

Empowering Women to Reduce HIV Risk: An Interview with Dr. Nancy Padian

Jenna Grant

Nancy Padian, PhD, recently became the first Director of International Research at the AIDS Research Institute. She is also Director of the Center for Global Research on Women's Health, co-founder of the Center for Reproductive Health Research and Policy, and a Professor of Obstetrics, Gynecology, and Reproductive Sciences, all at UCSF. She is an epidemiologist and holds a joint appointment at the UC Berkeley School of Public Health. I met with Nancy in her office on the eve of a three-week journey to Zimbabwe, where she has been conducting research on HIV, STDs, and contraception for the past seven years. She shared her vision for the ARI International Program, and talked about how she came to work in international AIDS research and about her current microbicide work in Zimbabwe. Nancy also articulated her hopes for improving female reproductive health, echoing a major theme of the ARI International Program: reduce gender inequality and, with it, HIV risk.



“For some women to feel better about being in control of their own bodies, they need to be less dependent on their male partners and know they can make it on their own.”

JG: Let's start by talking about the ARI International Program.

Our goal in establishing the International Program was to bring together all of the UCSF researchers working on HIV/AIDS in other countries and see if we could share resources and infrastructure, integrate current efforts, and position ourselves better for new projects.

JG: How did you get involved with work in Zimbabwe?

One of the first graduate students I had at Berkeley wanted to do research on HIV in Africa, specifically on heterosexual transmission. We linked with Stanford, who welcomed us into their existing research infrastructure. My student first considered factory workers, the population that Stanford was working with, but she soon became interested in women's susceptibility to HIV. That had been my focus here in the U.S., so it was a natural fit.

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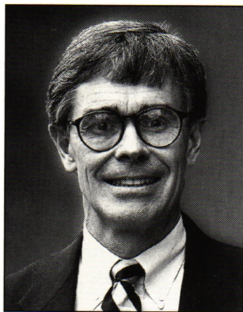
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University of California
San Francisco



AIDS Research Institute

Our Global Agenda



*Thomas J. Coates, PhD
Director, UCSF AIDS Research Institute*

I am writing this on my way home from the 8th Conference on Retroviruses and Opportunistic Infections, which occurred in Chicago February 4-8. The Conference was a large gathering of over 3000 individuals focused on basic, laboratory, and epidemiological science related to HIV and AIDS. What do we know and what do we have to do?

The following is a partial list:

- We need to make treatments better. Treatments help, but we know that they have side effects, and we also know that they lose effectiveness if used long enough. New treatments on the way may help, but it is going to require consistent effort to come up with better drugs to stay ahead of the virus.
- We need to make treatments available to the rest of the world.
- We need to realize HIV is not curable, at least so far; and it may never be. We do not know yet how to eradicate HIV from the body. It integrates itself into a person's genome, and there seem to be permanent reservoirs for both wild and mutated virus.
- We desperately need a vaccine. An HIV vaccine that prevents infection altogether is still a goal, but it will be a hard one to reach. HIV infects quickly, and once implanted, cannot be eradicated. Good ideas are being pursued for vaccines to prevent HIV, but few of these ideas have proceeded to the final clinical trials that are required prior to FDA approval and worldwide distribution.
- We need to plan for the day when we will distribute the vaccine worldwide. We have had effective polio vaccines for 50 years, and polio may be eradicated from the world in 2005. That's 55 years!
- We need to recommit ourselves to prevention, and to figure out how to approach prevention now that HIV is not seen as the deadly disease it once was, at least in developed countries. Rates of HIV transmission are going up in many places around the developed world, and this is a worrisome sign. How do we continue our prevention efforts when HIV is not as feared as it once was?
- We need to persuade the U.S. and other rich countries to save the developing world. To turn the epidemic around, \$4 billion is needed for Africa alone. Economist **Jeffrey Sachs** from Harvard reported that capital gains in the U.S. went up by \$6 trillion over the past five years, and yet Congress had a difficult time adding a mere \$100 million to this year's AIDS budget for the developing world.

The CDC's **Dr. Kevin DeCock**, now working in Kenya, said a troubling thing to me: "You and I will be long dead before we realize how profoundly this virus has ravaged Africa and the rest of the developing world." The same fate could await many communities, especially gay communities and communities of color (including those of all sexual orientations), in the U.S. if we do not act to stop them from being similarly ravaged.

UCSF was here at the beginning, in 1981, when we saw the first manifestations of HIV disease in San Francisco. We will work long and hard to insure that we put an end to it.

Mission Statement

The University of California San Francisco created the AIDS Research Institute in recognition of its obligations to the people of the city of San Francisco, the United States, and the world to prevent, understand, and treat HIV infection. The AIDS Research Institute fosters outstanding, innovative, and integrated programmatic research in HIV/AIDS and excellent training for new scientists to continue working on the HIV epidemic.

The AIDS Research Institute works in close collaboration with affected communities. Scientific results are disseminated as quickly as possible to maximize their usefulness to these communities and to fellow scientists, policymakers, community-based organizations, and the public.

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current information, go to
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What About the Orphans?

Nancy Padian, PhD

Numerous adult men and women in Zimbabwe are dying from HIV/AIDS, leaving behind their children, many of whom are also infected.

Grandparents find themselves caring for their children's children. Older children become heads of households, taking care of their younger siblings. Some simply live in the streets alone after their parents die.

All of them are scrambling for resources to provide for the families they have inherited...and for themselves. The economic effect of losing parents at a young age often presents nearly insurmountable obstacles. The situation is overwhelming.

A project for orphans has been established in one of the communities where we conduct research. We have developed a relationship with them and have begun to help, but so far, our assistance has been limited. We must do more.

Although we are hopeful our research will benefit these orphaned children, we are painfully aware that it may be years before we can really make a difference. These children need help now.

The economy in Zimbabwe is under enormous stress. AIDS has made the situation even worse. A little money can go far in Zimbabwe: \$5 or \$10 can make a huge difference for these children. They need everything: money for food and shelter, basic health care, and school fees.

If everyone reading this article gave just a little, the direct benefit to these children would be incredible. The Orphans of Zimbabwe Project is just a beginning. We have begun to develop a partnership with a group in the United States to help raise desperately needed funds. Please consider a donation. We can make a difference.



Kids at an orphan feeding station enjoying their meal of sadza (porridge) and beans. A used stove was recently purchased with donations to the project, but scarce resources limit the volunteer cooks to three meals a week for the children.



A young girl holding one of four younger children left after both parents died of AIDS. She is trying to look after the little ones.

The Orphans of Zimbabwe Project

A Little Goes a Long Way to Help a Child Orphaned by AIDS

- ★ \$5 helps buy milk and school lunches
- ★ \$8 buys a blanket to keep a child warm
- ★ \$10 pays the school fee for a child just beginning primary school
- ★ \$15 purchases books and school supplies for two children
- ★ \$25 puts food on the table for a week at one orphanage
- ★ \$40 buys a child her school uniform, including shoes and sweater, mandatory for attendance
- ★ \$100 buys groceries for an orphan feeding center for one month
- ★ \$250 buys a second-hand stove to cook meals for the children
- ★ \$500 puts shoes on 25 children for a year
- ★ \$1000 helps begin construction of a new building to house the growing number of children in need of shelter

To contribute, please send your check payable to
The Orphans of Zimbabwe Project/Ark of Refuge
c/o UCSF AIDS Research Institute
74 New Montgomery Street, Suite 200
San Francisco, CA 94105
or contact dkent@psg.ucsf.edu
(415) 597-9370

Empowering Women

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We put together a project looking at the phenomenon of “dry sex,” and whether that practice increased a woman’s risk of HIV infection. Some women in Zimbabwe use various substances to dry the vaginal and cervical mucous because men prefer the sensation of “dry sex.” When the study ended, not only were we able to determine that this practice most likely increased the probability of HIV transmission, we found that we had created the beginnings of a research infrastructure involving UCSF’s Department of Obstetrics and Gynecology and the University of Zimbabwe—the UZ-UCSF Collaborative Research Program in Women’s Health. What’s more, this collaboration gave us the opportunity to apply for many more HIV prevention projects. The rest is history; we grew from something very small, one project, to a big operation.

JG: What are your goals in addressing the epidemic?

One focus of my research in Zimbabwe has been the intersection of contraception and HIV and sexually transmitted diseases [STDs], looking at whether different forms of contraception put a woman at increased or decreased risk. Right now, we’re doing a condom promotion study and a study looking at women who use hormonal contraceptives, to see whether there is an increased risk for HIV and other STDs. We’re gearing up for a new microbicide study. In addition, we’re studying the acceptability of diaphragms. If we find that women are willing to use them, then we will do an efficacy study.

One area of research that I hope to develop involves micro-financing. Right now, many teen girls become involved with older men who give them financial support while they are in school in exchange for sex—“sugar daddies.” With the appropriate micro-financing plan and skills training, we hope to give these teens an alternative to compensated sex (for more, see page 10).

JG: What’s entailed in developing such a project?

The first step is to identify our partners. This kind of study requires enormous amounts of community involvement. Look at the kinds of questions we have to answer before we start:

- What is the job training we should do, particularly in the face of an economy that’s crumbling?
- What does it take to keep girls in school?
- Should it be our goal to keep all girls in school? If not, what should the goal be?

- How can we do something sustainable that allows adolescent girls to be economically independent?

Clearly, we can’t answer these questions without significant input and participation from the local community. So, this year and the next, we’re doing all of the formative research figuring out who our partners are and piloting various interventions. One absolutely essential piece is to define the economic component, be it a loan or a grant.

JG: How does this project fit with your microbicide work?

One of my worries about microbicides is that even if one can be made that works, and even if it can be used by a woman without her partner’s knowledge, the idea that one can use something like this clandestinely may be so foreign to the way women think of themselves and their relationships that it could be difficult for women to use them consistently. The idea of a stealth product that you don’t need to negotiate with your partner to use is very novel. Combining female-controlled methods with the idea of economic empowerment and independence is an incredibly appealing model. I’m really excited about getting this study started to see if all of these pieces will work together to slow the spread of HIV.

JG: It seems to be a crucial point.

It is crucial. I think that in order for some women to feel comfortable using microbicides or engaging in any prevention programs, they need to be less dependent on their male partners and

know that they can survive on their own. It’s an absolutely critical component of prevention. We will also be involving men in the program. Another way to approach female-controlled methods of protection is to engage men to support their use—men will be protected from infection as well. We may also try to involve some of the “sugar daddies” in the micro-financing program to get their point of view.

JG: What is the microbicide work that you’re doing right now?

We are going to be looking at two different microbicides: BufferGel, a pH-lowering gel, and Pro 2000, which inhibits viral entry. We’re designing a four-arm study looking at BufferGel, Pro 2000, condom only, and placebo. However, all of the participants will be counseled to use condoms.



Dr. Nancy Padian with part of the Zimbabwe team, Prisca Nyakumbwa and Gertrude Khumalo-Sakutukwa.

JG: That's a given now...

It's very much a given. Ethically, you have to counsel people to use a method of protection that works.

JG: Was there something else you wanted to mention about your research efforts?

Training. An essential aspect of doing research is having a training component. If your goal is sustainability—and ours is—part of your work must be training people on-site so that they can do the research and continue the work, with or without you. One of my goals is to improve the link between UCSF's international training programs and its international research efforts. For instance, I have a large collaborative research program with investigators in Zimbabwe, and we have done some training of Zimbabwean investigators. But the model that I'm really trying to create with **Art Reingold**, who has a training program at UC Berkeley, and with **George Rutherford** and **Jeff Mandel** from the CAPS International Training Program, is one where the people running the projects in their own countries have been able to participate in our training program. It should be seamless: you train the people who will do the research. Right now, there's a little bit of disconnect between the sites where we have research projects and where the people we have trained over the years work. The good news is that we have the potential to conduct research in a number of countries because we trained so many people from so many different places.

JG: You mentioned how you got started in this work. Did you go to Berkeley?

I did. I started in the epidemiology program when this disease—we hadn't coined the term "AIDS" then, it was called "GRID"—had just come on the scene. My advisor had gotten one of the first research grants in the country to do a descriptive epidemiology study of the people who were experiencing this unknown disease. Remember that HIV hadn't even been identified. My background was in behavioral science and education. I was making something of a career switch with this move into epidemiology, but I thought I would end up doing something more related to social epidemiology rather than infectious diseases. But I was completely fascinated by this new, undefined disease, and there was a position open that no one else wanted. I took it. My advisor, **Warren Winkelstein**, and I decided that I would look at the female partners of bisexual men in a study that was already underway.

Next, I did a study on the transmission of HIV, both from men to women and from women to men. This study lasted ten years and took place here in the Bay Area. From there, I got involved studying other sexually transmitted diseases, and through my graduate student, started doing research internationally. I've always been interested in HIV prevention in women; now I do research on women's health. But the idea of looking at susceptibility actually came first. Women are particularly susceptible to HIV. Now almost all of my work is on women's health, but I didn't think of it that way when I started.

Interviewer Jenna Grant is a Project Assistant at the AIDS Research Institute's Center for AIDS Prevention Studies. She works on the Maternal Caregivers Study with PIs Susan Folkman and Judy Moskowitz.

Center for Global Research on Women's Health

Significant and sustained advances in the health of women around the world will only be achieved when health programming attends to the status of women and girls in society. The Center for Global Research on Women's Health is dedicated to developing innovative health initiatives that address gender imbalances and use expanded educational and economic options for women as effective means to fight disease and promote reproductive health. Based at the UCSF AIDS Research Institute, the Center draws upon a wide range of expertise within the University and among affiliated researchers around the world.

In many countries, the social status of women undermines health promotion and disease prevention efforts. With limited educational and economic opportunities, countless women, particularly those who live in poverty, are unable to make choices regarding

sexual and contraceptive matters. Many are susceptible to pressure to exchange sex for money or goods. For these women, particularly those who are adolescents, simplistic health education campaigns will have only marginal effects. Powerless to demand safer sex either with husbands, casual sex partners, or partners in sex-for-trade exchanges, and powerless to openly participate in other prevention programs, numerous women and girls remain vulnerable to disease.

Nancy Padian, PhD, is the Center's Director. For the last 15 years, Dr. Padian has developed and directed a range of research and intervention projects on sexually transmitted infections, HIV, and contraception in high-risk populations in the U.S. and internationally.

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Center

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The Center for Global Research on Women's Health has also established a partnership with the International Center for Research on Women (ICRW). ICRW is a private, non-profit organization based in Washington, D.C., dedicated to promoting social and economic development with women's full participation.

With limited educational and economic opportunities, countless women, particularly those who live in poverty, are unable to make choices regarding sexual and contraceptive matters.

ICRW conducts empirical studies of women's productive and reproductive roles and provides technical assistance. The Center and ICRW are now planning joint research studies in several countries. The Center also works closely with researchers at the UCSF Institute for Global Health, Johns Hopkins University, and Harvard University.

The Center's research examining the effects of micro-enterprise and self-esteem programs on reproductive health outcomes including HIV infection are already breaking new ground in Zimbabwe, Peru, and India. Expansion of women's health research in Mexico, Vietnam, South Africa, and China is planned.

For more information about the Center for Global Research on Women's Health and giving opportunities, please contact Dr. Nancy Padian at npadian@psg.ucsf.edu.



Prisca Nyakutombwa is an HIV counselor in Harare, Zimbabwe. She is participating in the International Women's Day briefing on March 8th.

The CAPS International Training Program

The Center for AIDS Prevention Studies (CAPS) International Training Program at the UCSF AIDS Research Institute has provided training for scientists from developing countries in AIDS prevention research for the past 13 years. It is our goal to recruit and train first-rate developing-country scientists who will produce high-quality research. We support them in becoming self-sufficient researchers, and assist them in disseminating their research findings to the scientific and lay communities involved in AIDS prevention and care. Simultaneously, the program enables UCSF faculty to build collaborations with AIDS research institutions, universities, ministries of health, and other non-governmental organizations globally.

We sponsor three types of training: (1) a summer institute in designing and conducting AIDS prevention research, (2) a writing sabbatical program that facilitates publication of study research in peer-reviewed journals, and (3) opportunities for formal graduate study at the School of Public Health at UC Berkeley. Each summer eight to ten scientists from developing countries come to CAPS for a ten-week intensive training program. The product of this course is a study protocol. Visiting scientists subsequently receive funds to conduct pilot studies with technical assistance from a CAPS faculty preceptor.

Those who complete their projects and wish to conduct further research can receive an "Innovative Intervention" grant, which can fund a larger-scale prevention intervention study. Every two to three years, we invite back alumni who have completed data collection for a writing sabbatical. We provide the statistical support and faculty consultation needed to complete a manuscript. We also serve as a "portal of entry" for the AIDS International Research and Training Program at Berkeley for advanced study leading to MPH and doctoral degrees in epidemiology. We have trained 99 scholars from 34 countries; they completed 60 pilot and 22 innovative intervention projects. Our alumni have published 117 papers and 354 abstracts.

There are inevitably cultural barriers to overcome in bringing scientists from all over the world to CAPS. Foremost, the scholars have to adjust to San Francisco and American culture: the technology, the pace of life, the communication and work styles, and the language barriers. There are occasionally misunderstandings that need to be worked out. But the difficulties are far outweighed by the energy and excitement the visiting scientists bring to CAPS.

The next ARI newsletter will profile some of the CAPS scholars who have continued their HIV work in countries throughout the world.

The Santos Study

Kimberly Page Shafer, PhD, Principal Investigator

A grant from the NIMH funded an exciting study conducted in Santos, Brazil, formally titled "Molecular Epidemiology of HIV Infection." **Katia Alves**, a Fogarty Fellow working at Blood Centers of the Pacific, and I worked from San Francisco with collaborators **Marcos Caseiro** in Santos and **Ricardo Diaz** in São Paulo. Using sensitive/less sensitive (S/LS) EIA technology (the "detuned" test developed and used in studies conducted in San Francisco to detect recent HIV infection), we undertook to evaluate trends in infection rates, HIV subtypes, and antiretroviral resistance in Santos.

Why Brazil? The HIV epidemic has hit Brazil hard; in the past six years, the AIDS epidemic has grown 7 percent in men, but almost 70 percent in women, according to Brazil's National AIDS Program. Currently, Brazil has a program guaranteeing universal access to antiretroviral agents for persons with AIDS or advanced HIV disease. Our study analyzed blood samples from HIV tests conducted from 1994 to 1999 at an anonymous HIV testing site. Using the S/LS EIA, we tested frozen HIV positive blood specimens to identify recent HIV infections and to calculate an annualized incidence rate for each of the five years. Additionally, the 1999 specimens were tested to monitor HIV subtypes and antiretroviral drug resistance.

Using the S/LS EIA to detect these new infections has made it possible to monitor the epidemic as it happens. If new strains are being introduced, or if antiretroviral resistance is emerging, the most likely place to detect it is among those who are newly infected. In short, we aimed to pinpoint populations in which new infections were occurring and new risks.

We presented preliminary results and analyses from the Santos study at the International AIDS Conference in Durban, South Africa. Since 1995, both prevalence and incidence have increased in Santos among those testing for HIV. The increases are especial-



Principal Investigator Kim Page Shafer's work brings her to Rio de Janeiro.

ly worrisome since they followed a period of decline, much like what we have seen in San Francisco: HIV incidence went from 2% in 1995 to 1.25% in 1997, and increased to 3.2% in 1999. An increasing proportion of new infections is occurring among women.

Katia Alves and I are currently planning other studies in Brazil. We are preparing to collaborate with **Mauro Schechter** in Rio de Janeiro to conduct a new case-control study evaluating whether persons on antiretroviral treatment are more or less likely to trans-



mit HIV infection to their partners. The unique public health policy guaranteeing HIV treatment in Brazil makes it an especially important place to study HIV transmission. This month, we will conduct pilot testing at the Praça Onze site in Rio de Janeiro. **Megan McGuire** will join Katia and me and our friends, including **Sonia Batista** (pictured with Katia at left) in Brazil as we begin laying out this new study.

AIDS Prevention among Youth Inmates in Brazil

*Camila Peres, International Scholars Fellow,
Principal Investigator*

One of the most innovative projects that CAPS has helped to fund in Brazil works with incarcerated teenagers in São Paulo. This project is a collaboration with the São Paulo State AIDS Control Program and the NEPAIDS research group of the University of São Paulo. The young men involved in the project are inmates of the state juvenile prison system. Most are black and come from the city's poor "favelas" (slums). Most have been involved with crime, drugs, and high-risk sex since an early age. Rather than AIDS, however, their greatest fear is of being killed by a policeman's bullet. Gaining the confidence and interest of these young men was not easy, but principal investigator **Camila Peres** and her team were up to the challenge. The trick was to listen rather than preach. Project staff worked with their "subjects" to create their own AIDS prevention activities. One of the most important outcomes of this process was an original hip-hop music CD, written and performed by the youngsters and dedicated to the theme of AIDS prevention. The catchy songs are now being played on radio stations all over Brazil.

NORTH AMERICA

Canada

Philippe Bourgois, PhD

Anthropology, History, and Social Medicine
Study of HIV seroconversion associated with needle exchange patronage in Montréal and Vancouver.

LATIN AMERICA

Brazil

Camila Alves Peres, MA

Norman Hearst, MD, MPH

CAPS Int'l Collaborative Research Program
Evaluating prevention program targeting juvenile delinquents in a governmental institution in São Paulo.

Maria Amelia DeSousa Veras, MD

Kim Shafer, PhD, MPH

CAPS Int'l Collaborative Research Program
HIV infection and risk behavior in a cohort of men who have sex with men (MSM) in São Paulo.

Michael P. Busch, MD, PhD

Laboratory Medicine

AIDS epidemiology study of blood donors; Fogarty Foundation Int'l Training Program in AIDS.

Christina Antanes, MA

Norman Hearst, MD, MPH

CAPS Int'l Collaborative Research Program
AIDS Prevention among MSM in Brazil.

Edward L. Murphy, MD, MPH

Laboratory Medicine, Medicine, Epi Biostat.
HTLV-I and HIV co-infection and HAART in Brazil.

Colosio Robson, BA

Kim Shafer, PhD, MPH

CAPS Int'l Collaborative Research Program
Evaluating a model for attendance at a public health service for STD/HIV patients.

Silvana Freitas Barbosa, MD

Kim Shafer, PhD, MPH

CAPS Int'l Collaborative Research Program
Evaluation of factors associated with adherence to antiretroviral therapy and strategies to improve drug compliance.

Dominican Republic

Jay A. Levy, MD

Medicine

Seroprevalence.

George W. Rutherford, MD

Medicine

Subcontractor for technical assistance and consultation to support improved HIV prevention and AIDS treatment services.

Daniel Halperin, PhD

CAPS Medical Anthropology, Community Health Systems

Design and evaluation of HIV/STD programs; study of dry sex practices.

UCSF AIDS Research Institute International



Guatemala

Janet Ikeda, MA

Norman Hearst, MD, MPH

CAPS Int'l Collaborative Research Program
Reducing high-risk sexual behavior among seasonal migrant workers in Mam-speaking rural communities.

Mexico

Jay A. Levy, MD

Medicine

CD8+ cell suppression in long-term survivors.

Peru

Thomas J. Coates, PhD

Carlos Cáceres, MD, DrPH

Susan Kegeles, PhD

Jeff Klausner, MD

Steve Morin, PhD

CAPS, SF Dept. of Public Health

Part of multi-site intervention trial involving "community popular opinion leaders" in STD and HIV prevention among youth.

ASIA

Cambodia

Samnang Po, MD

Kim Shafer, PhD, MPH

CAPS Int'l Collaborative Research Program
Demographics, sexual behavior, HIV/AIDS knowledge, and HIV status among fishermen in Sihanouk village.

China

Shuquan Qu, MD

Kyung-Hee Choi, PhD

CAPS Int'l Collaborative Research Program
Pilot study of HIV infection, risk behavior, and health demand among prostitutes in China.

Georgia

Nino Badridze, MD

George W. Rutherford, MD

CAPS Int'l Collaborative Research Program
Sero-epidemiological and behavioral study among high risk populations.

India

Brinele D'Souza, MA

Ariane van der Straten, PhD, MPH

Global HIV/AIDS Research Projects by Country



CAPS Int'l Collaborative Research Program
Safer sex negotiation among HIV serodiscordant married couples in Mumbai.

Sunita Krisnan, PhD (cand.)
Jeffrey S. Mandel, PhD, MPH
CAPS Int'l Collaborative Research Program
Developing family approaches to HIV counseling in Southern India.

Maninder Setia, MD
Maria Ekstrand, PhD
CAPS Int'l Collaborative Research Program
A study of sexual risk and health-seeking behavior as practiced by MSM reporting with STDs.

Nalini Sahay, PhD
Maria Ekstrand, PhD
CAPS Int'l Collaborative Research Program
Impact of a risk reduction intervention on HIV-related behaviors, attitudes, knowledge, perceived stress and coping, and job placement in street children of Nizammudin in New Delhi.

Japan
Mitchell Feldman, MD
Medicine, DGIM

AIDS clinical training; HIV/AIDS registry—Int'l perspectives; Japanese doctors' knowledge/attitudes about HIV/AIDS.

Naoki Onizuka, MA
Jeffrey S. Mandel, PhD, MPH
CAPS Int'l Collaborative Research Program
Japanese Nurses Training Program.

Tooru Nemoto, PhD
CAPS
HIV risk behaviors among Japanese nationals temporarily staying in Hawaii; drug use and HIV risk behaviors among Japanese nationals in the U.S.; AIDS/HIV care and policy research.

Thailand
Peter Kunstadter, PhD
Anthropology, History, & Social Medicine
Testing and counseling for HIV/AIDS in Northern Thailand.

Jay A. Levy, MD
Medicine
Mother-to-child transmission.

Aum Buavirat, PhD
Andrew Moss, PhD
CAPS Int'l Collaborative Research Program
Study of the association between incarceration

and HIV infection in IDUs in Bangkok.
Kriengkrai Srithanaviboonchai, MD
Kyung-Hee Choi, PhD
CAPS Int'l Collaborative Research Program
Risk factors for HIV infection among Burmese migrant workers in Chiang Mai.

Vietnam
Janice Louie, MD
George W. Rutherford, MD
CAPS
Observational study of prevalence and causes of bacteremia in AIDS patients in Ho Chi Minh City.

Jeffrey S. Mandel, PhD, MPH
Kryisia Lindan, MD, MSc
Medicine
Testing the efficacy of anonymous testing sites in Ho Chi Minh City.

Nguyen Thanh Son, MD
CAPS Int'l Collaborative Research Program
Risk behavior and patterns of migration among sex workers along the Cambodian border.

AFRICA
Botswana
Daniel Halperin, PhD
CAPS, Medical Anthropology, Community Health Systems
Feasibility/acceptability research on male circumcision services, dry sex prevention.

Cameroon
Edward L. Murphy, MD, MPH
Laboratory Medicine, Medicine, Epi Biostat.
HTLV-I and II epidemiology.

Egypt
Ezz Saleh, MD
Willi McFarland, MD, MPH
CAPS Int'l Collaborative Research Program
Prevalence of HIV and related risk behaviors among STD clinic attendees in Alexandria.

Nigeria
Ademola J. Ajuwon, BSc, MPH
Willi McFarland, MD, MPH
CAPS Int'l Collaborative Research Program
Trial of a peer education intervention for AIDS prevention among female apprentice tailors in the Agbowo area of Ibadan.

South Africa
Daniel Halperin, PhD
CAPS, Medical Anthropology, Community Health Systems

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Research Projects by Country

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Feasibility/acceptability research on male circumcision services, dry sex prevention.

Girish Vyas, PhD

Laboratory Medicine

Putative clinical trials, Natal.

Zimbabwe

Katherine Fritz, PhD

Dennis Osmond, PhD

CAPS

HIV seroprevalence, seroincidence, and sexual risk taking among male beer hall patrons in Harare.

John Greenspan, BDS, PhD, FRCPath

Stomatology & Oral AIDS Center

Zimbabwe project with Deborah Greenspan and Caroline Shiboski.

Roderick Rhadv Machezano, PhD

Willi McFarland, MD, MPH

CAPS Int'l Collaborative Research Program

STD management and investigation of partner notification among those seeking STD treatment in Harare.

Witness Moyo, MSc

Willi McFarland, MD, MPH

CAPS Int'l Collaborative Research Program

Impact of women's socioeconomic status and perception of HIV/AIDS prevalence on the

proximate determinants of fertility.

Nancy Padian, PhD

Medicine, Ob-Gyn

Hormonal contraception and the risk of HIV acquisition; Phase III clinical trial of N-9; acceptability of diaphragm use to prevent HIV/STDs; acceptability of barrier methods to prevent HIV/STDs.

International (Multi-site)

John Greenspan, BDS, PhD, FRCPath

Stomatology & Oral AIDS Center

Laboratory collaborations in the UK, Hong Kong, Denmark, Australia, China, and Brazil.

James H. McKerrow, PhD, MD

Pathology

Tropical disease research in Egypt, Brazil, Argentina, Nicaragua, Venezuela, Cameroon.

Donald I. Abrams, MD

Medicine, UCSF Positive Health Program

Evaluation of subcutaneous proleukin in a randomized international trial in Argentina, Australia, Belgium, Canada, Denmark, France, Germany, Greece, Israel, Italy, Japan, Netherlands, Norway, Portugal, Spain, Sweden, Thailand, and the UK.

Philippe Bourgois, PhD

Anthropology, History, & Social Medicine

Qualitative component of trials of HIV prevention outreach model based on training community opinion leaders in Peru, India, China, Russia, and Uganda.

William L. Holzemer, RN, PhD, FAAN

Dept. of Community Health Systems, School of Nursing

International HIV Research Network in Norway, Taiwan, Botswana, Sweden, and Brazil.

EDITOR'S NOTE: *We have endeavored to make this list as complete as possible.*

Programs and studies change over time.

We regret any omissions.

Compensated Sex among Adolescent Girls in Zimbabwe

Current research in one African country highlights the efforts of the Center for Global Research on Women's Health to design health programming within the economic contexts of risk behavior. Adolescent girls in Zimbabwe are particularly vulnerable to infection with HIV and other STDs, with reported AIDS incidence six times greater among girls compared to their male counterparts. Most girls lack education and economic opportunities, forcing many to form relationships with "sugar daddies" or "sponsors"—older men who provide them with economic support in exchange for sex. A Zimbabwean survey found that approximately 50% of female students are dependent on compensated sex, generally unprotected, with "sugar daddies," yet there is almost a complete absence of scientific literature on this widespread and growing phenomenon.

The Center is currently implementing pilot intervention research to help reduce HIV and other sexually transmitted infections among Zimbabwean adolescent girls aged 15 to 18. The inter-

vention will include multiple components aimed at giving girls expanded economic and educational options:

- An **economic strategy** to help keep adolescent females in schools or develop marketable skills.
- A **grant and micro-lending program** to help young women get started on their next step after school, whether college, a job, or establishing their own business.
- An **information, education, and communication program** to address the "sugar daddy" problem.

Program outcomes will be measured through behavioral questionnaires, school records, monitoring of business ventures and job performance, and tests for HIV, STDs, and pregnancy. This study is unique because few such micro-enterprise programs have been rigorously evaluated, and none have been designed to establish direct links between the program and measurable reductions in HIV infection.

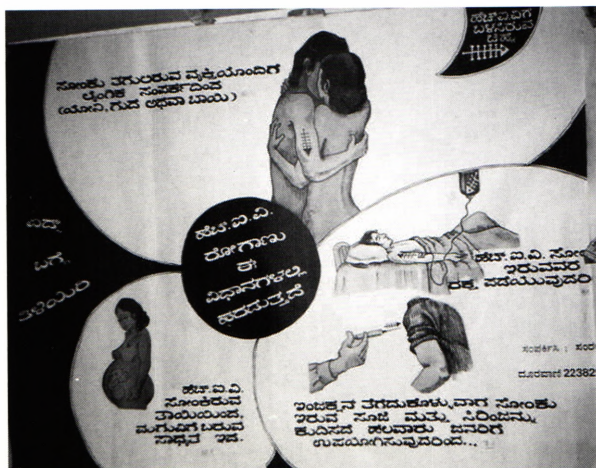
Developing New Models for VCT in India

Maria Ekstrand, PhD

With HIV/AIDS having reached epidemic proportions in India, there is a tremendous need for HIV counseling and testing. Unfortunately, despite a considerable amount of local experience and expertise in HIV/AIDS testing and counseling, the procedures followed in India are often modeled on Western, individual-oriented service models. These models place great emphasis on the individual: on informing the individual about HIV risk; on the impact of HIV status disclosure on the individual; on individual self-efficacy and behavior change, and on the emotional and physical care needs of the individual. In cultural settings in which the individual is part of a strong family system as in South Asia, these protocols become inadequate and, sometimes, even inappropriate.

Nearly two year ago, **Jeff Mandel**, **Suneeta Krishnan**, and **Maria Ekstrand** conducted a pilot study to address this problem. The study was funded by Levi-Strauss, in collaboration with three NGOs in South India—YRG Care, Asha Kirana, and Swasthya—to examine the needs of HIV positive individuals and their families and to develop a more culturally appropriate HIV counseling and testing model. The project was launched by holding a workshop, “Current Approaches to HIV/AIDS Testing and Counseling in India: Individual and Family Models,” in Bangalore.

A number of challenges facing HIV/AIDS service providers and organizations were identified both during the workshop and our follow-up visit to Asha Kirana. We found that concepts such as “confidentiality,” “disclosure,” and “informed consent” often are not interpreted the same way as they are in the West. Doctors and laboratories are sometimes requested by family members to test individuals without their knowledge, and HIV positive diagnoses are disclosed by health care professionals to the patients’ friends, families, and sometimes even their employers. Counseling often



An HIV prevention poster in India.

takes place in a cubicle, a hallway, or some other space that does not provide sufficient privacy.

Gender inequalities also bring special challenges: Although it is typically straying husbands who first become HIV infected, their wives end up carrying the heaviest burden; first by taking care of their sick husbands (often while being accused by his family of being responsible for his ill health), and later, after their husbands have died, when they and their children are evicted by their in-laws. We are planning to address some of these issues in a series of Fogarty-sponsored workshops targeting health care staff in clinics in both Bangalore and Mumbai, India. We are submitting additional requests for funding so that we may continue to learn more about gender and family issues in HIV prevention and treatment.

Secure the Future

The UCSF School of Nursing recently received \$342,080 in funding from the Secure the Future Foundation, Bristol-Myers Squibb Company, for a two-year project in southern Africa. The project, Self-Care Symptom Management for Persons with HIV Disease, is a research and practice project linking HIV clinicians and educators to describe and disseminate self-care symptom management strategies for persons living with HIV/AIDS and their family caregivers. Country teams are led by nursing professors from the participating universities: **Dr. Seboni** (University of Botswana); **Dr. King** (University of South Africa); **Dr. Sukati** (University of Swaziland); and **Dr. Holzemer** (University of California, San Francisco). The first team meeting was hosted by the University of Botswana, Gaborone, in January 2001.



Clockwise from left: **Dr. L. King**, University of South Africa; **Dr. N. Seboni**, University of Botswana; **Dr. N. Sukati**, University of Swaziland; **Dr. W. Holzemer**, UCSF; **Dr. A. Hudson**, UCSF Post-Doc Fellow, School of Nursing; **B. Goodroad**, UCSF Pre-Doc Fellow, School of Nursing, in Gaborone, Botswana.

Profiles in Leadership



*An interview with donor Virginia Peacock,
Chair of the ARI Leadership Council*

Currently a realtor with Coldwell Banker, Virginia Peacock has been a junior high school English teacher. While her home is in Montara, she spends a good deal of time in Oakland with her partner and her partner's two teenage daughters.

ARI: You've had a long history with fighting a variety of issues on the front lines. Yet, here you are leading the charge again. What brings you back?

VP: I feel like I've gained a lot of experience that has prepared me for the challenges ahead. I'm a member of the board of ARA House, and I've served previously on the boards of the San Francisco AIDS Foundation, Henry Ohloff House, and 18th Street Services (now New Leaf). These are fine institutions with worthy causes. And altogether, they give me much better perspective on all that we still have to do.

ARI: There are some around town who are concerned that all of us associated with battling HIV/AIDS haven't been able to attract a leadership beyond "the same, small group," and that people are burning out as a result. Yet, in establishing the ARI Leadership Council, we see a lot of new faces. Why is that?

VP: This disease has as many different faces as we have neighborhoods; indeed, as we have countries around the world. And we've been fortunate to be able to reach across many communities to find people who see the global implications of all that we're doing locally. This is, to me, a very inspiring group indeed.

ARI: You've made a five-year pledge in helping to establish The Breakthrough Fund. That's a significant commitment.

VP: Oh, that's an easy one. We must all make long-term commitments if we're serious about getting to the cure. You know, I just couldn't stand on the sidelines as the challenges facing us seem to become more urgent than ever. I also have a good sense of the link between drug and alcohol abuse and HIV, and I know there is more work to be done here as well.

ARI: Well, you certainly dispel the myth of "donor burn-out"!

VP: These scientists and physicians on the front lines must know we're going to be right there with them all the way. The science is our hope.

Founding Donors of The Breakthrough Fund

June 1, 2000 – November 30, 2000

Visionary level (\$50,000 and above)
The McBean Family Foundation

Vanguard level (\$15,000 to \$49,999)
Roderick Kiracofe
Don H. and Rita M. Lee Foundation

Explorer level (\$5,000 to \$14,999)
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Racquel Newman
Virginia Peacock

Pathfinder level (\$2,500 to \$4,999)
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Joseph (Mike) McCune III MD
Rick Turley and Brendan Koon

Trailblazer level (\$1,000 to \$2,499)
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Mark Jacobson MD, David Johnson,
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Laura Lodato, Barbara Van Oss Marin PhD,
Pathways Personnel Agency Inc.,
Michelle Roland MD, George Rutherford III MD,
Kimberly Page Shafer PhD, Maureen Shannon,
Daniel Shields, Paul Volberding MD

Development News

Breakthrough Fund Celebrates Supporters

On the eve of World AIDS Day, inaugural donors to The Breakthrough Fund toasted the establishment of ARI's new pool of venture funding and the breakthrough science it will foster. Congresswoman **Nancy Pelosi** and State Assembly Majority Leader **Kevin Shelley** were on hand to offer congratulations.

"We are delighted by the fervor and commitment with which The Breakthrough Fund has been established," commented ARI Director **Thomas J. Coates, PhD**. "AIDS science must move quickly to keep ahead of this evasive virus and address the complexity of neutralizing HIV and ending the epidemic. Our Executive Committee frequently hears from our faculty of innovative ideas worth pursuing, but until now we had no source of funding for this kind of breakthrough science. We are grateful to all our donor partners for making this possible."

The dinner, hosted by **Donald and Roslyn Kahn** at their home in Sea Cliff, was chaired by **James O. Kahn, MD**, a member of ARI's Leadership Council and chair of the major gifts campaign.

The spirit of the Fund is about developing promising ideas that could lead to the next critical breakthrough in the quest to cure HIV/AIDS. Lively dinner conversation featured members of the ARI faculty discussing aspects of their science. Guest table hosts included **Warner C. Greene, MD, PhD**; James Kahn, MD; **Steve Morin, PhD**; **Michelle Roland, MD**; and Thomas J. Coates, PhD.

In an evening dedicated to acknowledging the founding donors to the Fund, Dr. Kahn announced several significant gifts, including a \$50,000 grant from **The McBean Family Foundation** and lead gifts from the Kahn family, **Roderick Kiracofe**, and **Alvin H. Baum Jr.**; and major multi-year pledges from ARI Leadership Council Chair **Virginia Peacock** (see profile at left) and members **Racquel Newman**, **Ken Hedrick**, **Rick Turley** and **Brendan Koon**, and **Hedy Holmes** and **Dale Jacobson**. A highlight was the presentation of a check from the **Don H. and Rita M. Lee Foundation** to Dr. Kahn.



Don Lee (left), founder of the Don H. and Rita M. Lee Foundation, with son Ken (second from left) and daughter Laurie Bemis, presents the Foundation's gift to James O. Kahn, MD.



Congresswoman Nancy Pelosi (left) with Sarai Obermeyer and her parents, Vera and Walter Obermeyer.



Assembly Majority Leader Kevin Shelley (R) with Steve Morin, PhD, Director of ARI's policy programs.

ARI faculty members have also contributed to the establishment of The Breakthrough Fund, with a committee chaired by **John Greenspan, BDS, PhD**. Members of the committee for the faculty/staff drive include David Bangsberg, MD; Thomas J. Coates, PhD; Molly M. Cooke, MD; Mark A. Goldsmith, MD, PhD; Cynthia A. Gómez, PhD; Robert M. Grant, MD, MPH, MS; Ruth M. Greenblatt, MD; Warner C. Greene, MD, PhD; Frederick M. Hecht, MD; William L. Holzemer, RN, PhD, FAAN; Jay A. Levy, MD; Michelle Roland, MD; Kimberly A. Shafer, PhD, MPH; Diane W. Wara, MD; and Craig Palmer.

Upcoming Meetings

13th Annual National HIV/AIDS Update Conference (NAUC)

"AIDS Treatment and Care:
Translating Progress into Practice"
March 20-23, 2001
San Francisco, CA
Sponsored by amfAR
Jennifer Attonito, Conference Director
212-806-1633
jennifer.attonito@amfar.org
www.amfar.org

2001 Capacity Building for HIV Prevention

"Enhancing the Capacity for HIV
Prevention: A Formula for Success"
April 1-5, 2001
Hilton Atlanta Hotel
Atlanta, GA
Rob Newells, National Minority AIDS
Council
202-234-5120, Fax 202-234-6404
rnewells@nmac.org

Global Health Council 28th Annual Conference

"Healthy Women, Healthy World"
May 29-June 1, 2001
Omni Shoreham Hotel
Washington, DC
802-649-1340
conference@globalhealth.org
www.globalhealth.org

Summer Institute on Sexuality, Society, and Health in San Francisco

June 18-July 15, 2001
Sponsored by San Francisco State
University
415-405-3570
www.sfsu.edu/~hmsxdept/

AIDS Impact 2001

"Biopsychosocial Aspects of HIV
Infection"
July 8-11, 2001
Brighton Conference Centre
Brighton, UK
44-20-8670-1964
admin@aimp.freemove.co.uk
www.aidsimpact.com

First International AIDS Society Conference on HIV Pathogenesis and Treatment

July 8-11, 2001
Buenos Aires, Argentina
Registration and abstract submission:
aids2001@congresosint.com.ar
www.aids2001ias.org

2001 National HIV Prevention Conference

August 12-15, 2001
Atlanta, GA
Sponsored by Centers for Disease
Control and Prevention
www.2001HIVPrevConf.org

Global Strategies for the Prevention of HIV Transmission from Mothers to Infants

September 9-13, 2001
Kampala, Uganda
Christine McFeeley
617-432-4400
mcfeeley@eci.harvard.edu
www.globalstrategies.org/uganda

5th Annual United States Conference on AIDS (USCA)

September 13-16, 2001
Fontainebleau Hilton Resort and
Towers
Miami Beach, FL
Sponsored by National Minority AIDS
Council
Paul Woods, Conference Registrar
202-483-6622, ext. 343
www.nmac.org/usca2001

6th International Congress on AIDS in Asia and the Pacific (ICAAP)

October 5-10, 2001
Melbourne, Australia
6icaap@icms.com.au
www.icms.com.au/6icaap

5th International Conference on Home and Community Care for Persons Living with HIV/AIDS

December 11-14, 2001
Lotus Hotel Pang Suan Kaew
Chiang Mai, Thailand
www.hiv2001.com

Microbicides 2002

May 12-15, 2002
Antwerp, Belgium
Yvette Jacob, Dept. of Microbiology
Institute of Tropical Medicine
yjacob@itg.be
www.itg.be/micro2002

8th Annual Retrovirus Conference Now Online!

UCSF was well-represented at
this year's Conference, held
February 4-8 in Chicago. Virtually
all of the information presented,
including abstracts, posters, and
webcasts of invited sessions,
is available on-line at:
<http://www.retroconference.org>.

Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How



Geeta Rao Gupta, PhD, is President of the International Center for Research on Women (ICRW) in Washington, D.C.

...We have known for at least a decade that gender and sexuality are significant factors in the sexual transmission of HIV, and we now know that they also influence treatment, care, and support. Both terms, nevertheless, continue to be misun-

derstood and inappropriately used.

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other....

Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior and is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity, and other factors, influence an individual's sexuality.

At ICRW, we talk about the components of sexuality as the "P's" of sexuality—practices, partners, pleasure/pressure/pain, and procreation....But we have learned through data gathered over many years that there is an additional "P" of sexuality that is the most important—power. The power underlying any sexual interaction, heterosexual or homosexual, determines how all the other P's of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place. Each component of sexuality is closely related to the other, but the balance of power in a sexual interaction determines its outcome....

How is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can we change the cultural norms that create these damaging, even fatal, gender disparities and roles? An important first step is to recognize, understand, and

publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic....

In the ultimate analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women. Policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence are key to empowering women. We now have two international blueprints—the Cairo Agenda and the Beijing Platform for Action—that delineate the specific policy actions that are essential for assuring women's empowerment. Since governments worldwide have committed to these blueprints, the HIV/AIDS community must join hands with the international women's community to hold governments accountable for their promises....

As we look to the future, let us be alert to the potential impediments to our success. Let us ensure that new, promising HIV/AIDS biomedical technologies, such as vaccines, which have the potential for making a substantial dent in the epidemic, are not impeded by entrenched gender barriers....

And let us work together to fight against two commonly held beliefs that continue to stand in the way of our efforts. The first mistaken belief is that empowering women will disempower men. This is not true. Empowering women is not a zero-sum game....

And the second is the fear that changing gender roles to equalize the gender power balance conflicts with the value of multiculturalism and diversity.... We know that the customs and practices associated with male and female roles and sexuality in many societies today are compromising the rights and freedoms of individuals and promoting a cycle of illness and death. This must stop. There can be no more powerful reason for change; gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years. This must change. That is the message that must be communicated....

These remarks are excerpted from Dr. Rao Gupta's plenary address at the XIIIth International AIDS Conference in Durban, South Africa, on July 12, 2000. Dr. Rao Gupta is a speaker at the International Women's Day briefing on March 8th.

HIV InSite International Update

HIV InSite and the AIDS Policy Research Center, a program of the UCSF AIDS Research Institute, have been granted \$500,000 by USAID to create multidisciplinary HIV/AIDS country profiles. These online, "download-friendly" policy profiles present research on and analysis of epidemiological factors, and determinants of the epidemic, its impacts, and responses to it at the household, sectoral, and macroeconomic levels.

The profiles are designed to assist USAID priority countries in national planning, priority setting, interagency coordination, and intercountry knowledge sharing; they will also inform the work of USAID missions and cooperating agencies, as well as U.S. and international investigators, policy-makers, and donors.

The profiles will be accessible on HIV InSite (<http://hivinsite.ucsf.edu>), facilitating quick access to extensive treatment, prevention, and policy informational resources. An online, searchable database of key socioeconomic indicators will also be created. The project will utilize interactive tools to gather input from in-country stakeholders for use in the profiles and to allow them to participate in electronic discussions around key issues. The profiles, to be updated on a continual basis, mirror the explosive growth, even in many poor countries, of web-based technologies; they will therefore be poised for dissemination via a variety of formats.

For more information, contact Steve Morin, PhD, Principal Investigator (smorin@psg.ucsf.edu), or Lisa Garbus, MPP, HIV InSite Project Director (lgarbus@php.ucsf.edu).

Daily NewsWatch

HIV InSite has expanded its news section. The daily "NewsWatch" (<http://hivinsite.ucsf.edu/ads/>) presents articles culled from media around the world. InSite also offers links to other daily news services that focus on HIV/AIDS and allied topics; major media that index AIDS-related stories; and regional news sources. The InSite policy section's "New & Noteworthy" highlights key issues (current focus is HIV/AIDS and young people), tracks new policy reports and research briefs from around the world, scans articles from peer-reviewed journals and periodicals, and links to global conferences.

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Kaisernetwork.org, a free health policy
webcasting and news summary service of the
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[http://www.kaisernetwork.org/
healthcast/ucsfhivwomenmar2001](http://www.kaisernetwork.org/healthcast/ucsfhivwomenmar2001)

0884
Carrell Crawford

Reflections on 20 Years of the AIDS Epidemic

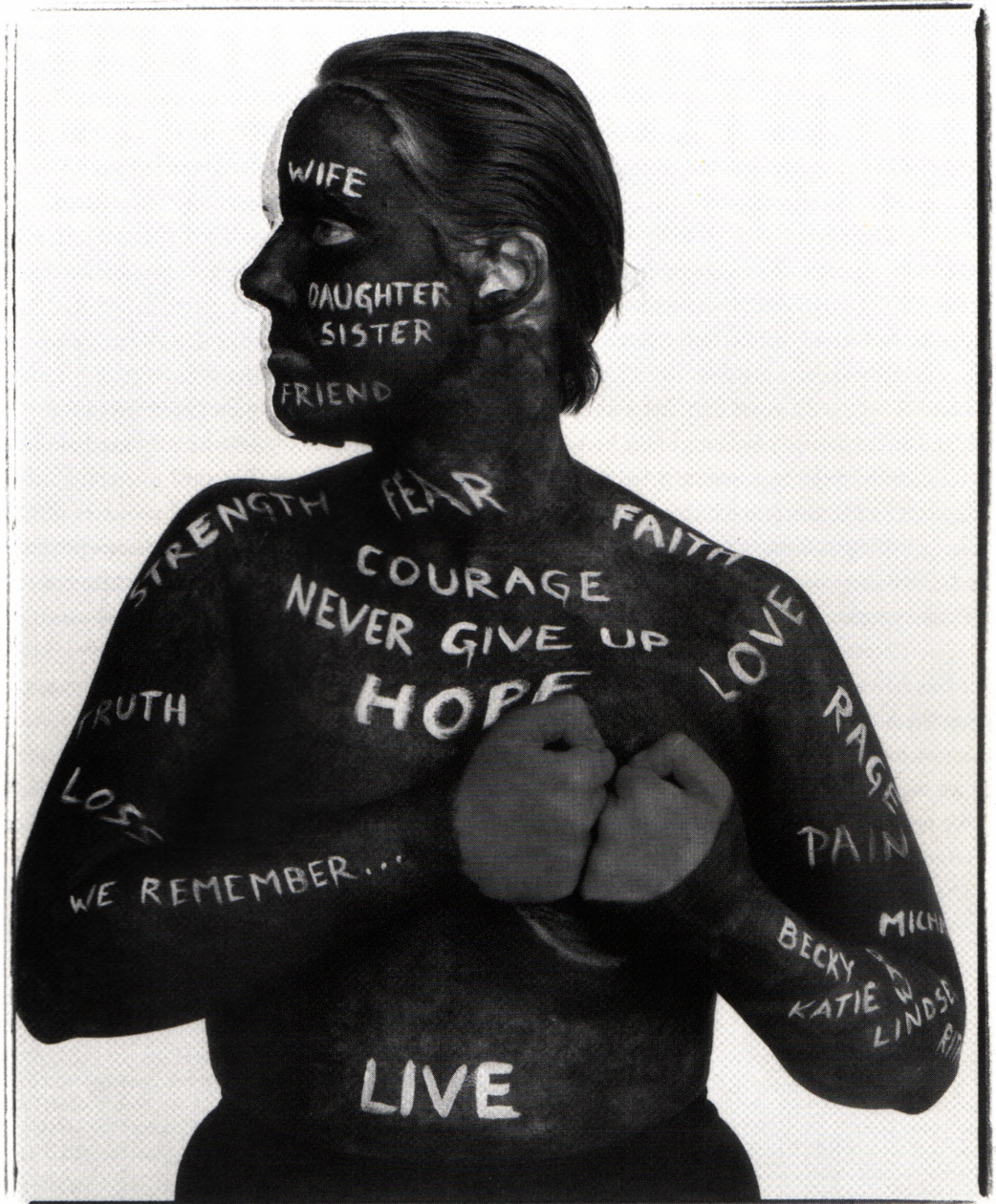
Annie Stuart

"No one thought this would be a history-altering or career-altering event. We had seen toxic shock. We had seen Legionnaire's Disease. Everyone thought this was some aberration—some unusual thing with a simple answer."

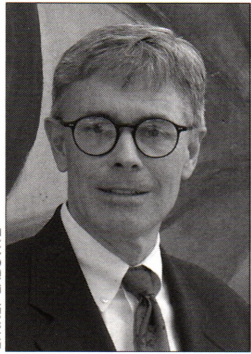
Marcus Conant, M.D.

Unusual, yes. Simple, no. Four physician veterans of the epidemic—**Jay Levy**, **Donald Abrams**, **Diane Wara**, and **Marcus Conant**—would agree. It's fair to say that this epidemic has challenged them, both personally and professionally, in ways they never imagined possible when first embarking upon their careers.

Their stories appear on page 3 of this special edition of the ARI newsletter.



Rebecca Denison, founder and former Executive Director of Women Organized to Respond to Life-threatening Diseases (WORLD), photographed by Annie Leibovitz. Used with permission of the artist. Ms. Denison shares her experiences as an HIV positive woman on page 7.



LYNNLY LABOVITZ

Thomas J. Coates, PhD
Director

Recommitting to the Future

HIV fooled everyone. No one imagined that this, the 20th anniversary of the first reports of what would come to be known as AIDS, would be marked by such mixed feelings. Advances have been made, but we've got a long way to go.

No one imagined 20 years ago that such a lethal disease would spread so rapidly around the world in so many different populations. When I was doing my graduate studies in the '70s (those same '70s that brought us the sexual, drug, and gay liberation movements), the mantra was that the infectious diseases had been conquered and that the chronic diseases—especially heart disease, stroke, and cancer—were next.

No one expected 20 years ago that a simple retrovirus would infect and affect so many systems of the body (the immune, nervous, and digestive systems, to name a few) and that it would have so many mechanisms to allow it to escape control. The drugs we have now are buying us time, but everyone who dispenses and uses them knows that they are not a cure. We are a long way from having an effective vaccine.

But this newsletter, like the work of the scientists of the ARI, is about the future and not about the past. We reflect on the past only to know how to behave in the future. What do we need and what do we need to do?

- We need to continue to support and train the next generation of scientists. Our scientists have been at this from the beginning. The contributions of **Drs. Wara, Levy, Conant, and Abrams** are priceless; but, clearly, cultivating a new generation of com-

mitted AIDS scientists must be a top priority. **Dr. David Bangsberg** (see page 5) is of the generation of UCSF scientists who will hopefully lay HIV to rest.

- We need to apply the lessons we have learned. HIV changed forever the ways in which science is conducted. **Jon Cohen** reminds us on page 6 that those lessons have not always been applied to the search for vaccines.
- We must listen to those living with HIV. The heroism of long-term survivors is inspiring, and the wisdom they impart provides lessons for all of us about dealing with HIV and its burdensome consequences. We thank **René, Michael, and Rebecca** for sharing their stories with us in this issue.
- We need to encourage personal philanthropy. The **St. Geme** family (see page 15) exemplifies the personal commitment and contribution to fighting AIDS shared by many. Their devotion to UCSF's pediatric AIDS effort helps to assure that mothers living with HIV will dance at their sons' and daughters' weddings.
- We must do our part for the rest of the world. HIV disproportionately affects the less powerful in this country—women, youth, those at the bottom of the economic ladder—and those in the poor countries of the world. **Mr. Justice Edwin Cameron** delivers a profound message on page 12.
- We must overcome the stigma surrounding AIDS. People with HIV and societies affected by it are shamed, stigmatized, and subject to discrimination. Why is that? HIV is spread by sex and drugs, two subjects we alternatively love and fear. On page 18, **Peter Teague** shows us a way out.

The scientific challenges in HIV/AIDS are clear, and we at the ARI are committed to ensuring that this and the next generation of scientists stay focused on finding solutions. It is also clear that the social challenges surrounding AIDS are complex. We need to ensure that they get addressed even after we figure out how to prevent HIV transmission through a vaccine and how to treat the disease better with drugs. It would be easy to pursue the medical and the scientific challenges and leave the social alone.

ARI Mission Statement

The University of California San Francisco created the AIDS Research Institute in recognition of its obligations to the people of the city of San Francisco, the United States, and the world to prevent, understand, and treat HIV infection. The AIDS Research Institute fosters outstanding, innovative, and integrated programmatic research in HIV/AIDS and excellent training for new scientists to continue working on the HIV epidemic.

The AIDS Research Institute works in close collaboration with affected communities. Scientific results are disseminated as quickly as possible to maximize their usefulness to these communities and to fellow scientists, policymakers, community-based organizations, and the public.

ARI Executive Committee

Donald Abrams, MD, Michael Busch, MD, PhD, Margaret Chesney, PhD, Warner Greene, MD, PhD, John Greenspan, BDS, PhD, FRCPath, Alan Lessik, MBA, MA, Jay Levy, MD, Steve Morin, PhD, Nancy Padian, PhD, Leslie Roos, Paul Volberding, MD, Diane Wara, MD
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University of California
San Francisco



AIDS Research Institute

Reflections on 20 Years of the AIDS Epidemic

Annie Stuart

Though all of the physicians I spoke with made shifts in their careers to meet this epidemic head-on, each also initially brought skills and experience that made them particularly well-suited for the challenge: **Donald Abrams**, an oncologist active in the gay community; **Jay Levy**, a virologist with a background in mouse retroviruses; **Marcus Conant**, a dermatologist who would see more than his share of Kaposi's Sarcoma patients, building the largest private AIDS practice in the country; and **Diane Wara**, a pediatrician with expertise in primary immunodeficiency. Each of them looks back now with the wide range of emotion you might expect from people so intimately involved.

"In the beginning, we were racing to find out as much as possible in the hope we could find a treatment, and to learn about the immune system," says Levy. In an effort to stay one step ahead of the epidemic, they and their colleagues moved at a breakneck pace. Says Abrams, "Being a member of the gay community, I never stopped working. Once I got home at the end of the day, I had friends calling to ask me, 'What does this mean? What does that mean?'" Wara recalls, "Eighty hours a week was an easy week. When I think back now, it seems pretty miraculous that the physicians and scientists who started with it all in the early '80s are still around."

Those immersed in the epidemic at the very beginning knew the kind of battle fatigue that no one ever hopes to experience. "It was a sad time because we were treating only what we could see, and that was just the tip of the iceberg," says Wara.

The earliest period was shadowed by an almost surreal fear of the unknown. Abrams says, "Being a member of the group most at risk, I was always a little paranoid." He recalls the weekend that he made an emergency visit to Marcus Conant's office to have him evaluate purple spots on his hands. They turned out to be liquid nitrogen burns.

Levy recalls the panic that prevented centrifuging of the virus in other facilities. A co-discoverer of HIV (then called AIDS-associated retrovirus), Levy and his colleagues made many of the first observations in AIDS research, including demonstrating that HIV grew in cells other than the lymphocytes and isolating the virus in the brain and the bowels. "People just didn't want to believe it," he says.

"And everyone thought it would happen to someone else," says Conant. But when Conant spoke out about the bathhouses to the

gay community, even they protested. "They said, 'It's those who don't take a shower or change their sheets who will become infected.' Everyone had convenient responses."



THOMAS F. WALTERS

Dr. Conant examines a patient early in the epidemic

Complacency plagued the early days of the epidemic. It wasn't until people saw first-hand the impact of the disease that they started to change their behavior.

"If my sainted mother could have seen me handing out condoms..." said Conant. "People just threw them away or used them for balloons. But when they saw neighbors, lovers, and brothers dying of AIDS, then they started using the condoms. Living next to the disease motivated them to take steps to prevent it."

This pattern, mirrored in other parts of the globe, has Conant reflecting that the lessons learned by the last generation will likely not be fully absorbed by the next. The supreme irony of the current antiretroviral therapy is that with its advent, a new form of complacency has settled in, particularly among the younger generation.

A recent conversation with a young patient had Conant reflecting on how rampant denial still is. When he asked a patient recently whether he could be at risk for HIV infection, the patient responded, "No, I'm married." When Conant further prompted him, the man replied, "Well, we kind of play around with other partners every now and then."

The staggering nature of the epidemic has not deterred these four from continuing to commit the majority of their time to AIDS research, clinical work, policy development, or community outreach. Each has managed to find that delicate balance between scientific stimulation and burnout, buoyed by a 20-year-long professional exchange between the lab, the clinic, and the classroom. These relationships have been "a powerful force" in progress made with HIV and literal lifesavers for those who continue this work.

Though Abrams needed to give himself some distance following the death of his partner in 1989, he continues to split his clinical time between HIV and oncology. Abrams was instrumental in the formation, in 1985, of a network of clinicians called Community Consortium. He considers one of its primary accomplishments the pioneering of a new model of community-based clinical trials. Recently, Abrams received funding to look at the effectiveness of marijuana in treating HIV-related peripheral neuropathy.

Levy, who worked years ago primarily with animal models, now has 30 HIV-infected subjects in his lab each month. "That's family," he says. "You can't turn away from that. It's a constant reminder that we can't sit around. We can't idle. We're all the time conscious that we have to find a solution."

"But," he laments, "nature doesn't open its secrets easily. Now we're in the really hard stage, with tough questions that can't be answered overnight." Such has been the case with his ten-year attempt to uncover the mystery of CD8+ lymphocytes, which suppress HIV replication through production of a novel antiviral factor. CD8+ explains the anomalous cases of people who have been infected for years but never developed full-blown AIDS. Though the secrets of this protein have eluded him thus far, Levy believes they could one day lead to an effective therapy for all HIV-infected people.

Conant, too, is excited about the prospects for another innovative approach to treating the disease. He was principal investigator for a recent clinical trial that involved removing immune and stem cells from the body, altering them genetically, and introducing them back into patients where they successfully engrafted. These results are very encouraging to Conant, indicating that it might be possible to restore the immune systems of HIV-infected patients. He believes this approach could change the paradigm of treatment in ways that the combination therapy approach cannot.



"When it first started, our lab was reduced to virtually three or four people. This was 1981. The Reagan years had cut budgets for all science. We were doing this on a shoestring."

Dr. Jay A. Levy

Says Wara, "It's been a privilege to be involved in the laboratory and see what begins as a routine clinical trial transform into a major breakthrough." Wara was the first to demonstrate that AZT given to infected women during pregnancy, delivery, and labor and to their newborns during the first six weeks after birth could decrease transmission of HIV to the newborn. Today, transmission from mother to child has been reduced from 28 percent to 1 percent or less. "Nothing has been more thrilling," she says.

Wara and the others share frustrations about policy limitations and the paucity of resources. For example, she's struggled for the mandate to offer HIV testing to all pregnant women (with the right to decline; concerns about stigmatization still exist).

Wara also notes that the focus on HIV funding may be diminishing. "We need to sustain a minimal amount of funding to keep programs going and continue at the current pace. ... We're losing the biotech companies," she says. "They're moving their investment into other areas."



"It was difficult and frightening. Difficult because our patients—the children—were so sick and they all died. Frightening because I knew that this was a transmissible infectious disease."

Dr. Diane Wara

that a vaccine—although not imminent—will come. "The vaccine gives me the greatest cause for hope," he says. "It allows us to go international. In the next ten years, we're going to have a much

Still, Wara believes a vaccine will be developed. Where will the initiative come from? "The impetus has got to come from combined funding from the government and the pharmaceutical companies," says Wara. "On their own, the pharmaceutical companies aren't going to put huge resources into a one-in-a-million shot, so there has got to be a better partnership, where risks and benefits are shared."

Conant shows less faith in the intrinsic good will of the government and more in the perseverance of a dedicated group of scientists who will continue to work diligently on a vaccine. Among them is Levy, who also believes

better chance for control, mediated by the immune system.”

For Abrams, there is the inevitable frustration that drug development did not come fast enough to benefit the many who died in the early '80s. “When I think about the magnitude of loss that we in San Francisco have suffered... We’ve lost some very talented, highly functional people.” Still, he says, this pales when compared with the magnitude of the epidemic in other parts of the world.

Abrams and Levy both recently returned from trips to Africa, where, in places, 60 to 70 percent of the people would be HIV positive if they were all tested. Wara is all too aware of the number of HIV-infected infants who are born to women in developing countries where the drug regimens are just not available.

Looking back over the last 20 years, she muses, “It’s been an incredible ride...the opportunity, the privilege to provide care for a group of patients, to work in the laboratory and watch the development of strategies that allow for improved care.”

Adds Abrams, “What a surprise it’s been to see how many people have really committed their careers to this disease with such good intentions, hard work, and acceptance of disenfranchised populations.”

Four veterans of the epidemic—still hopeful, still here, after all these years.



DAVID POWERS

“I was a fellow in hematology/oncology at the Cancer Research Institute at UCSF. It was my first year of fellowship. In the airport on my way to Seattle one day, I caught a news story about an epidemic of cancer among gay men. When I got to Seattle, no one had heard a thing about it.”

Dr. Donald Abrams

New Frontiers: Working with the HIV Positive Urban Poor

Science is a series of suppositions. Some end up right on target; others miss the mark. For **David Bangsberg, MD, MPH**, many gratifying moments of his career have come when his assumptions about science—and people—were blown right out of the water.

Typical of progeny from an upper middle-class suburban family, Bangsberg had some serious stereotypes to overcome when he found himself transplanted to East Baltimore in the late '80s, “where people were poor, drug use was common, and people were dying like flies.”

“I remember hearing the juniors and seniors talking about drug users and how difficult they were,” says Bangsberg, recalling his early medical school years at Johns Hopkins. “I had developed quite a mindset. When I encountered my first ‘shooter’ with a fever, I was frightened. I wondered, ‘What will this be like?’” But the “kind, articulate, and gentle man” he came to know turned that mindset right on its head.

The psychological somersaults continued for Bangsberg in what might be considered another unlikely place: Columbia-Presbyterian, the second largest hospital in the nation, serving an incredibly impoverished population. While completing his residency there in Internal Medicine, Bangsberg met a homeless, HIV positive, crack-addicted sex worker “with the wickedest humor I’ve ever seen in my life.” At a time when HIV care was death management, “she was facing her terminal illness with righteous humor.” And despite an extremely chaotic life, this woman had “the wherewithal to save enough money to put her daughter through college. She later died of AIDS.”

Though HIV has long since moved into the mainstream, Bangsberg continues to work with the marginalized. He is one of 17 recipients of a 2000 Doris Duke Clinical Scientist Development Award, which he is using to investigate the use of antiretroviral therapy in the HIV positive urban poor. He is primarily studying the relationship between adherence, viral suppression, and HIV resistance.

Working with this population, Bangsberg says, “suits my personality” because of a unique intersection of issues. Among the indigent in the United States, he says, poverty concentrates the problems of mental health, addiction, and infectious disease in a way not found anywhere else in the world.

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“The Wayward Search for an AIDS Vaccine”

An Interview with Jon Cohen

Jon Cohen began following the AIDS vaccine research field in 1989 while working as a general reporter. A year later, he started contributing to *Science* magazine, where he has written dozens of articles on the progress and difficulties along the road to an AIDS vaccine over the years. In January 2001, Norton published his *Shots in the Dark: The Wayward Search for an AIDS Vaccine*, a chronicle and critique of the 15-plus-year effort. He spoke with International AIDS Vaccine Coalition (IAVI) Report editor Patricia Kahn at the 2001 Conference on Retroviruses and Opportunistic Infections.

PK: *Why did you decide to come out with the book now, even though there isn't an AIDS vaccine coming to market?*

I've catalogued all these problems, and I want to put it out there: here are all these promising leads that have gone nowhere; creative ideas that haven't been put to use; research gaps and legal liability problems that aren't being addressed; and market problems that aren't being solved. I wanted to put it all in one place and then offer my own idea of a solution. HIV is a tough bug. That's a given. The science is the biggest obstacle. All I'm saying is, given this difficult problem, are researchers as organized as they could be? Is the field taking advantage of everything that it could? And I think the answer is No.

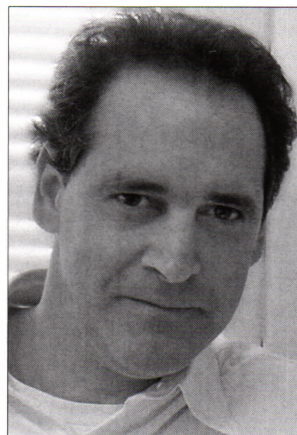
PK: *Where do you see the fundamental failures?*

One is that industry hasn't rushed forward here. You have two, three, four pharmaceuticals that are serious, but their interests wax and wane. The biotechs come and go; they're always cash-strapped, and they always are in danger of selling hope rather than a product. Another failure is that the monkey model isn't being effectively exploited. Again and again, leading researchers have called for organizing a large-scale, comparative trial of all the best vaccine ideas in monkeys, and setting it up in such a way that new vaccines which come along can be plugged into that protocol—or several protocols, even.

There's a clock ticking. We've known for years that a 60 percent efficacious vaccine introduced today will prevent more infections and disease ten years down the road than a 90 percent effective vaccine introduced five years later. So there's a great reward in coming up today with a mediocre vaccine that is crudely understood.

PK: *You also said that many scientific ideas are prematurely dropped.*

That's another one of the big failures. There is no real gap-filling committee, no group of people who meet regularly and ask, “What are all



Jon Cohen

the promising leads? Who's doing what? How can we speed these things along?”

PK: *What type of organization should this be?*

I call it a “March of Dollars” in the book. I think we have a lot to learn from the March of Dimes model. It's an organization that wouldn't be wildly different from IAVI, but would have some different approaches. The new organization would raise money from philanthropists. It would also draw on the public, which IAVI hasn't tapped into.

PK: *What are some specific examples of research gaps or missed opportunities?*

There is an incredible fascination with new technology, to the detriment of old technology. We have never seen the whole-killed experiment cleanly done, with monkey-grown SIV to make the vaccine and a monkey-grown SIV challenge. We do not have definitive information saying that the Th1/Th2 concept [describing the inter-relationships among T-cell subclasses] is worthless. I don't know that low-dose vaccination is a worthless idea; the same with attenuated vaccines. Another neglected area is cellular proteins. Those are several ideas that I think deserve more attention.

PK: *What are some of the positive signs you see now?*

I like the fact that there is so much creativity happening right now, and that different targets are getting serious attention. But it's important to recognize that we've moved the goalposts. We went from aiming for sterilizing immunity to delay of disease. And when we look at old “failed” data using today's criteria, we see that some of those older vaccines didn't actually fail—there's data from ten years ago showing some real protection.

PK: *How do you now see the prospects for a vaccine?*

There's more serious attention being paid to the problem than ever before. I think a vaccine is eminently doable. I would hope that, within the next ten years, we at least have conclusive data that something doesn't work, and maybe have a vaccine ready to go out to the world.

Excerpts reprinted from an interview published earlier this year with permission from IAVI. For the full interview, go to: http://www.iavi.org/reports/243/interview_jon_cohen.htm.

The Hardest Decision I Ever Made

Rebecca Denison

The following is excerpted from an article originally published in the WORLD (Women Organized to Respond to Life-threatening Diseases) newsletter in 1995. Treatment advocate and former Executive Director of WORLD Rebecca Denison has been living with HIV for 18 years, since long before marrying Daniel in 1989.

When I first tested positive...the first thought that came to my mind was, "Does this mean I can't have a baby?" I quickly turned my thoughts to other concerns, like when I was going to die, whether I'd infected my husband Daniel, and how I would tell my family. Daniel tested negative, and over the years, I learned to deal with having HIV...but I never got over the grief of thinking I would never have children.

My decision-making process was a five-year battle between my mind and my heart. My mind said, "It's too big a risk. There are other ways to feel fulfilled. It's selfish to put a baby at risk. You've been healthy for years—What if this triggers something and you get sick?"

I tried to "get over it." But my heart wouldn't let go of this baby thing. I reached a point where I couldn't paint or write in my journal anymore. I guess I was too afraid of what I'd find. I resented condoms for being so effective. If only one would break and I got pregnant by accident! It would be a lot easier to reject an abortion than to take responsibility for choosing to get pregnant.

I'd pretty much decided to get pregnant until I got a call from an HIV positive woman I respect very much—the day after she'd buried her 3-year-old daughter. She didn't know I was thinking about getting pregnant. She said, "Rebecca, my daughter suffered every day of her life. I don't understand these women who get pregnant when they know they have HIV. Don't they realize? If your child gets AIDS, it's not you who suffers, it's your child." I knew she was right, and I had to back up and go through my decision-making process all over again.

One day I was talking to my best friend, who is 42 and HIV negative. She and her husband had also decided to try and have a baby. Suddenly it hit me: Hers would also be a high-risk pregnancy. Miscarriage was pretty likely. She was also more likely to have a baby with Down's syndrome. Yet, lots of women in their early 40's are trying to get pregnant and there is no social condemnation of them like that we experience as HIV positive women. There is a double standard: There is greater stigma when you have HIV.

It became clearer and clearer that my heart wasn't going to let go of this, no matter what my mind said. It was as though my child already existed in spirit, and was pleading to be allowed into my life. Finally, one day I got the urge to write in my journal for the first time in ages. I wrote, and cried, and wrote some more, and out poured this letter...

My dear beloved child,

I pray one day to hold you in my arms and not merely in my heart and dreams. I pray harder that you live long enough to know how to read this—in cursive no less! And I pray harder still to be there, with your daddy, when your first child is born. Your daddy will be the most loving, gentle, and patient man to come into your life.

Physically, you have not yet even been conceived. Spiritually, my love for you, the hope you make me feel, has been with me for years. You are as real to me as love, which everybody knows exists, but none can package to sell or prove. We are both afraid. For you. For me. For us.

For you, because you may not live long, you may suffer, you may hurt. If you live, you will likely lose your mother, and surely you will hurt anyway. But all humans hurt sometimes. So do not wish for a pain-free life, or you will always be disappointed and may one day become bitter. Instead, pray for the courage to face it, to improve it, to accept it.

Fear for me, because I may not survive to see you grow. I may suffer too, not so much because of physical pain, but the emotional pain of not always having the strength to be the kind of mom I want you to have.

I am learning, evolving, from the complex to the simple, the fast to the slow, the intellectual to the spiritual, the rational to the intuitive, the fearful to the accepting, which includes accepting that thanks to HIV, the fear—no, the terror—will always be there.

There was a time when I could not see anything but fear. Yet, over time, I learned to see through it, with it, because of it, and at rare times, to forget it.

My fear for you is the most painful of all. It is not visual in any way. It is physical. While hope lives in my heart, fear lurks in my belly. You are conceived in my heart, and if only you could spend nine months growing there, I would not care what amount of pain it would bring me. But if I want to

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Two Decades of HIV/AIDS Policy

Chris Collins

Twenty years ago, there was little room in American politics for a drug policy focused on harm reduction and treatment. Opposition to gay and lesbian rights was rampant. Enormous disparities in health status and access to health care existed between races. Tens of millions of Americans had no health insurance.

When a seemingly new and particularly deadly virus was thrown into that mix, it changed many things, but not those intractable social realities. Two decades on, America's reluctance to confront the politics of drugs, sex, race, and health equality continues to exacerbate the tremendous human and social cost of AIDS.

The first 20 years of HIV/AIDS policy making are replete with victories. New systems of care and prevention were developed and funded, and the worst threats to civil liberties were defeated. The work of activists revolutionized health policy, and the expertise of people living with HIV changed the way health care is delivered. Finally, after years of national neglect, federal funding successes were impressive and sustained.

All of this progress demonstrates that some things are more amenable to change than others. Some fundamental policy changes were harder to accomplish. As **Steve Morin**, now Director of the ARI's AIDS Policy Research Center, said after ten years of work on Capitol Hill, "Congress is unwilling to deal with sex and drugs, which are at the core of the epidemic. If you can't deal with those things, it's hard to deal with HIV."

In every area of AIDS policy, there were hard fought victories and a laundry list of work unfinished. A fleeting look back over the last two decades bears this out.

Access to Treatment and Services

In the provision of health care to uninsured people with HIV, major advances included 1987 Congressional approval of \$30 million for purchase of the newly approved drug, AZT. By 1989, following ACT UP protests, the FDA had shortened the drug approval process and Burroughs Wellcome announced a 20% price cut in AZT. In 1990, Congress passed the CARE Act, providing direct funding to heavily impacted cities and states and offering support for community-based services in addition to traditional health care.

Federal appropriations for CARE increased steadily over the following decade. Yet, even with these impressive accomplishments, half to two-thirds of people living with HIV/AIDS in America today are not receiving regular health care. Medicaid, upon which many with HIV rely, remains unavailable to most low-income people early in the course of HIV disease.

It is clear from CDC surveillance reports as far back as 1982 that people of color have borne a disproportionate burden in the epidemic. In 1998, **Representatives Louis Stokes** and **Maxine Waters** and other members of the Congressional Black Caucus created the Minority AIDS Initiative to provide targeted funds for research, prevention, and care for communities of color. And yet, African Americans continue to suffer wide disparities in the number of new infections and in access to care.

Prevention

There were many accomplishments in HIV prevention policy as well. Federally funded research established that prevention interventions can work, even for the most at-risk and disenfranchised populations. Funding for prevention at the Centers for Disease Control and Prevention (CDC) saw many significant increases. In 1994, the CDC implemented Community Planning, a new, community-based approach to prevention programming.

Unfortunately, in prevention there were as many frustrations as advancements. An increasing share of new HIV infections is due to drug use, yet many leading politicians continue to use drug policy as a political football and pay little regard to the facts. Drug treatment is a proven effective HIV prevention measure, but funding for treatment continually lags far behind federal spending on drug-related incarceration, interdiction, and other law enforcement strategies. Starting in 1991, publicly funded studies have consistently found that needle exchange programs prevent HIV infection, but the government continues to impose a ban on federal funding for needle exchange.

In 1987, **Senator Jesse Helms** succeeded in placing restrictions on federal HIV prevention monies, prohibiting any form of education that "promotes homosexuality." Initial ad campaigns from the CDC avoided explicit references to the main routes of infection (i.e., sex and drugs). Later CDC education campaigns improved markedly, but publicly funded outreach to youth continues to neglect the prevention needs of young gay men and others. For all the funding going into HIV prevention, year after year the HIV infection rate has remained steady at 40,000.

Vaccine Research

In 1997, **President Clinton** borrowed a page from a John Kennedy

speech and challenged the scientific community to develop an AIDS vaccine within a decade. One year later, the AIDSVAX Phase III vaccine trial began in the U.S., followed by a trial in Thailand. But twenty years into the epidemic, AIDSVAX remains the only AIDS vaccine to reach a large-scale efficacy trial.

International

In the late 1990s, the enormity of the epidemic in developing countries grabbed the attention of the public in countries of the industrial North. Funding for international AIDS gradually increased, and today there are hopeful discussions about the creation of a global purchase fund for AIDS medications. South Africa and Brazil set examples for developing countries by battling the pharmaceutical industry over the right to buy and make generic drugs. But signs from the Bush Administration are that the U.S. contribution to such a global fund will fall far short of the \$10 billion annual need identified by UNAIDS.

The next decade

An accessible cure and a vaccine remain our ultimate dreams. Many of the issues for the coming years, however, are stubbornly familiar, like making treatment accessible in our own country. "Several states have waiting lists for life-prolonging drugs through the ADAP program," said **Representative Nancy Pelosi**. "We need to continue to fight for increased funding for the Ryan White CARE Act, including ADAP." As a member of the House Appropriations Committee, Pelosi has for years been a leader in the fight for increased funding for global AIDS efforts. Pelosi has also introduced legislation to provide incentives for private sector research on vaccines and microbicides for HIV/AIDS, malaria, and TB, and will soon introduce a bill to expand Medicaid access for people with HIV.

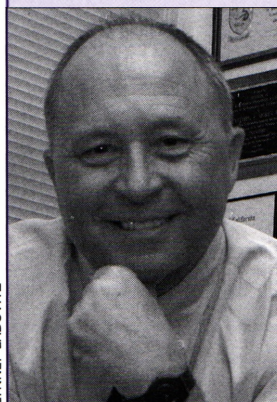
Local elected officials continue to be among the leaders on the U.S. response to the global epidemic. Last year, **Representative Barbara Lee** worked to establish an international trust fund to provide grants for HIV services. This year, she introduced two bills to expand AIDS treatment access in developing countries. As Lee sees it, "The global HIV/AIDS pandemic is the most important humanitarian crisis of our time."

Senator Dianne Feinstein has authored a bill to provide funding to fight AIDS in developing countries, and to explicitly allow countries with an AIDS crisis to use provisions in international trade agreements to expand access to patented AIDS medications. "We must remember that AIDS is not just an American problem or an African problem, but a global problem that threatens the lives and well-being of so many people," said Feinstein.

Two decades of AIDS have shown the power of advocacy to move politicians and define the issues. Advocacy victories are all the more impressive because they battled uphill against political and social forces seeking to avoid the fundamental issues of drugs, poverty, sexuality, race, and health care access that have shaped the AIDS epidemic in America. After 20 years, those social fundamentals remain critical to understanding and working to end the epidemic.

At the Epicenter: AIDS Policy Research Center Director Steve Morin

For over a decade, **Steve Morin** was at the epicenter of Congressional action on AIDS policy. Today, Steve serves as Director of the ARI's AIDS



LYNNLY LABOVITZ

Dr. Steve Morin

Policy Research Center. In the early 1980s, Steve was involved in the first policy responses to the emerging epidemic. Twenty years ago, Morin was a psychologist working in San Francisco's Castro District and an advisor to the California legislature on mental health reform. He helped the state legislature develop

AIDS policy, and was part of a team that wrote the first UCSF grant to fund AIDS behavioral research.

In 1987, Steve went to Washington as a Special Assistant to newly elected **Congresswoman Nancy Pelosi**. By the time Pelosi arrived, the U.S. government had begun to provide dedicated funding to AIDS, but resources were limited and several lawmakers were pushing for restrictive AIDS policies including mandatory testing and prohibitions on targeted messages to gays.

Steve played a pivotal role as major AIDS programs were first being designed and debated in Congress. In 1988, he helped Pelosi pass two amendments to establish demonstration projects for AIDS-related counseling and mental health services and model protocols for clinical care of people with HIV. Morin was involved in drafting the hallmark *COBRA* amendments of 1989, allowing people with disabilities to maintain their health insurance for 29 months after they leave work; the *AIDS Opportunity Housing Act*, folded into a larger housing bill to become the Housing Opportunities for People with AIDS program; and the *AIDS Health Care Financing Act*

of 1988, to fund demonstration programs in cities hard-hit by AIDS, a concept central to Emergency Assistance to Cities in the *Ryan White CARE Act* (1990).

In 1992, Pelosi became a member of the coveted Appropriations Committee and made it her top priority to raise federal spending on AIDS research, care, and prevention. Steve was involved in negotiating significant increases in the AIDS accounts over the next several years.

Steve also worked with Pelosi on groundbreaking HIV prevention and care legislation. *The Comprehensive HIV Prevention Act of 1993* sought to establish a "community planning process" for delivery of HIV prevention programming through the Centers for Disease Control and Prevention; the Clinton Administration implemented major provisions of the legislation through executive action in 1994. In 1997, Steve wrote Pelosi's *HIV Treatment Improvement Act*, seeking to expand the federal Medicaid program to cover people early in the course of HIV infection and to set a minimum drug formulary for state AIDS Drug Assistance Programs. These goals continue to be important to advocacy efforts to expand access to HIV/AIDS care.

In 1997, as Steve decided to come home to San Francisco to set up the ARI's AIDS Policy Research Center, **Representative David Obey**, lead Democrat on the House Appropriations Committee, paid tribute to Steve: "We will miss his expertise on many health and labor programs, most notably, his great work on the issues relating to AIDS, and trying to minimize the terrible damage that that disease causes, and giving researchers the resources they need to search for a cure."

Steve's former boss, Representative Nancy Pelosi, noted the legacy of AIDS research at his new place of employment: "UCSF has always been a leader in AIDS research, and it continues to make very important contributions in AIDS treatment, prevention, and policy. I am confident that, in the years to come, UCSF will remain at the forefront in the fight against AIDS."

Current Projects of the AIDS Policy Research Center

- **Access to Publicly Supported Pharmaceuticals by Racial/Ethnic Minorities:** Assesses the social and policy facilitators and barriers that racial and ethnic minorities confront in accessing HIV pharmaceuticals. The goal of the study is to better understand these barriers in order to identify solutions to overcoming the racial/ethnic disparities in HIV care.
- **Perception of HIV Counseling and Testing by Racial/Ethnic Minorities:** Assesses differential utilization of HIV counseling and testing services among racial/ethnic minorities. The goals are to determine community perceptions toward HIV testing and produce recommendations on promoting HIV testing in racial/ethnic communities.
- **The Ryan White Prevention Project:** Assesses prevention practices for HIV-infected patients in a sample of clinics funded under the *Ryan White CARE Act*. The findings are intended to help the Health Resources and Services Administration respond to recent recommendations of the Institute of Medicine to provide more prevention services for HIV-infected individuals in primary care settings.
- **Expanding Access to HIV Care in California:** Studies six California-specific policy options for expanding access to HIV care. The goal is to improve the uniformity and quality of data used by advocates and policy makers for policy development and evaluation of legislative options.
- **The Policy of AIDS Vaccines:** Reviews the various legislative options for expanding research and development of AIDS vaccines and securing their delivery around the world. The goal of this project is to determine the policy barriers to and facilitators of development and deployment of an effective vaccine in order to create more effective guidelines for vaccine policy.
- **Enhancing Community Participation in the HIV Prevention Trials Network:** Assists the HIV Prevention Trials Network (HPTN) in fostering partnerships between researchers and local study communities. This project will evaluate community involvement in the HPTN domestic sites of Los Angeles, Birmingham, and Philadelphia, and the international sites of Peru, Zimbabwe, and Thailand.
- **AIDS Profile Project:** Provides information to 20 of USAID's Rapid Scale-Up/Intensive Focus countries by creating timely, online HIV/AIDS country profiles on HIVInSite (<http://hivinsite.ucsf.edu>). This project will develop and disseminate accessible, multidisciplinary scientific research on HIV/AIDS to strengthen in-country ability to plan and implement effective interventions.

The Kaiser Family Foundation has published

The AIDS Epidemic at 20 Years: The View from America Survey Report and the *Selected Milestones Timeline*. These documents mark the most significant scientific, policy, cultural, and community milestones of the past 20 years. To view, please visit:

www.kff.org/docs/AIDSat20

We Have Made a Difference

Michael Lauro, Survive AIDS Activist

I can remember getting tested for HIV when the test first became available in the mid-1980s. Adding together what we still see today, with the controversy regarding mandatory HIV name reporting proposals, with a healthy dose of paranoia back then, it's easy to understand why my doctor sent me across the street to the local P.O. Plus office to get an anonymous money order to pay for the test.

The LaRouche Initiative, a statewide ballot proposal that many believed was the warm-up act for mandatory quarantining of anyone testing HIV-positive, was on people's minds. Some had gone so far as to begin forming secret cells in the event the initiative passed and they needed to go underground and disappear quickly. Many folks, like myself, believed the proposal would pass handily, so this community paranoia was widespread and seemed entirely reasonable at the time.

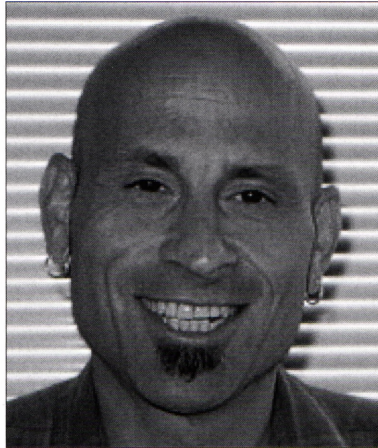
Even my doctor wasn't immune to the tenor of the times, electing to encrypt all of his patients' medical files, rendering them useless to even his patients when he died of AIDS in the late '80s and took the codes to the grave with him.

I remember him looking up from my file and giving me the news: "Well, it's positive," he said. And although people seemed to be dying all around me—you couldn't sell a house in the Castro—the only advice he could offer was to avoid stress, caffeine, and nicotine. Then he added, "You're OK with this, aren't you?"

So ended my post-results counseling session. I walked out of his office into a beautiful Castro Street day totally devastated and forever changed. These were the times I was born into as a person with AIDS, which perhaps helps to explain why I've spent 15 of the last 20 years of the epidemic involved with some form of activism and making the epidemic my life's work.

I'm hoping that post-results counseling is more effective today than it was for me years ago. One thing that is more effective today than it was back then is the variety of treatments that North American and European people with AIDS can access.

I was lucky enough to survive until the AIDS medications I needed to continue living were finally available. Most of my friends were not so fortunate. I know that the medications I'm surviving on today will not work forever. Moreover, important issues like global



"There just doesn't seem to be any real alternative to my work as an AIDS activist that would add as much value and be as meaningful for whatever time I have left."

Michael Lauro

to be any real alternative to my work as an AIDS activist that would add as much value and be as meaningful for whatever time I have left.

I suppose I retain more than a bit of that morbid perspective most of us shared throughout the '80s and early '90s that helps fuel my continued resolve; but that's only part of it, and probably the smallest part. As AIDS activists, we have accomplished many great things and, more than once, have done some things which mattered very little. But we have made a difference. And, every so often, we get it right. Of that I am sure.

Michael Lauro is a member of Survive AIDS and co-organizer of the annual AIDS Candlelight March in San Francisco, a part of the local observance of the International AIDS Candlelight Memorial, the largest grassroots AIDS event in the world.

access to these medications, especially for those facing the daily devastation of AIDS in Africa, continue to be defining moral issues of our time.

After volunteering at several AIDS organizations immediately after getting my test results, I joined ACT UP New Haven in 1989 in what the well-known activist **Maxine Wolfe** calls the "beginning of the second wave of AIDS activism." In 1991, I returned to San Francisco to be a part of that great wave of activism, a decision I have never regretted.

Throughout the years, I have joined with other great activists to work on virtually any issue affecting the lives of people with AIDS/HIV. Today, there just doesn't seem

The Deafening Silence of AIDS

*Justice Edwin Cameron,
High Court of South Africa, Johannesburg*

Jonathan Mann's earliest experience with the epidemic was not amongst the gay white men of North America where the virus was first detected. It was in Africa, where from March 1984 to June 1986 he was director of the Zaire AIDS Research Programme. It was here that Mann first confronted the social complexities and the dire implications of the disease.

In the fourteen years since Mann left Zaire for Geneva in 1986, the epidemic has manifested momentous changes. The two most considerable are these: demographics of its spread; and the medical-scientific resources available to counter it.

Amidst the welter of disheartening data, two facts, well-recited though they are, obtrude with overwhelming force: nine-tenths of all people living with HIV/AIDS are in poor countries; and two-thirds of the total are in sub-Saharan Africa.

But the demography of HIV has been overlain by a shift even more momentous. It is the fact that over the last half-decade, various aggregations of drug types, some old and some new, have been shown, when taken in combination, to quell the replication of the virus within the body. The result has been exciting, life-altering, and near-revolutionary.

In most of Europe, in North America, and in Australia, illness and death from AIDS have dropped dramatically. In these regions, hundreds of thousands of people who a few years ago faced imminent and painful death have been restored to living.

But this near-miracle has not touched the lives of most of those who most desperately need it. For Africans and others in resource-poor countries with AIDS and HIV, these drugs are out of reach. For them, the implications of the epidemic remain as fearsome as ever. In their lives, the prospect of debility and death, and the effects of discrimination and societal prejudice, loom as huge as they did for the gay men of North America and Western Europe a decade and a half ago.

From every side, those millions living with AIDS in resource-poor countries have been disappointed. International agencies, national governments, and especially those who have primary power to remedy the iniquity—the international drug companies—have failed us in the quest for accessible treatment.



Justice Edwin Cameron

Moral dilemmas are all too easy to analyze in retrospect. It is often a source of puzzled reflection how ordinary Germans could have tolerated the moral iniquity that was Nazism; or how white South Africans could have countenanced the evils that apartheid inflicted, to their benefit, on the majority of their fellows.

Yet, the position of persons living with AIDS or HIV in Africa and other resource-poor countries poses a comparable moral dilemma for the developed world today. The inequities of drug access, pricing, and distribution mirror the inequities of a world trade system that weighs the poor with debt while privileging the wealthy with inexpensive raw materials and labor.

Those of us who live affluent lives, well-attended by medical care and treatment, should not ask how Germans or white South Africans could tolerate living in proximity to moral evil. We do so ourselves today, in proximity to the impending illness and death of many millions of people with AIDS. This will happen, unless we change the present. It will happen because available treatments are denied to those who need them for the sake of aggregating corporate wealth for shareholders who by African standards are already unimaginably affluent.

That cannot be right, and it cannot be allowed to happen. No more than Germans in the Nazi era, nor more than white South Africans during apartheid, can we at this conference say that we bear no responsibility for more than 30 million people in resource-poor countries who face death from AIDS unless medical care and treatment is made accessible and available to them.

The world has become a single sphere, in which communication, finance, trade, and travel occur within a single entity. How we live our lives affects how others live theirs. We cannot wall off the plight of those whose lives are proximate to our own.

That is Mann's legacy to the world of AIDS policy; and it is the challenge of his memory to this conference today.

This piece is excerpted from the first Jonathan Mann Memorial Lecture, which Justice Cameron delivered at the XIII International AIDS Conference in Durban, South Africa, July 10, 2000. Cameron will be a featured speaker at the UCSF Community Forum on June 20, 2001. See page 20 for details.

Twenty Years Living with HIV

René Valdés

René was born in Havana, Cuba, and came to the United States in 1980 with the Mariel boatlift. He believes he contracted HIV within a few weeks of his arrival in this country. He now lives in San Diego, where he works as a software developer.

July 1981: I see a small article in the paper about a bizarre illness affecting gay people in San Francisco and New York. Their immune systems are damaged, and they are not able to fight some exotic infections. They lose weight and become frail. Some are dying. My partner Bruce turns to me and says, "This is what I have."

August 1984: Bruce dies of a malignant lymphoma in his brain after having founded the Minnesota AIDS Project and having become an activist for the rights and care of people living with AIDS.

August 1985: As expected, I test positive for HIV. I am told it is believed that only 10% of the people infected with the virus will ever become ill.

June 1986: I move to San Francisco to fight the INS to gain resident status, having been told that I would be deported because people "afflicted by sexual deviation" are not eligible to become U.S. residents. Before moving, I destroy the bulk of my medical records, which mention homosexuality and HIV and could negatively affect my INS process.

January 1987: I complete my BA in Computer Science. I am told that "something" is eating my liver when unexplained elevated liver enzymes are found.

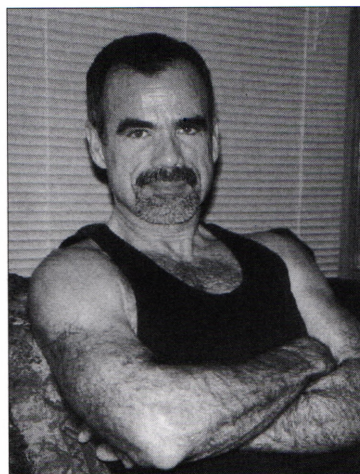
April 1988: My first CD4 count is 489. I discuss with my doctor the possibility of medicating. Later that year, I buy my first home and move in with my partner, David.

February 1989: Following a court hearing in which the INS opposes my citizenship, I am sworn in as a U.S. citizen. My CD4 count is down to 65. I start taking AZT and pentamidine.

December 1990: I sell my house and move with David to Fort Lauderdale to be closer to my mother, who I plan to bring for yearly visits from Cuba.

Fall 1991: My mother is diagnosed with terminal colon cancer. Cuba does not open up despite the fall of the Soviet Union. I am depressed. David and I decide to return to Minneapolis.

January 1992: My new doctor tells me that I will most likely not see the end of the year, given my CD4 count of seven.



René Valdés

July 1992: My mother dies in Havana. I am only allowed to enter the country three weeks later. Upon return, I continue to work full time, while taking AZT, 3TC, Bactrim, Diflucan, and Biaxin. A strange growth in my mouth becomes more and more of a concern.

May 1993: I undergo laser surgery to eliminate my mouth lesions, now identified as caused by HPV [Human papillomavirus], possibly due to a weakened immune system. That fall, my

15-year-old twin sons arrive from Havana to live with David and me. My mouth lesions are back and start spreading faster and growing bigger. I lose the ability to whistle.

Fall 1994: I suffer from depression and fatigue. A tense family situation between David and my sons and serious difficulties at work develop. My doctor writes a letter stating that I have about six months to live, which is used to obtain a humanitarian visa for my sons' mother. My CD4 counts linger between one and two digits.

Early 1995: David breaks up with me and leaves. My sons' mother convinces them to live with her in Florida. I drive my boys to Miami to move in with their mother. I sell my townhouse, which I cannot afford without David. Mouth lesions continue to grow and do not respond to any treatment.

Early 1996: I return from my first visit to my sons in Florida sick with persistent flu, fatigue, and nausea. I start taking Norvir and suffer severe side effects, an unbearable metallic taste in my mouth. I go on disability, mostly for depression, aggravated by drug side effects and a growing concern about my uncontrollable mouth lesions. To put some structure in my life, I join the Aliveness Project and volunteer at the Minnesota AIDS Project. I start on antidepressants and psychotherapy again. I believe I have only six months to live.

Fall 1996: Having stopped taking Norvir because of side effects, I get on a protocol for Viracept. My CD4 counts climb rapidly and my viral load becomes undetectable. I travel to Washington, D.C., to see the panel I had made for Bruce at the AIDS Quilt display.

(continued on page 14)

(continued from page 13)

On my last day there, I meet Hal, who does research to find some treatment for my HPV lesions.

January 1997: Hal puts me in contact with Dr. Snoeck in Belgium, who sends me Cidofovir in Orabase to apply topically to my lesions. Viracept stops working; I switch to Crixivan. By summer, the mouth lesions are practically gone. Difficult to tell whether this is the result of the treatment or the improvement in my immune system. I stop taking medication against opportunistic infections.

September 1997: I start taking classes at the University of Minnesota towards an MA in Hispanic Linguistics. Soon after, I start teaching Spanish. I visit my friends in Germany, Norway, and Italy. I feel good.

1999: I switch to Fortovase to avoid stomach problems caused by Crixivan. I graduate in November with an MA in Hispanic Linguistics.

September 2000: With my CD4 count over 500 and my viral load still undetectable, I accept a position as a software linguist in San Diego. Soon after arriving, I attend a presentation about HIV and Hepatitis C co-infection, and join a support group for co-infected people.

Spring 2001: I visit a hepatologist, who prescribes a liver biopsy and takes for granted that I will be treated with Interferon and Ribavirin. I am apprehensive of the possible side effects because I want to remain productive in my new job. I decide to join a treatment study.

One of my best friends calls from Minneapolis and tells me that he recently became infected with HIV through unprotected sex.

I travel to Miami to visit my sons, and am now planning a trip to Spain in September with the new man in my life, Alan.

Bangsberg

(continued from page 5)

It is here, studying the people of San Francisco's Tenderloin district, that Bangsberg finds inspiration. It is also where certain scientific surprises have abounded for him. Leading, with co-director **Andrew Moss, PhD**, a study known as REACH (Research on Access to Care in the Homeless), he has found that "a good third take the antiretroviral medications as well as anyone would hope." And, though many in the public health arena have extrapolated lessons about drug resistance from earlier experiences with tuberculosis, Bangsberg's preliminary work suggests that people with poor adherence are least likely develop drug resistance.



Dr. David Bangsberg

"We still think the more medications patients take, the better they do. It's just that neither adherence nor clinical benefit are 'all or none' phenomena," says Bangsberg. "It is better to provide the medications, even if people can't take 100 percent, than never to receive the medications at all."

Another surprise? Those who are only 50 to 90 percent compliant still obtain clinical benefit from antiretroviral therapy.

Though these findings certainly have implications for the indigent of this country, Bangsberg points to even broader ramifications. He is concerned that strongly held preconceptions about drug resistance may be used as justification for withholding therapy from developing countries.

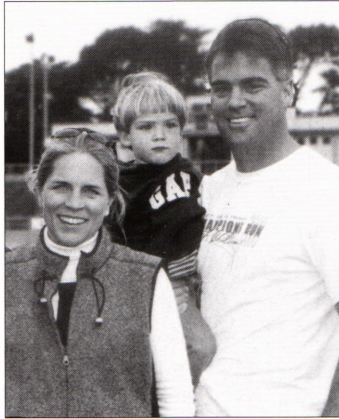
Despite his global perspective, Bangsberg sees himself as a county hospital doctor for the rest of his life. "It's where the humor is the richest, the population the most diverse, and where I have the most fun," says Bangsberg. "I'm just waiting for the next surprise. There certainly hasn't been any shortage of them."

Walter A. Gray (center) is honored by ARI Director Dr. Thomas Coates (at left) for his recent planned gift to the AIDS Research Institute. They are joined by Mr. Gray's friend and ARI supporter Bob Hill.



Profiles in Leadership

Recently, we talked with **Peter** and **Polly St. Geme**, the founders of San Francisco's *Champions Run for Children*, which benefits the pediatric AIDS research programs at UCSF. Polly is the devoted mother of two small children and an active member of the Breakthrough Fund's Leadership Council. Peter leads the investment management company which bears his name. They live in San Francisco and both are avid runners.



Polly, Peter Jr., and Peter St. Geme

ARI: *Let's start with your commercial: When is the 2001 Champions Run?*

Polly: The third annual *Champions Run for Children* will be held Sunday, September 16, at Kezar Stadium. We have a website, www.rhodyco.com, where people can get all the details and an entry form.

Peter: Last year, more than 2,000 runners participated in the one-mile race. We're hoping to have even more this year.

ARI: *How did you become interested in pediatric AIDS?*

Polly: Through a personal connection with **Diane Wara** at UCSF. She's a long-time family friend. She actually worked with Peter's father, who was Chairman of Pediatrics at UCLA for 19 years. We think she does such incredible work with children. And the *Champions Run* is a great way to raise money, but also to bring a lot of awareness to the issue of pediatric AIDS. Peter and I both enjoy running, so we put our two interests together to create this race to benefit UCSF.

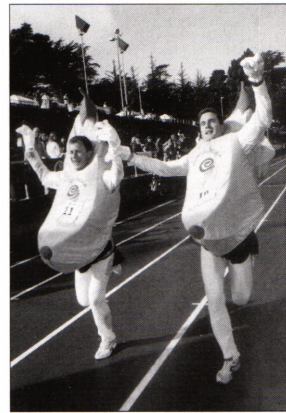
Peter: My interest is three-dimensional. First, the race we support highlights the health and spirit of the world's greatest asset, children. Second, profound ideas germinate in laboratories. This happens at UCSF. AIDS is a huge hurdle to cross, but I believe it can be done. And the third thing we hope to do is to encourage private investment in research projects. Private investment allows scientists to do their work unencumbered, without all the red tape that comes with many funding sources.

ARI: *Wait a minute, Polly! You ran in last year's Champion's Run? Weren't you pregnant then?*

Polly: Yes, I was seven months pregnant last September. So I walked...and ran...last year. We'll see if I can run this year.

ARI: *Do you still hold the national high school mile record of 4:35?*

Polly: So far, I do!



Banana Men Robert Flatland (L) and Paul Catherwood cross the finish line in the Jamba Juice 5K Banana Man Chase at last year's Champions Run for Children



Margaret Hearst hosted a working dinner in her home to help build support for UCSF's new international AIDS programs focused on reproductive health and gender equity issues. Shown above (L-R), Nancy Padian, PhD, Director of International Programs at ARI; ARI Director Thomas Coates, PhD; Congresswoman Barbara Lee; and Margaret Hearst.



Congresswoman Barbara Lee, who represents the East Bay, spoke eloquently about the need for increased federal funding for AIDS care in Africa. Lee was the only member of Congress to attend the 2000 International AIDS Conference in Durban, South Africa.

Development

The Third Decade: Stemming the Tide of the Global Epidemic

Annie Stuart

Few would claim that HIV prevention efforts alone can stem the tide of the AIDS pandemic. Yet, prevention must be combined with antiretroviral therapy and further treatment and vaccine research to keep mind-numbing AIDS statistics from continued skyrocketing. To this end, the Center for AIDS Prevention Studies (CAPS) International Training Program at the UCSF AIDS Research Institute has been providing training for scientists from developing countries in AIDS prevention research for the past 13 years.

Several CAPS International scholars have recently spent several weeks here on writing sabbaticals, working closely with UCSF faculty to analyze data from their AIDS prevention research and to gain experience preparing their studies for submission to peer-reviewed journals.

From Nigeria to Viet Nam—studying fishermen to female apprentice tailors—these scholars are scrutinizing the scientific and behavioral idiosyncrasies of this disease in the hope they can have some impact on its course within their countries, if even on a microcosmic level.

Six of the visiting scholars, from Brazil, Zimbabwe, Thailand, and China, provided a glimpse into the unique challenges their countries face in the battle against HIV and spoke about their specific research projects.

Brazil

Brazil, which three visiting scholars call home, has some successes to its name. A program that provides AIDS drugs free of charge and a decision to manufacture its own AIDS drugs have been mainstays in stabilizing AIDS-related mortality in this country.

“Brazil has a very good AIDS program, good public assistance for HIV positive people, and a network of drug distribution,” says **Katia Alves**, a Fogarty Program Research Fellow who has been studying the risk factors of people anonymously tested at a site in the port city of Santos. But, she says, prevention is more sporadic, happening irregularly at events like Carnival. “We had a recession two years ago, and the government cut almost all money spent for prevention, not only HIV prevention.”

Alves is particularly concerned about the increasing incidence of HIV among women in Brazil. In 1995, the ratio of infection between



ALL PHOTOS BY LYNNLY LABOVITZ

CAPS International Training Program participants (L-R) Edgar Hamann, Camila Peres, Katia Alves, Program Coordinator Ritu Sehgal, Qu Shuquan, Aumphornpun Buavirat, and Priscilla Mataure

men and women was 25 to 1. Now it is 2 to 1, and in some cities, 1 to 1. Preliminary results from Alves's pilot study in Santos show that women were eight times more likely to have recently acquired HIV than were men. Past prevention campaigns attempted to improve women's negotiation skills with men, but they didn't work well.

Women continue to become infected by men who refuse to wear condoms but who have multiple partners. “Now they're changing the focus of the prevention campaign so it's targeting the men, saying ‘Please don't bring this to your home,’” says Alves.

Edgar Hamann, also visiting from Brazil, agrees that prevention measures—in particular, the availability of condoms—continue to be critical in a country that attempts universal treatment but can't really reach everyone. Hamann says that HIV infection in the large cities actually declined since the onset of the epidemic. “People got scared because a lot of people died,” he says. “People organized, pushed, rallied for availability of preventive measures, drugs, and information.” But the same has not been true for the smaller cities and the Amazon basin, he says.



Edgar Hamann

Hamann, a professor of epidemiology and health education at the University of Brasilia, is studying AIDS prevention among adolescents in school settings. For two years, he has been comparing the effectiveness of a basic educational approach such as a lecture (“all that most of the schools want”) with approaches such as role playing or interactive dynamics—“something closer to reality.” Looking at data concerning frequency of drug use, sexual initiation, and number of partners, he is now evaluating the changes in attitude and condom use that follow each of these educational interventions.

The work of **Camila Peres** centers around ways to reach incarcerated youth in São Paulo who are so focused on a criminal life (and death) that their survival instincts don't entertain much of a concern about AIDS. "They think they may not live long enough to even be affected by AIDS, so they're not concerned with it," says Peres, a psychologist with the Public Health Department of the State of São Paulo. If the prospect of death from AIDS isn't a motivator, where do you begin? "They wanted to talk about sex, violence, drug use, and race," says Peres. "We started by integrating AIDS into these discussions." Then they contracted with 30 musicians, actors, and break dancers to come into the prisons and educate through entertainment.

Peres, who is the coordinator, supervisor, and trainer of the community participants, says the intervention has been successful. "This project is now being considered a model for education in other places," she says. "We now get money from the federal government to support these efforts."



Camila Peres

Thailand

By contrast, getting funding for either AIDS treatment or prevention in Thailand is very difficult, says **Aumphornpun Buavirat, MPH**, who is studying HIV-related risk behaviors among incarcerated drug users in Bangkok. Although HIV infection rates have fallen among blood donors, male military conscripts, and pregnant women, they have increased substantially among intravenous drug users over the past decade.

A psychologist with the Bangkok Metropolitan Administration Department of Health who has worked with drug addicts for nearly 20 years, Buavirat organized a retrospective study to examine the risk behavior of addicts released from prison. In 17 methadone clinics scattered across Bangkok, about 350 addicts have been questioned about their current behavior and that before, during, and after their stay in prison. One interesting finding: The riskiest behavior commonly occurred in the police station, right before addicts enter prison. "During this time, they began to experience severe withdrawal symptoms," she says, so they desperately shared needles in an attempt to feel better.

In this study, tattooing was also found to be a big HIV risk factor in prison. Buavirat believes this knowledge could help with the development of better prevention interventions.



Qu Shuquan

As in Thailand, drug use is a major contributor to HIV transmission. In Guangxi autonomous region, the area of his study, the infection rate among drug users is as high as 60 to 80 percent.

A general concern was that this group was infecting sex workers, thereby introducing the infection to the general population. What Qu found was surprising. "None of the sex workers tested was HIV positive," he says. It turned out that there were very few drug users among them, "so the virus had not been introduced to sex workers extensively, but some risk factors which can drive the epidemic in this population were found." Qu concludes that "now is the time to do the intervention," and hopes that his data "may be useful in guiding interventions in other places."



Priscilla Mataure

People's Republic of China

Even while Premier Zhu Rongji was cutting China's Ministry of Health staff by half a couple of years ago, he was creating a National Center for AIDS Prevention and Control. It is this organization through which **Qu Shuquan, MD, MS**, works as Deputy Director at the Department of Epidemiology. Qu says that, though the reported numbers of HIV infection stand at only about 22,500, more realistic estimates are closer to 600,000.

Zimbabwe

In the city of Harare, where cases of tuberculosis have more than quadrupled due to HIV and overcrowding, **Priscilla Mataure, BSc**, is studying the relationship between alcohol use and high-risk sexual behavior among adolescents and young adults. A form of "recreation" starting from the colonial era, alcohol use has become prevalent among young people, especially since it is available throughout the day. "Some of the 'bottle stores' [alcohol outlets] open early in the day," she says.

Working for the Southern Africa AIDS Information and Dissemination Service, Mataure has had more than 300 young people, ages 15–21, interviewed at both the bottle stores and nightclubs. Although it's too early to evaluate the results of this study, other studies have shown a clear correlation between alcohol use and increased risk. Mataure's intent is to design prevention interventions with separate messages to men and women, incorporating a new prevention approach that will capture the attention of this young group of people before many more become infected.

On Being Shameless

Peter Teague

The world is now learning what the researchers at the Center for AIDS Prevention Studies have understood for some time: Men who know everything they need to know about HIV prevention are getting infected, and in larger numbers.

It can't surprise anyone to learn that human beings do not always act in ways that are predictable, or in ways that are obviously rational. As we move into this new reality, numbers and data are useful only to a point. We are treading into the territory of sex and emotion, mystery and meaning.

This is important territory to explore, especially now, as we mark the 20th anniversary of the first AIDS cases to be diagnosed as such. This virus has an accomplice—shame—that is not easily quantified, measured, or evaluated. Shame, according to the American Heritage Dictionary, is a painful emotion caused by a strong sense of guilt, embarrassment, unworthiness, or disgrace.

It is something our culture heaps on any number of groups, not because of anything they've done, but because of who they are: women, Africans, poor people, Jews, Arabs, lesbians, gay men, and transgendered people. Those of us who are shamed are taught that we are fundamentally flawed, that there is something wrong with us at a constituent level. Shame is a weapon so powerful that it becomes unnecessary to go on using it—its victim continues to inflict it on himself long after the initial act of shaming is complete.

We also know that shame belongs to a moment in time. Within the last two or three generations, Jewish, Polish, and Chinese Americans have been born who have not experienced the deep shaming that the dominant culture inflicted on their parents and grandparents. Consider the case of the Irish: Just two hundred years ago (a brief moment in human history), the English rulers of Ireland considered the Catholic communion mass so shameful they outlawed it.

How does this help us understand what is happening here in San Francisco? The data tell us that the local epidemic remains largely focused on gay men and men who have sex with men. And we know that we are having more unsafe sex and that the rates of HIV infection are rising. Like Irish peasants gathered for an illegal mass, I believe that gay men are finding fleeting ways to block the shame imposed by the culture. For brief moments, crystal, or Ex, or G, or barebacking—or some combination—are more potent than shame.



Peter Teague

We may find, in our own death-defying acts of communion, something that makes the risk irrelevant. At those times, we don't feel like foolish gamblers, like suicides or homicides. We may feel more like those Irish Catholics of two hundred years ago. We may feel brave, like heroes, or simply like people who find safety only in each others arms, and for the moment, that may be all that matters. The threat of death, whether at the end of an English rope or on an AIDS ward,

may well feel irrelevant to someone who has found a place where no one tells you that you're wrong, or bad, or dirty.

But we can learn something important from the history of the Irish. The power felt in that moment of communion did not make the Irish powerful. They went on being the victims of their landlords, understanding themselves as weak and inferior, even through an epidemic of starvation that killed two million.

The Irish remained weak, and in their own eyes and the eyes of the world, inferior, until two things gradually happened: The culture changed and forgot why fellow Europeans should be thought of as savages, and the Irish became shameless.

Shame just doesn't stick when it is inconsistent with our fundamental understanding of ourselves.

And that is the problem with some of the acts of communion we share. Drugs and high-risk sex, though they may make us feel momentarily connected, do not make us genuinely shameless, because they do not change our core beliefs about ourselves. We will, like the Irish, become truly shameless as the culture changes and as we change the way we see ourselves. For gay men, shamelessness—the wholesale abandonment of shame about who we are and who we love and how we love—should be the goal.

As has happened for people who are Irish, or Jewish, or Polish, or Chinese, fundamental shifts can occur in the ways we see ourselves and in the ways the culture sees us. I believe we have an opportunity to be brazen, barefaced, and bold about who we *really* are. In a word, to be shameless, not briefly, but permanently. Of course we have to go to the source of our shame and demand and educate and advocate for cultural and political change. But we must also

take responsibility for the shame that infects us and our communities, for the ways in which we victimize each other and ourselves.

When we act out of disgrace and victimhood, we can treat each other as objects, making it easier to knowingly or carelessly infect other men. When white gay men react to the culture treating us like victims by victimizing and stigmatizing men of color, we contribute to the disproportionately high rates of infection in those communities.

It will be when we begin to treat each other as subjects—subjects, not objects—of our shared liberation, when we see each other as partners in creating the best community we can create, that we will heal ourselves. When this becomes the predominant ethos of relating, infections and drug and alcohol abuse and homelessness and depression and suicide will drop dramatically. Ultimately, shame won't stick when we make it inconsistent with our core beliefs about ourselves and our community.

My reading of the latest prevention ads that CAPS worked on with the San Francisco AIDS Foundation tells me that we are moving in this direction, as we enter a “post-prevention message” prevention era.

It looks as if we are changing the terms of the discussion. We are moving from admonitions about what we can and cannot do, to helping us understand ourselves as agents of our own and each other's capacity to express and receive love, affection, and dignity.

This is the other story that might be told, the way we might own our future by learning from our past. This new story could go beyond AIDS prevention and help nurture community and a culture where it is more difficult to objectify each other.

Rebecca's letter *(continued from page 7)*

hold you in my arms, I have to grow you in my belly. I am afraid to subject you to that place of fear.

Anyway, it's time. I feel it. I know it. I've been terrified to take this step, but I can say now with terrified conviction: My beloved child, I am ready.

Rebecca Denison received prenatal care from the UCSF team in the BAPAC (Bay Area Perinatal AIDS Center) program at San Francisco General Hospital. She lives in Berkeley with her husband Daniel Johnston and their healthy twin daughters, Sophia Claire and Sarah Catherine, who turned five this year.

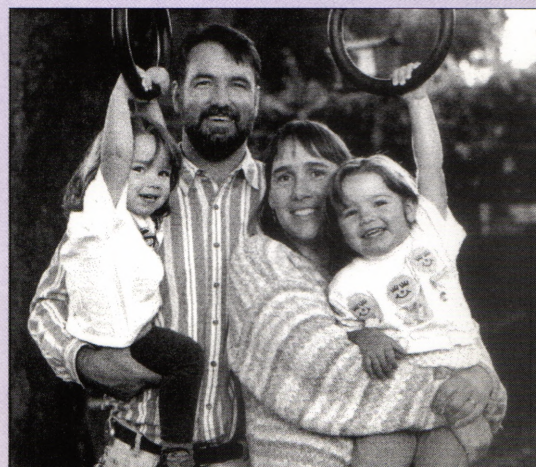
I am hopeful that prevention dollars can be spent to help us understand the obligation we have to foster each other's well being, to treat each other as having inherent dignity, as well as sharing in the delight and pleasure of our bodies and sentience. I recognize that an appeal to the feminine will have a hard time in a culture that worships the hyper-masculine. That's certainly likely to be true for messages that emphasize our shared humanity, the obligations we owe each other, or the good life we could create together. And I understand as well as anyone that our sense of shame about being gay is not something we cast off with no fuss, no muss.

But we shouldn't forget that there was a time when African, Irish, Jewish, and Chinese Americans were more despised in this country than lesbian, gay, bisexual, and transgendered people are today—a terrible truth that can, in an odd way, give us hope about our future. We can also find hope in the fact that there are so many of us who want to find in ourselves and in each other the good life that should be the inheritance of all human beings.

The upswing in the rate of new infections is a tragedy, a challenge, and an opportunity.

The tragedy is that for some men, information is no longer enough to prevent infection. The challenge is to move beyond prevention messages as we have known them, to embrace a larger vision of what prevention means. And the opportunity is to construct messages for the whole community about the costs of shame, and messages to inspire queer people to achieve shamelessness.

Peter Teague is Executive Director of the Horizons Foundation. These remarks are adapted from the keynote speech Teague presented at the ARI's community forum, "Men Make a Difference," on World AIDS Day, December 1, 2000.



Upcoming Meetings

Summer Institute on Sexuality, Society, and Health

June 18-July 15, 2001
San Francisco, CA
Sponsored by San Francisco State University
415-405-3570
<http://hmsx.sfsu.edu/summerinstitute1.htm>

AIDS Impact 2001: Biopsychosocial Aspects of HIV Infection

July 8-11, 2001
The Brighton Centre
Brighton, UK
44-20-8670-1964
admin@aimp.freereserve.co.uk
www.aidsimpact.com

1st International AIDS Society Conference on HIV Pathogenesis and Treatment

July 8-11, 2001
Sheraton Buenos Aires Hotel & Convention Center
Buenos Aires, Argentina
Registration and abstract submission:
aids2001@congresosint.com.ar
www.aids2001ias.org

2001 National HIV Prevention Conference

August 12-15, 2001
Hyatt Regency Atlanta Hotel
Atlanta, GA
Sponsored by Centers for Disease Control and Prevention
www.2001hivprevconf.org

Global Strategies for the Prevention of HIV Transmission from Mothers to Infants

September 9-13, 2001
Uganda International Conference Centre
Kampala, Uganda
Contact: Christine McFeeley
617-432-4400
mcfeeley@eci.harvard.edu
www.globalstrategies.org/uganda

5th Annual United States Conference on AIDS

September 13-16, 2001
Fontainebleau Hilton Resort and Towers
Miami Beach, FL
Sponsored by National Minority AIDS Council
Contact: Paul Woods, Conference Registrar
202-483-6622, ext. 343
www.nmac.org/usca2001/home.htm

41st Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC)

September 22-25, 2001
McCormick Place Lakeside Center
Chicago, IL
Sponsored by American Society for Microbiology
www.asmsa.org/mtgsr/41icaac.htm

6th International Congress on AIDS in Asia and the Pacific (ICAAP)

October 5-10, 2001
Melbourne Convention and Exhibition Centre
Melbourne, Australia
6icaap@icms.com.au
www.icaap.conf.au

5th International Conference on Home and Community Care for Persons Living with HIV/AIDS

December 17-20, 2001
Lotus Hotel Pang Suan Kaew
Chiang Mai, Thailand
www.hiv2001.com

¡Vamos a Barcelona!

XIV International AIDS Conference

July 7-12, 2002

aids2002@aids2002.com
www.aids2002.com

The AIDS Research Institute is planning a full year ahead for the XIV International AIDS Conference. To be added to the ARI email list for conference planning, please contact dkent@psg.ucsf.edu.

UCSF AIDS Research Institute

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June 20, 2001

The Palace Hotel
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11:30AM-1:30PM

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