Local News: *Two New Websites Serve Local Community,* **p.4**

Opinion: *Should we March on Washington?,* **p.8**

Front Page

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AIDS Services Organizations in Crisis in U.S.

By Bob Roehr
Contributing Writer

The Whitman-Walker Clinic, the major AIDS services provider in the Washington, DC area and one of the largest in the nation, capped a month long financial crisis on June 1 by announcing massive reductions in personnel and services.

The action reflects what has been occurring at AIDS services organizations (ASOs) across the country for several years, and what is likely to continue unless both government and private funding keeps pace with the increasing demands for services.

The Clinic will close its satellite facilities in the Maryland and Virginia suburbs, each of which serves more than 300 clients; lay off 50 of its 270 employees and not fill 12 existing vacancies; and cut its annual operating budget by $2.5 million.

Interim executive director Roberta Geidner-Antoniotti said that programs had expanded to meet the need rather than the available funding.

The reorganization cuts "back to the cores services that we know are the most sustainable."

She said closing the suburban facilities "will save the Clinic approximately $920,000 annually." They will remain open for a period of months while attempts are made to find other organizations to take on some or all of their responsibilities.

Whitman-Walker will suspend its $60,000 contribution to a needle exchange program that it spun off as a separate agency several years ago and perhaps lead to its demise. It will close two residential treatment and housing programs for substance abusers, and it will end prevention activities not directly funded by grants or contracts.

The food bank serving more than 300 clients will be closed, the research program will be scaled back, and case management services and administrative overhead pared back.

The Clinic had insufficient funds to meet its mid-May payroll and employees were paid only half their salaries.

That was blamed in part upon a cash flow problem exacerbated by delays in payment from the DC government, which has since been rectified.

However, the longer term financial picture has been one where flat or declining government funding, coupled with a downturn in private giving, particularly after 9/11, has

continued on page 12

The Prognosis of Prevention

Despite Public and Private Efforts, 40,000 new HIV Cases are Diagnosed Annually in the US

By Bob Roehr
Contributing Writer

"We've failed," said Howard Grossman pointing to the estimated 40,000 new HIV infections a year in the US, a number that has held steady for more than a dozen years. "Maybe it would have been much worse without our intervention, but culturally, something is wrong and we are not getting the messages across."

He spoke from his experience at the epicenter of the American epidemic, Manhattan, where for two decades he treated primarily gay men in his HIV practice, and now as executive director of the American Academy of HIV Medicine.

Grossman tied the successes in Europe and Australia at controlling infection rates to simple and explicit messages about using a condom every time. He also thought that the American psyche of individualism, versus a more societal perspective elsewhere, played a role.

Steven Tierney, director of HIV prevention for the San Francisco Department of Public Health, pushed for "targeted programs and services for gay men," as well as increased federal funding for those activities.

CDC funding for prevention programs has remained flat for the last five years, even while the agency was directing money toward populations where the epidemic appeared to be growing most rapidly, among heterosexuals and people of color. That has meant less money for prevention programs targeting gay men.

The result often has been a kind of whack-a-mole where the hammer of prevention funding comes down on one population and rates of infection fall, only to pop back up elsewhere.

The latest case numbers from Florida, the state with the third largest number of HIV infections in the nation, are a good example. From 1999 to 2004, the number of new HIV cases among blacks declined by 30%. During that same period they shot up by 23% among whites and 29% among Hispanics.

Ronald O. Valdiserri is the deputy director for the CDC's National Center for HIV, STDs and TB Prevention

"We need more resources tailored to the black gay community," said Gary English, with the People of Color in Crisis in Brooklyn, an area hard hit by HIV. "What works for the white gay community is not necessarily applicable for the black gay community."

English urged the black gay community "to take a page out of the civil rights movement and bring attention to the epidemic."

"Prevention is not a one shot deal. Each generation must be reached with HIV prevention as they come of age. Both at risk and infected populations need assistance maintaining safer behaviors over the long term," said Ronald O. Valdiserri, the CDC's deputy director of the National Center for HIV, STD, and TB Prevention.

Prevention and Positives

A handful of studies from around the country suggest that gay men, both positive and negative, appear to be serosorting—making calculated decisions in choosing their sexual partners, engaging in certain acts, and deciding whether to us or not using condoms—based upon HIV status and viral load.

A study from Denver found that gay men seeking sex online were more likely to discuss HIV status, more likely to report having unprotected anal intercourse, and more likely to be diagnosed with gonorrhea. It concluded; this serosorting may in part explain why an increase in sexually transmitted diseases (STDs) among gay men does not appear to have resulted in a parallel increase in new HIV infections.

A study of 104 HIV-positive gay men at Fenway Community Health in Boston found that 64% believed that viral load affects their likelihood of transmitting the virus. If the person has an undetectable viral load as measured in their blood, then the risk of transmission is thought to be low. And they use that information in deciding whether or not to use a condom.

The calculation is not without risk, sometimes substantial risk. The genital tract is a separate compartment behind a blood barrier that some anti-HIV drugs do not penetrate very well. Also, a STD in the genital tract can amplify HIV viral load significantly and lead to transmission, even though the person has an "undetectable" viral load as measured in their blood.

Studies have shown that anywhere from 52% to 92% of gonococcal and chlamydial infections will be asymptomatic at a typical physicians office. The exception is an STD clinic, where most people visit because their either have symptoms or acknowledge having had a sexual contact that put them at risk for acquiring an STD.

The frequent asymptomatic nature of many STDs is why all sexually active patients should be screened for those infections, not merely for symptoms. A survey by

continued on page 13