name VD Action coalition. "We did a yearly conference, and were about to do a conference on Chlamydia, this was in '82, when something called 'Gay-Related Immune Disorder (GRID),' later renamed AIDS, came onto the radar screen."

Not only is Simmons well prepared

Related programs

CHOW Links

Community Health Outreach Workers Linking Individuals into Networks for Knowledge and Services (LINKS) is a voluntary multi-disciplinary coalition of service providers and community leaders committed to improving the health status of African Americans (and others) at risk of or living with HIV/AIDS, STD, TB, Mental Illness and/or Substance Abuse within the City of Detroit. To learn more about this, see the PowerPoint presentation from the April MHAC meeting at www.mihivnews.com/pdf/CHOWlinks.pdf or call CHOW (313) 963-3352.

CHAG Point of Change

African Americans in the City of Detroit who are at-risk for HIV infection through drug use are now able to get everything they need through one organization. On March 18 Community Health Awareness Group (CHAG) held an open house celebration of the new substance abuse program, Point of Change, at its own satellite location, on the eastside of Detroit. See the *Village Drum*, Spring 2003 Issue at www.mihivnews.com/pdf/CHAG-Spring03 or call CHAG (313) 872-2424 for a copy.

to develop the physician's tool kit, one of the planning group members, Dr. Dexter Shurney, is also an AWBS Board member and former medical director for Blue Cross Blue Shield of Michigan.

"We have to get doctors on board" with this prevention and education program, said Simmons. Due to ageism, a diagnosis of HIV disease is often missed. "AIDS dementia is often mistaken for Alzheimer's," she said.

The grant program will also work with local 'wraparound services' at various agencies providing services to older African Americans. Upon request, the Initiative will work with various service agencies to revise screening tools. So, for example, a mental health services intake worker would have a more appropriate tool with which to screen for SA and HIV risk.

The Call to Action was to start the dialogue between service providers and older African Americans. "Real collaboration is the only way we are going to address this issue. It's respecting what older people tell us about how to provide them with life-enhancing prevention information" as well as respecting what the agencies have shared in the needs assessment

with regard to their limitations. "It's about strategizing together."

Importantly, Adult Well-Being Services is currently recruiting older peer educators to work with the 50-64-year-olds in Detroit and Wayne County. Peer education positions are very part-time, involving intensive certification training and then a commitment of at least 2 series annually. Those interested in peer educator positions should contact Education Coordinator Stephanie Kitchen at (313) 825-2524.

Kitchen is also the contact if you are a Wayne County agency or consumer and would like to arrange substance abuse and HIV prevention workshops for older African-American consumers, staff or volunteers (who work with them).

Though this program specifically targets the Detroit and Wayne county population of older African American adults, Simmons said professionals from around the country are interested in the program and it's applicability in other areas. For more information or to obtain a copy of the Service Delivery Plan, contact the ABWS Community Health Promotion Department at (313) 825-2519 or e-mail abosman@awbs.org.

TABLE 1: Characteristics of Michigan Residents Living with HIV or AIDS as of 4/1/03

	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	15,500	156	5,135	100%	5,581	100%
SEX						
Male	11,940	245	4,109	80%	4,166	75%
Female	3,570	70	1,026	20%	1,415	25%
BEHAVIOR						
Male-Male Sex	8,530	N/A	2512	57%	2332	53%
Injecting Drug Use ⁵	2,950	N/A	881	20%	796	18%
<i>IDU w/ heterosexual</i>	1,400	N/A	416	9%	379	9%
<i>IDU w/o heterosexual</i>	1,550	N/A	465	10%	417	9%
Male-Male Sex/IDU	930	N/A	282	6%	279	6%
Blood Products	160	N/A	76	2%	50	1%
Heterosexual ⁶	2,640	N/A	645	15%	843	19%
<i>Partner IDU</i>	780	N/A	207	5%	265	6%
<i>Partner Bisexual</i>	160	N/A	28	1%	40	1%
<i>Partner Rec'd Bld</i>	60	N/A	13	0%	22	1%
<i>Partner HIV +</i>	1,550	N/A	397	9%	516	12%
Perinatal	160	N/A	33	1%	98	2%
Undetermined/Other ⁴	Not Applicable	N/A	706	(14%)	1183	(21%)
<i>Presumed Heterosexual⁷</i>	<i>Not Applicable</i>	<i>N/A</i>	<i>548</i>	<i>(11%)</i>	<i>789</i>	<i>(14%)</i>
<i>Other⁸</i>	<i>Not Applicable</i>	<i>N/A</i>	<i>158</i>	<i>(3%)</i>	<i>394</i>	<i>(7%)</i>
AGE AT DIAGNOSIS						
0 -12 years	160	9	34	1%	114	2%
13 -19 years	310	31	44	1%	184	3%
20 -24 years	1,400	217	232	5%	725	13%
25 -29 years	2,480	379	614	12%	1072	19%
30 -34 years	3,260	461	1095	21%	1132	20%
35 -39 years	3,100	394	1149	22%	1013	18%
40 -44 years	2,330	287	918	18%	647	12%
45 -49 years	1,240	169	552	11%	350	6%
50 -54 years	780	123	303	6%	201	4%
55 -59 years	310	64	114	2%	87	2%
60 -64 years	160	42	52	1%	37	1%
65 years and over	70	6	28	1%	19	0%
RACE / ETHNICITY						
White, Non-Hisp.	5,740	74	1,984	39%	1,939	36%
Black, Non-Hisp.	7,600	542	2,911	57%	2,389	44%
Hispanic	620	191	206	4%	177	3%
Asian	50	28	23	0%	14	0%
American Indian	50	94	10	0%	26	0%
Unspecified/Other ⁴	Not Applicable	N/A	1	(0%)	136	(2%)

Footnotes for Table 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.
- Rates are calculated per 100,000 population in 2000.
- Includes reports that contain patient name or are otherwise unduplicated.
- Age, sex, race, and behavior percentages are calculated excluding missing data. The percentages of total cases missing this demographic information are given in parentheses.
- The IDU risk category is further sub-divided 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).
- The heterosexual category includes only those persons with "high risk" heterosexual partners as defined in footnote 5.
- This subset of undetermined includes persons who had heterosexual sex but their partner(s)' risk is unknown. This includes unconfirmed occupational exposures (1).
- 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).

TABLE 3: Michigan Residents Reported Living with HIV or AIDS: Sex by Race by Behavior as of 4/1/03

MALES:	White		Black		Hispanic		Other or Unknown		TOTAL	
Male-Male Sex	2,517	74%	2,127	48%	134	45%	66	41%	4,844	59%
Injecting Drug Use	172	5%	773	17%	57	19%	6	4%	1,008	12%
Male-Male Sex/IDU	215	6%	326	7%	14	5%	6	4%	561	7%
Blood Recipient	81	2%	23	1%	1	0%	2	1%	107	1%
Heterosexual	85	3%	321	7%	30	10%	6	4%	442	5%
Perinatal	12	0%	53	1%	2	1%	0	0%	67	1%
Undetermined/Other	312	9%	801	18%	57	19%	76	47%	1,246	15%
<i>Presumed Heterosexual</i>	186	5%	558	13%	44	15%	24	15%	812	10%
<i>Other</i>	126	4%	243	5%	13	4%	52	32%	434	5%
MALE TOTAL	3,394	(41%)	4,424	(53%)	295	(4%)	162	(2%)	8,275	100%
FEMALES:	White		Black		Hispanic		Other or Unknown		TOTAL	
Injecting Drug Use	126	24%	522	29%	15	17%	6	13%	669	27%
Blood Recipient	11	2%	8	0%	0	0%	0	0%	19	1%
Heterosexual	269	51%	709	40%	52	59%	16	33%	1046	43%
Perinatal	11	2%	47	3%	5	6%	1	2%	64	3%
Undetermined/Other	112	21%	490	28%	16	18%	25	52%	643	26%
<i>Presumed Heterosexual</i>	97	18%	402	23%	15	17%	11	23%	525	22%
<i>Other</i>	15	3%	88	5%	1	1%	14	29%	118	5%
FEMALE TOTAL	529	(22%)	1,776	(73%)	88	(4%)	48	(2%)	2441	100%
GRAND TOTAL	3,923	37%	6,200	58%	383	4%	210	2%	10,716	100%

Status of the HIV/AIDS Epidemic in Michigan, 2002

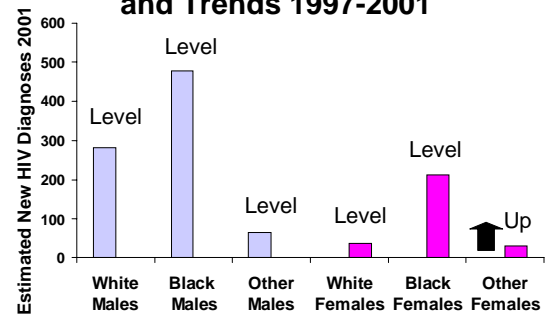
The MDCH HIV/AIDS Surveillance Section looked at Michigan's HIV/AIDS Epidemic and trends in new infections from 1997 through 2001, reported with the April 2003 *Quarterly HIV/AIDS Analysis*. The full report with graphs is available on the website: www.mihivnews.com/stats. Following is the conclusion from that report.

HIV mortality has dropped markedly over the past five years while the number of new diagnoses of HIV infection did not change significantly. However, because there are still more new HIV diagnoses each year than deaths among HIV-infected persons, the total number of persons living with HIV infection is increasing.

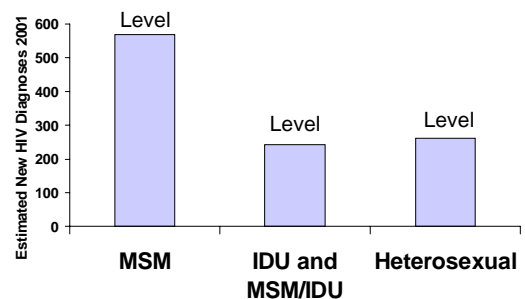
Michigan residents with HIV infection continue to be predominately men who have sex with men and/or residents of Southeast Michigan. The proportion with heterosexually acquired infection is now slightly more than the number infected through injection drug use, although these two groups are closely intertwined. New diagnoses of HIV infection have increased significantly over the past few years among non-white/non-black females but did not change significantly for any other race, sex, or risk group.

Approximately 24 percent of new HIV infections are diagnosed at the same time as AIDS with men being diagnosed with HIV and AIDS concurrently more frequently than women. The proportion of new HIV infections diagnosed at the same time as AIDS decreased significantly in black females but did not change significantly in any other race/sex group.

Number of New HIV Diagnoses in 2001, and Trends 1997-2001



Number of New HIV Diagnoses in 2001, and Trends 1997-2001



The 10th Conference on Retroviruses and OIs

This convergence of the world's frontrunners in HIV/AIDS research, held Feb. 10-14 in Boston, provided a wealth of information. A great place for full coverage and a good layperson's recap of this event is The Body. Some edited highlights from The Body's coverage follow, with update sources noted. Quotes are from Dr. Cal Cohen, research director of the Community Research Initiative of New England and an instructor at Harvard Medical School.

PROTEASE INHIBITORS GET SIMPLER

"Most drugs are getting simpler and getting better," Cohen said. At the top of that list: Kaletra (lopinavir/ritonavir), a three-pill, twice-a-day drug that's the most powerful protease inhibitor on the market. A contender, fosamprenavir (GW433908, known as "908"), is a new pumped-up version of Agenerase (APV, amprenavir) that may be approved for use in the U.S. within the next year or so. Recent studies have shown it works almost as well as Kaletra in people who have built up resistance to many other HIV drugs, and is also a powerful choice for people who have never taken HIV drugs. Another promising protease inhibitor, atazanavir (Zrivada), did excellently in clinical trials — and there are no signs yet that the drug causes lipodystrophy, the same body-fat problems that other protease inhibitors are known to cause.

Since the Conference, it was reported that Bristol-Myers' atazanavir is nearing FDA approval. This once-daily dosing makes it more convenient than rival protease inhibitors, which include Abbott Laboratories' Kaletra. Ease of use "is a big advantage for the drug," said Philippe Chiliade, medical director of Washington's Whitman-Walker AIDS Clinic. "It will probably be used most of the time as a

For First-Line Treatment and a look at Nukes, HAART Side Effects and HIV-Related Health Problems, see The Body's full recap at: www.thebody.com/confs/retro2003/helfand.html.

front-line drug, as a first potential regimen," Chiliade said. *Hartford Courant* (05.13.03)

ONE-CLASS THERAPY?

Right now only three classes of HIV drugs are approved for use here in the U.S.: protease inhibitors, NRTIs and NNRTIs. HIV treatment consists of a combination of drugs from two of these classes, under the theory that barraging HIV with different drug types will help keep the virus off its guard and under control.

Some researchers have proposed a new option for therapy, though: treatment that consists of only one class of drug — like three or even four NRTIs, or a pair of protease inhibitors. There are two possible benefits to this strategy. First, it may be less toxic (fewer side effects). Second, the one-class strategy could provide more drug options in the future by ensuring that, even if a combination fails, a person will become resistant to only one class of drugs at most.

TREATMENT INTERRUPTIONS

Most hopes about the benefits of structured treatment interruptions (STIs) seem to have been shot down. Dr. Cohen reported that, according to research by Dr. Bruce Walker of the Harvard Medical Center, only about 20 percent of those who go on structured treatment interruptions have any success with them.

Two other types of treatment interruption show signs of promise, Dr. Cohen noted. The first is called "cycling," in which a person spends a few days taking meds, then a few days off. The second

strategy is called "CD4-based" treatment interruption, because it involves stopping and starting therapy based on a person's CD4 levels.

Treatment interruption studies are still ongoing to figure out just how much chance these strategies, and others, have of succeeding. In the meantime, Dr. Cohen warns, don't take a break from your drugs without consulting your doctor.

A NEW DRUG CLASS

Entry inhibitors — which attempt to keep HIV from invading CD4 cells in the first place — make up a whole new class of meds. The flagship drug in this new class is T-20 (brand name Fuzeon; generic name enfuvirtide), and ongoing studies have shown it to be very effective in those who are already resistant to most of the drugs currently on the market. The downside to T-20: It has to be injected, and sometimes a person's skin can become badly irritated where the needle was inserted.

Shortly after the conference, FDA approved the drug for use in combination with other antiretroviral medications to treat advanced HIV infection in adults and children ages six years and older. Fuzeon can also cause "serious systemic allergic reactions," including breathing problems, fever, skin rash, chills, vomiting and low blood pressure, according to the FDA. The approved labeling for Fuzeon also warns doctors to monitor patients for signs and symptoms of pneumonia. (FDA release, 3/13)

There's more where T-20 came from, though. For people who become resistant to T-20, there's already another option being studied: T-1249, a very similar drug that appears to work even better than T-20, and with fewer skin reactions. And a whole slew of additional entry inhibitors — as well as drugs that attack HIV using other means — are in the works. "Some of them seem safe, some of them are working, and some of them will probably get here someday," Dr. Cohen said hopefully.

Prevention issues

Edited from summaries provided by the CDC

“Advancing HIV Prevention: New Strategies for a Changing Epidemic — United States, 2003”

MMWR (02.18.03) 52(15):329-332

The new CDC recommendations to state health departments form part of a new strategy aimed at preventing HIV transmission by people who do not know they are infected. The strategy places HIV on a par with other health problems — such as high cholesterol — for which people are screened once they are suspected to be at risk.

“Each year we continue to see about 40,000 new HIV infections domestically,” said CDC Director Dr. Julie Gerberding. “We have well over 800,000 people living with HIV in our country, but an estimated 200,000 of these people do not know they are infected. ... This is an intolerable situation,” she said.

New CDC prevention strategy has four main components:

- Routinely offering HIV tests as part of medical appointments in high HIV-prevalence locations, or when personal background makes it likely patients are at high risk.

- Making 20-minute rapid HIV tests available in nonmedical settings such as jails and homeless shelters. These recently approved tests are mostly used in medical institutions.

- Tracing the partners of those found to be HIV-infected and offering them testing and training in prevention.

- Making HIV one of the conditions for which pregnant women are checked, unless they specifically refuse to be tested, and encouraging testing of all newborn children. About 300 children are born with HIV in the United States each year. CDC did not specify whether newborn testing should be mandatory.

This summary article from the *Atlanta Journal-Constitution* (04.18.03) The CDC recommendations can be found at

www.cdc.gov/mmwr/preview/mmwrhtml/mm.

“Interventions to Reduce Sexual Risk for HIV in Adolescents, 1985-2000: A Research Synthesis”

Archives of Pediatrics and Adolescent Medicine (2003;157(4):381-388)

Intensive programs designed to prevent HIV infection in teens can delay the onset of sexual activity, decrease the number of sex partners, and increase the use of condoms, according to a review of studies conducted 1985-2001. In addition, teens who participated in intensive HIV risk reduction programs developed better skills for negotiating lower-risk sexual encounters and talked about safer sex more often with their partners than teens who did not participate in HIV programs.

Programs that provided more information about condoms or gave out condoms were more likely to reduce teens' risky behavior, according to the report. In studies in which adolescents in HIV prevention programs that taught students behavioral skills were compared to students who received generic sex education, the gap in risky behavior tended to be larger, with students in the generic sex-ed classes less likely to use condoms.

“Support Among Persons Infected with HIV for Routine Health Department Contact for HIV Partner Notification”

Journal of Acquired Immune Deficiency Syndromes (02.01.03) Vol. 32; No. 2: P. 196-202

The authors' central finding is that most people with HIV, including MSM, support the universal provision of confidential and voluntary public health partner notification (PN) services and that restricting PN programs to public health deprives some patients of desired services. In consideration of these findings, clini-

cal providers, community-based organizations, and health departments should reassess whether narrowly focusing PN services on persons at public health sites truly reflects patient preferences.

“Efforts to improve PN should concentrate on greater integration of the process into the provision of the medical and social services patients already receive,” the authors concluded.

“Mandatory Reporting of HIV Infection and Opt-Out Prenatal Screening for HIV Infection: Effect on Testing Rates”

Canadian Medical Association Journal (03.18.03) Vol. 168; No. 6: P. 679-682

In this study, the authors evaluated the effect of mandatory reporting of HIV infection and routine screening for prenatal HIV infection on requests for HIV testing in Alberta. This study shows a clear trend toward increased HIV testing in Alberta despite the introduction of mandatory reporting of HIV infection to public health authorities. These results are consistent with other studies showing that reporting of HIV infection does not provide a distinct disincentive to testing. The authors also found a dramatic and sustained increase in rates of prenatal HIV testing after the opt-out policy was introduced.

The finding that mandatory reporting of HIV infection has not adversely affected the number of HIV tests done in the province is reassuring. It is unclear, however, whether reporting has had a differential effect by deterring people who may be at higher risk of HIV infection, such as men who have sex with men, injection drug users and recent immigrants to Canada, from undergoing testing and seeking treatment and prevention services. Continued monitoring and evaluation are required to ensure that surveillance policies do not adversely affect HIV testing.

Treatment issues

“Older HIV-Positive Patients in the Era of Highly Active Antiretroviral Therapy: Changing of a Scenario”

AIDS (01.03.03) Vol. 17; No. 1: P. 128-131

The authors used a prospective case-control study to determine the impact of HAART on the virological and immunological response in a cohort of older HIV-positive patients when confounding variables — adherence to therapy, side effects and non-HIV-related co-morbidities — were evaluated.

Patients age 50 or older and patients age 20-35 who were given HAART regularly, with a follow-up of at least six months, were included as cases and controls respectively, ratio 1:2.

The researchers considered three outcomes: immunological success; virological success; and viro-immunological success defined as a CD4 T-lymphocyte count greater than 200 cells/mm³ and an HIV viral load less than 50 copies/ml, both conditions together, respectively, at the end of the follow-up.

The authors’ multivariate analysis

showed that after adjustment, no statistically significant difference existed between cases and controls for immunological, virological and viro-immunological success. They obtained similar results when they added HIV- and HAART-related variables to the model.

“In conclusion,” they noted, “an early diagnosis of HIV infection in older patients is mandatory because the use of HAART allows them to achieve the same viro-immunological response as younger individuals.” (*Edited from CDC summary*)

Researchers Develop Model for Lipodystrophy Case Definition

Kaisernetzwork HIV/AIDS Daily Report (02.28.03)

Researchers involved with the HIV Lipodystrophy Case Definition Study Group have developed a model to diagnose lipodystrophy — a “common and disfiguring” problem in which fat redistributes improperly in the body in patients taking antiretroviral therapy — in HIV-positive adults, according to a study published in the March 1 issue of the *Lancet*.

The researchers used the information they collected in their study to create a “broadly applicable” model for lipodystrophy case definition, including 10 variables. The model includes age, sex, duration of HIV infection, HIV “disease stage,” waist to hip ratio, anion gap, the amount of HDL cholesterol in the blood, trunk to peripheral fat ratio, percentage leg fat and “intra-abdominal to extra-abdominal fat ratio.”

They concluded that using the model in HIV research will “allow for more reliable estimates” of lipodystrophy prevalence, incidence, cause and responses to prevention and treatment, adding, “Our study serves as a model for the development of objective measures for other common, subjectively defined, adverse events associated with antiretroviral treatment.”

The researchers also said that further research was needed to determine if the connections between any of the symptoms are “direct or indirect” with lipodystrophy and if the case definition changes when applied to children (Carr et al., *Lancet*, 3/1).

DHAS conducts Statewide Needs Assessment

Continued from page 3

zations exist in our communities that could be of service to PWAs? And how well connected are they to the RW continuum of care?

The needs assessment design was formulated based on past needs assessment activities (e.g., the recent PWA conference survey, provider surveys, etc.) in Michigan and also incorporates methods used by other Title I and Title II programs throughout the country. The proposed design will include the following four primary information collection strategies, which aim to have PWAs directly influence decisions related to funded services in their area:

1) Survey questionnaire targeting PWAs throughout the state, to gather

demographic information, determine extent of service utilization, discover what services are needed, but cannot be accessed, and satisfaction with services and barriers experienced.

2) PWA open forums, in select areas of the state in collaboration with ASOs, PWAs and others. The purpose of using open forums as a means of data collection, lies in the desire to more fully understand what the barriers are to care, what services are needed, but cannot be accessed, and how to better facilitate getting people into care. Transportation (bus) will be made available where appropriate. Gas cards will also be available for those with their own transportation.

3) Direct service provider interview,

to capture qualitative/quantitative information about clientele, service trends, perceived unmet needs, gaps in services and getting people into care.

4) Out of care brief interview, to be conducted by case managers/client advocates. Interview designed to ask *new* clients about why they were not in case management or medical care, what barriers they faced and how they got into care.

DHAS will be working with a PWA Advisory Group as well as the MHAC Needs Assessment Committee to plan and conduct this process. If you have questions, or would like to participate in this process, please contact Jane DuFrane, Continuum of Care Unit Manager at (517) 241-5920.