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TAG
Treatment Action Group

tagline

NEWS ON THE FIGHT FOR BETTER TREATMENT, A VACCINE, AND A CURE FOR AIDS

AIDS Funding Backlash
A Conversation with Sue Perez and Gregg Gonsalves

Pressure is increasing to redirect international funding for HIV into broader health initiatives. TAG's policy director Sue Perez and international AIDS activist Gregg Gonsalves talk about these challenges.

BY SCOTT W. MORGAN

The Kaiser Family Foundation recently published a survey that stated "the public's sense of urgency about the HIV/AIDS epidemic around the world has declined." This sentiment appears to be reflected in President Barack Obama's 2010 proposed budget, which fails to fully fund the President's Emergency Plan for AIDS Relief (PEPFAR) at the level authorized by Congress. The Global AIDS Alliance estimates that diminished AIDS funding will result in one million people around the world who will not receive lifesaving HIV treatment, and 2.9 million women who will not receive treatment to prevent transmitting HIV to their infants during childbirth.

Over the past few years, many large global health donors have become interested in funding and promoting broader initiatives such as health system strengthening, insisting the HIV problem is well supported and now in need of less attention. Whether or not this trend will continue is yet to be seen. Yet, the scale-up of AIDS treatment and prevention around the world has itself resulted in broad-based benefits for health systems in the form of improved supply chains for all medications—not just HIV drugs; human resources task-shifting that allows key clinical jobs to be performed by nurses, clinical officers, and community health workers; and increased laboratory and clinical infrastructure, to name a few.

Continued on page 2

The HIV Entry Ban: What's Next?
A Talk with Nancy Ordover

Nancy Ordover, PhD, has served on the International Task Team on HIV-Related Travel Restrictions, convened by UNAIDS and concerned with issues relating to the human rights, public health, and economic impact of HIV entry bars on immigrants, migrants, refugees, asylees, detainees, and other mobile populations.

BY BOB HUFF

Bob Huff: Roughly 60 countries in the world, the United States among them, have restrictions on whether people with HIV infection can legally cross the border as a tourist or worker or immigrant. The U.S. restrictions have been generically termed the "HIV travel ban"—but it's about more than just travel, isn't it?

Nancy Ordover: Yes, much more. The word *travel* suggests that people are barred from coming to the United States for vacation or for business. A more comprehensive description of these types of restrictions has been adopted by the International Task Team on HIV-related Travel Restrictions: HIV-related restrictions on entry, residence, and stay, which refers not only to

Continued on page 5

WHAT'S INSIDE

AIDS Funding Backlash 1
Wavering commitment in the global health response to AIDS?

HIV Entry Ban 1
Nancy Ordover on the human rights of mobile populations.

25 Years of the MACS 3
Gregg Gonsalves recalls the sense of hope upon learning about long-term nonprogressors with HIV.

Hepatitis Assistance Programs 7
State-by-state coverage of hepatitis treatment by ADAP programs.

Two New Publications 8
TAG uncovers funding gaps in AIDS, hepatitis, and TB research.

AIDS Backlash, continued from page 1

Despite these gains, many critics argue that too much money has been spent on a single disease, and that HIV treatment scale-up has consumed the resources of national health systems in low-resource settings at the expense of treating other preventable and curable diseases that kill far more people every year.

I spoke to TAG's policy director Sue Perez and international AIDS activist Gregg Gonsalves about these challenges.

Scott Morgan: AIDS is slipping as a top priority among global health funders. This is a huge concern, but equally distressing is the desire among some key voices in this field to return to certain strategies such as sector-wide approaches [SWAPS] that focused on building up health systems as a whole. Despite the well-intentioned purpose of SWAPS, these strategies were not entirely successful in the past and in some ways they were disastrous. Do you think that global health initiatives are headed in the right direction?

Gregg Gonsalves: When the AIDS epidemic arrived, health systems in developing countries were already weakened and hobbled by macroeconomic policies of the International Monetary Fund and the World Bank that pushed countries to drastically cut back on their public sector investments in favor of pursuing economic growth. These policies had a huge negative impact on poor countries' health systems by setting up years and years of chronic underinvestment and institutional decay. AIDS activists are often pigeonholed as single-issue advocates, but we understand the need for strong health systems more than most people—AIDS is a disease of primary care where it is treatable. What AIDS activists found when they started pushing for treatment was that health systems were a wreck—so health systems strengthening and AIDS treatment scale-up needed to go hand in hand. But the old style of health sector reforms—SWAPS—hasn't had a great track record. What we've learned in AIDS is that programs require a strong component of accountability and transparency to ensure proper governance. Advocates in AIDS have provided such oversight, and attempts to strengthen overall health systems need to learn from and build on our experiences in AIDS and not revert to ways of working that simply did not work!

Sue Perez: Donors look at the major health indicators and they see less progress in reducing maternal and child mortality than with other health issues, and they try to understand why that is. The fact that health systems remain weak after years of investment is a very serious problem, and one that needs to be carefully analyzed, but some have jumped to the conclusion that the resources devoted to AIDS are to blame for these shortfalls in other areas. In my view, this is a tactic to divert attention away from addressing far more intractable root causes—lack of accountability, lack of capacity, inefficiency, and harmful donor policies.

There seems to be strong resistance to dig deep and learn the important lessons that AIDS has taught us.

Despite all the talk and good intentions to address these root causes, not many action steps have been taken. There seems to be this strong resistance to dig deep and learn from the past, correct bad behavior and bad policies, learn the important lessons that AIDS has taught us about health systems, and move forward.

SM: Sue, you are a civil-society representative for the International Health Partnership and related initiatives [IHP+]. Do you see the IHP+ backing away from disease-specific initiatives?

SP: The IHP+ is supposed to focus on the critical issues of accountability, country ownership and capacity, and inefficiency for health, but in many ways, it has become a political vehicle for moving forward a divisive agenda that pits the United Nations Development Program's Millennium Development Goals for child and maternal health [MDGs 4 and 5] against those focused on fighting HIV, malaria, and other diseases [MDG6]. Civil society has been strongly pressing the fact that *people* are at the center of all of these health goals and that people face multiple health issues that cut across all the MDGs. You can immunize a child against a preventable disease, but if you don't also support the efforts in that child's country to control malaria, that child may die.

SM: What do you think is the essence of this "AIDS backlash?"

GG: Well, there are a couple of things going on. It is reminiscent of the backlash against AIDS research funding at the NIH [National Institutes of Health] in the 1990s, when advocates for Parkinson's disease and heart disease were saying that AIDS was getting too much money. Back then we were able to cobble together a coalition that rejected these false notions and that recognized that the real problem was an overall underinvestment in research. That is, the pie needed to be bigger—we didn't need to continue to squabble for crumbs from the table. The current AIDS backlash is promoting the same zero-sum game. Some people are surrendering to the notion that the relatively paltry amounts devoted to global health simply need reallocation rather than asking for further substantial investment across the board. Yes, maternal and child health, respiratory diseases, diarrheal disease, chronic diseases are vastly underresourced, but so is AIDS when compared to the need for AIDS treatment and prevention services. Pitting diseases against diseases, conditions against conditions, is not helpful. AIDS advocates didn't steal resources from other priorities to support our programs; we made a better argument than others had before us for new investments in global health. The true villains here are not AIDS activists but national governments that have never spent enough on health. The current backlash is very convenient for these governments—instead of arguing for a vast investment in global health to lift all boats they can watch advocates fight among themselves over a too-small pie. We can't let this happen.

Continued on page 4

A Long-Term Survivor
The Pioneering MACS Cohort

Adapted from remarks given on May 12, 2009, at the Carnegie Institution for Science in Washington, D.C., at a celebration for the 25th anniversary of the Multicenter AIDS Cohort Study (MACS), an ongoing prospective study of the natural and treated history of HIV infection in gay men. Over 7,000 men have participated in the MACS since it began enrolling subjects in 1984. The study has produced over 1,000 research publications and has been a seminal influence on how HIV is studied, prevented, diagnosed, and treated.

BY GREGG GONSALVES

A few weeks ago a friend of mine, a young third-year medical student at Yale University, asked me to tell him about the "old days" of AIDS. He had just read that book about the old days, Randy Shilts's *And the Band Played On*, and wanted to know how the story turned out. He wanted to hear about what happened from the mid-1980s, when the book ends, through the intervening years. We had a very long lunch that afternoon.

One story I told him about the old days concerned a remarkable collection of people—both participants and scientists—known then and now as the Multicenter AIDS Cohort Study, or MACS. It's a story about hope, about inspiration, about the serendipity of scientific discovery, and about how activists and doctors working together opened the door for some truly great advances in AIDS research.

Back in 1991, during those terrible years when treatment was just not good enough and waves upon waves of our friends were dying, my old doctor, Joe Sonnabend, told my colleague Mark Harrington and me that he was seeing a few people with HIV in his Greenwich Village practice that weren't dying, that weren't getting sick, and didn't seem to be progressing to AIDS. These were gay men he knew from the 1970s whom he knew were HIV-positive, and surely had been for a long time, but whose T-cell counts had remained stable for years while most of their peers had watched their T cells inexorably decline month after month.

Mark wrote to Dr. Tony Fauci, who was then, as now, the most eminent AIDS researcher at the National Institutes of Health, to ask for a meeting to discuss what Joe was telling us. There had to be other special cases of long-term survivors—cases that might hold some clues about how to keep the rest of us from dying.

Joe, Mark, and I took the train down to Bethesda, Maryland, to meet with Tony. I can't remember everyone who was there, but I do remember Sten Vermund from the Division of AIDS, and I assume people from the MACS were there as well. Tony and Sten were polite as always, didn't dismiss us out of hand, and promised they'd look into it and get back to us.

Mark, Joe, and I went back to New York.

One night a few months later, Sten called me to say he was sending me a fax (this was before e-mail, this story is so old). At the time I didn't have a fax machine at home, but I was working at Columbia University, so I gave him the number of the administrative office of the biology department, got on the subway, found the janitor to let me in, and watched the fax spool out of the machine in a scroll of pages I later had to cut up. As I was reading in the dim light, I realized that this was the analysis we had asked for—it was a run of the MACS data for people like Joe's special cases—for people living with HIV who later became known as long-term nonprogressors.

In the dark of night I was filled with hope. In the bleakness of those terrible days it became possible to imagine that perhaps not all of us would die of AIDS and that there may be a way out of this horrible catastrophe. I found out that night that there were indeed long-term nonprogressors in the MACS cohort. In subsequent months I worked with Sten and others to organize a meeting that brought together people from the MACS and other cohorts with leading virologists, immunologists, and epidemiologists to examine this newly discovered phenomenon.

I can't explain to you the hope we felt in New York when we learned there were people living with HIV who seemed to be able to coexist with their virus when so many others just got sick and died. That was a gift to us from the MACS; though it was years before the powerful drug cocktails came along to offer a reprieve, at least we knew that HIV was not universally fatal.

I also mention this episode because it was an early example of how researchers and activists worked together on a common goal, utilizing insights and expertise drawn from scientific training and real-world experience. The MACS investigators were so generous with their time and so willing to collaborate with activists—and back then, that was such a new thing.

And, thanks to the MACS, one can draw a straight line from the data in that late-night fax to the discovery of how HIV uses coreceptors to infect cells, to the development and approval of a drug to block HIV from using the CCR5 coreceptor, and to the current, promising studies of elite controllers of the virus. This is only one example of how the MACS data were used, but there are many more. The MACS truly was the seed bed from which a thousand flowers bloomed.

Someone, someday will write the full history of the epidemic and start from where *And the Band Played On* left off. It will contain the tale of what the people of the Multicenter AIDS Cohort Study accomplished—and they will be heroes in that story. ●

Gregg Gonsalves is with the International Treatment Preparedness Coalition and is a student at Yale University.

AIDS Backlash, continued from page 2

SM: Where do you see the political and economic AIDS backlash manifesting domestically?

SP: The United States is still regarded by countries worldwide as a champion for AIDS. PEPFAR is the largest bilateral program directed toward a single disease in history. President Obama's launching of a "new, comprehensive global health strategy" focuses on a more integrated approach with emphasis on health systems strengthening and making more rapid progress in reducing maternal and child mortality. This unfortunately signals the beginnings of a shift in focus and attention away from AIDS, which is reinforced in President Obama's fiscal year 2010 budget proposal. Many AIDS activists, including TAG, were disappointed by his budget, which did not live up to the fully authorized level for PEPFAR.

GG: Sadly, the AIDS backlash is being perpetuated by the Obama administration. Look at the new NIH budget. The institutes' budgets are largely flat funded, except for a modest increase in the budget of the National Cancer Institute. With flat funding for biomedical research, we are undermining the search for new and better treatments for HIV/AIDS, tuberculosis, and all health conditions. We had expected President Obama to be a champion for biomedical research; I guess we were wrong. And there are worrying signs from the White House that the president's advisors are buying into the idea that international AIDS funding should no longer be a priority either. Zeke Emmanuel, the special advisor to the director of the White House Office of Management and Budget for health policy, seems to be the brains behind a move to take a bit of money out of PEPFAR and give it to maternal and child health efforts. The White House is calling this a new Global Health Initiative. I'm sorry, but taking a slice out of AIDS funding and giving a small bit to maternal and child health is called robbing Peter to pay Paul. Moving money around isn't helpful to AIDS or to maternal and child health—we need significant new investments for both. At this point, despite all the bad things about President Bush's AIDS policies, they were more serious about global health than the current administration's. I can't believe I would ever have to say that, but the numbers don't lie.

SP: On the plus side, domestically, after years of the United States requiring and promoting the development of national AIDS strategies in developing countries, we are finally moving toward developing our own National AIDS Strategy to be led by the Office of National AIDS Policy within the White House. We are seeing a genuine reflection at the highest levels of U.S. government on how to deal with the epidemic at home.

There are worrying signs from the White House that international AIDS funding should no longer be a priority.

SM: What evidence is there to support the notion that AIDS funding and initiatives have improved the ability for countries to deliver better health care across the board?

SP: There is definitely growing evidence. The Global Fund and PEPFAR have been compiling data. The International Treatment Preparedness Coalition's Missing the Target report number 6 also provides data. There is a new effort by the World Health Organizaation to demonstrate the positive synergies between efforts to strengthen health systems and global health initiatives such as the Global Fund and PEPFAR.

GG: AIDS can help or hurt health systems. In a recent paper I wrote with Nicoli Nattrass, from the University of Cape Town, we show evidence that distortions in the health sector due to AIDS scale-up did occur in places like Malawi. But there is other evidence that shows that AIDS programs can strengthen health systems. No one sets out to hurt health systems, nor do I think people set out to hurt AIDS or TB programs. The best approaches try to find a balance between breadth and focus in health systems; between horizontal approaches that strengthen the sector across the board and disease-specific priorities; and then try to keep an eye on what is happening, and adapt, looking for signs of problems along the way.

SM: What do you think of the notion of an expanded international aid and public health fund similar to the Global Fund?

GG: There is clearly momentum right now to invest in health systems strengthening and other areas of international health other than AIDS. If we can build on the success on AIDS as we move toward broader goals, I think there is a better chance of success. While this means securing a sizable new investment in global health overall, it's not all about ensuring that we have a much bigger pie. While the money is important, we also need to learn from the ways in which AIDS programs have been successful. Simply giving the Global Fund an expanded mandate without new money would be a disaster, but so would ignoring the lessons from AIDS as maternal and child health and other programs are scaled up. I guess the bottom line is that if there is real commitment from donors to support a broader vision for global health financially, and if we can keep from backsliding into old-style health sector reform, it will be a good thing. But achieving this is going to take a tremendous advocacy effort, dwarfing all we've done thus far as the AIDS movement.

SM: Where do you think we go from here?

SP: There are several battles—a battle against backsliding on donor commitments; a battle against political agendas and donor policies that hurt and don't help ensure the right to health for all; a battle to unite and not allow donors to divide civil society working on global health. We have a lot of work to do. ●

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To view a panel discussion on this topic go to http://www.kaisernetwork.org/health_cast/player.cfm?id=4448&play=1&offset=10#clip_1

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HIV Entry Ban, continued from page 1

restrictions on travel but also to restrictions on immigration, migration in search of work, and securing residency status.

When I speak or write about the U.S. policy, I encourage people to resist calling it a travel ban and to instead use the term *entry bar* with the understanding that we are dealing with barriers at two points of entry. First there is the literal barrier at the port of entry; but finding themselves on this side of the U.S. border, unable to adjust their immigration status, immigrants' entry into the workforce and the health care system is also barred, as is their full participation in civic life and their access to housing and welfare benefits. It is as if they have been caught in a vestibule between two doors. This is where U.S. policy becomes deadly.

BH: What are the current rules governing people with HIV seeking to live in the United States?

NO: Since 1987, people with HIV have been denied entry to the United States. And by entry I mean they have not been allowed to come into the country or to change their residency or immigration status if they are already here except in extremely limited circumstances. The ban started out as an administrative rule but became statutory in 1993 when it was enshrined in the Immigration and Nationality Act [INA]—a move championed by Jesse Helms. It remained a statutory ban until July 2008 when both chambers of Congress voted overwhelmingly to reauthorize the PEPFAR [President's Emergency Plan for AIDS Relief] program. That bill included language striking the HIV entry bar from the INA. There was debate on this language, and on the larger bill itself, which Senator Dana Rohrabacher [R-CA] characterized as "humanitarianism gone wild." But the vote was not even close, and PEPFAR was signed into law a few days later. This was an important first step, but it hasn't changed anything for immigrants, residents, travelers, or visa seekers with HIV. It simply brought us back to where we were from 1987 to 1993. It returned authority for determining the admissibility of HIV-positive people to the Department of Health and Human Services [HHS]. In other words, the entry bar went from being statutory back to being administrative. And it did plenty of damage during its first six years, when it was merely administrative. The administrative ban will remain in place until a new rule can be written, made available for public comment, then finalized. As of today, we have not seen the language of that new rule, though we have been told repeatedly that it is in the works.

There can be serious —and sometimes deadly— consequences for people with HIV seeking permanent resident status.

Here's how the policy works on the ground: If you are coming to the United States from a Visa Waiver Program [VWP] country and you do not have HIV, you do not need a visa to enter. However, if you are HIV-positive, the only way you can get into the country legally is to disclose your status and get a waiver for a short-term visit. If a waiver is granted, it is imprinted on your passport. It is not an easy waiver to obtain, and once you use it, you are committed to it—you've committed yourself to going through the process any time you want to come to the States, and you've pretty much shut the door on anything but a short-term visit. The Department of Homeland Security issued some changes in 2008—a new option that is supposed to "streamline" the process for short-term visitors with HIV if they go this route. But this process retained and/or added some very problematic criteria for entry, and made appeal of a waiver denial practically impossible. You have to prove your HIV is in a "controlled state," that you have a sufficient supply of ARVs [antiretroviral medications], that you have adequate assets or insurance in case you need medical care here, etcetera. So, there is a financial bar here as well that applies to people with HIV. And who decides what constitutes a "controlled state" or sufficient supply of medication? Not a doctor, but a consular officer. And even if you get a waiver, it's only good for a visit of 30 days or less. Of course, you have the option of not disclosing your status, but if your HIV drugs are found by Customs, you're in trouble. Currently there are 35 VWP countries. Nearly all of them are in Europe. That means anyone coming from the global south—most of Asia, Africa, and Eastern Europe, whether they are HIV positive or not—needs a visa to come to the United States. These folks have even fewer options if they are positive and are trying to get into the country.

But the most serious—and sometimes deadly—consequences involve people who are seeking permanent resident [green card] status. There's a mandatory medical exam that includes an HIV test. If you test positive, that's it: the entire green card process stops and you are unable to adjust your status. In a few instances, people have been able to get a green card if they have a relationship with someone who is able to sponsor them, but in general they face an even tougher standard than other immigrants if they want to seek an exception. And in this climate where there is so much animosity toward immigrants in general and so little due process, that's really saying something. Only a spouse, parent, or child has standing to petition for an exception. People without HIV can be sponsored by siblings or employers, as well—but these relationships are considered insufficient for people with HIV.

Most people end up in limbo—without a recognizable legal status, which means no benefits, no ability to get a job with benefits, and no access to care and treatment. I often tell this story—I've changed the name: About 10 years ago there was a 17-year-old I'll call "Michael" who came from Guyana to get away from a very violent situation at home. He came through Miami and was detained at the Krome Detention Center for months. He was finally given what is called a "credible fear" interview. The authorities believed his father would kill him if he returned home, so he was released to the custody of relatives and he moved in with his aunt and uncle in the Bronx. After a while, he became extremely ill. He went to the emergency room and was hospitalized for several weeks. Michael's

Continued on page 6

HIV Entry Ban, continued from page 5

HIV test came back positive, but by this time he had pneumocystis pneumonia and was diagnosed with AIDS. His aunt and uncle threw him out. He couldn't go back to Guyana. If his father didn't kill him, then the lack of available treatment there would. Without recognizable legal status, he could not access housing assistance, medical benefits, or food assistance in the United States. He died in 2003, age 23.

This is a young man who was killed by the U.S. entry ban, even though he managed to get out of detention. Today accomplishing even that would be much more difficult. People who can't get a green card are at higher risk of being detained by Immigration and Customs Enforcement [ICE]. Even if they ask for asylum there is a good chance they will be placed in detention immediately and indefinitely, and that is a dangerous place for anyone, particularly for someone with HIV.

BH: What are conditions like for people held in detention who have medical needs?

NO: Immigrant detainees in the United States are held in local or county jails, with the general population; ICE detention centers; private, for-profit detention facilities; or federal prisons. Guidelines for medical care in ICE facilities seem designed to be litigation-proof. There are few enforceable standards for detention. We know of at least 90 people who have died in ICE detention, but ICE is not required to make these deaths public, so there are certainly deaths we do not know about. One we do know about is Victoria Arellano's. Victoria was trans[gender], and had been identifying and living as a woman for years, but during her detention she was housed in the men's dormitory. She was on dapsone when she was sent to the San Pedro detention center. They cut off her medication, despite the known consequences of discontinuing this antibiotic—namely, the onset of treatment-resistant pneumonia. Victoria's health deteriorated rapidly. She complained of severe nausea, headaches, cramps, and back pain. Other trans women placed in male facilities have reported violence at the hands of other detainees and the staff, but the men detained with Victoria Arellano responded with profound humanity. They cared for her; they advocated for her. They signed a petition appealing for medical care for Victoria. They staged a protest, refusing to line up for a head count before bed. All at great risk to themselves. And they were punished for it. One week before her death she was taken to the infirmary and given an incorrect antibiotic. Again, the standard of care for people living with AIDS was ignored. It was ineffective. When Victoria returned from

People are punished by this system whether they have HIV or not.

the infirmary, she began vomiting blood. The guys she was with again intervened and she was finally taken to a hospital, where she died shackled to her bed.

I should mention that legislation has been introduced in the House of Representatives that would set some standards of care and oversight for immigrant detention, including the mandatory reporting of deaths in custody.

I don't know if Victoria ever tried to adjust her immigration status and was denied or discouraged because of her HIV status or her gender identity. But the story of the last few months of her life tells us that the issue of the HIV entry ban and the fallout from the policy are inextricably bound up with larger issues of immigrant justice and human rights.

BH: So this is about much more than travel or even immigration procedures.

NO: Yes, it really needs to be dealt with from a comprehensive human rights perspective. It's not enough for advocates to talk about the decriminalization of HIV—important as that is. We have to talk about the decriminalization of migration. People are punished by this system whether they have HIV or not. And not just in the United States. We need to look at the larger picture of mobile populations. The real questions concern the rights and freedoms enumerated in International Covenant on Civil and Political Rights, the United Nations Declaration of Human Rights, and the UN's HIV/AIDS and Human Rights International Guidelines. These are: freedom of movement, freedom from discrimination, the right to privacy, and the right to the highest possible standard of health. Entry bans violate every one of them.

BH: What is the next step for the rule change on HIV entry for this country?

NO: We have been told that we will see a proposal for a new rule soon. We have to be ready to bombard the HHS with comments if we get something that we don't like. This means we don't accept any proposal that mandates disclosure of HIV status as a condition for entry or places any kind of designation of waiver or HIV status in people's passports. But what's most critical—and I can't say this often or loud enough—we must not allow the administration to split the ban by lifting it for travelers and some visa holders but keeping it in place for long-term visa-seekers and immigrants. If that happens, it could be years, maybe decades, before an administration returns to the issue and provides any kind of relief for HIV-positive immigrants without green cards. This would translate into another 20 years of people with HIV unable to become legal permanent residents, get decent jobs, or access benefits; 20 more years of immigrants with HIV left homeless, sick, and hungry; left without a country; in some cases, left for dead.

Now, if we get a rule we do like and HHS lifts the HIV entry bar in its entirety, we're still not done. The PATRIOT Act, the Homeland Security Act, the Welfare Reform Act, and the Illegal Immigrant Reform and Immigration Responsibility Act have all taken a ruinous toll on non-green-card-holding immigrants; making it difficult or impossible for most to access health care or housing; limiting options for asylum and appeal; and effectively criminalizing them. The bottom line is, policies that hurt immigrants hurt immigrants with HIV. ●

Nancy Ordover, PhD, is the author of American Eugenics: Race, Queer Anatomy, and the Science of Nationalism.

State AIDS Drug Assistance Program (ADAP) Hepatitis Coverage

Hepatitis C Treatment, Psychiatric Medications (SSRIs), Growth Factors, Hepatitis Vaccines

(March 2009)

Hepatitis C virus (HCV) is a common and serious comorbidity among HIV-positive people in the United States; up to 30%—approximately 332,000—are living with HCV. Hepatitis C can lead to complications such as cirrhosis, liver cancer, and liver failure. HIV worsens HCV by increasing both the risk for, and rate of serious liver damage. In fact, end-stage liver disease from HCV is a leading cause of death among HIV-positive people in the U.S. But HCV can be treated with a combination of pegylated interferon (IFN) and ribavirin. Access to HCV treatment, supportive medications, and vaccines is crucial for coinfected people, and many rely on state ADAP Programs to provide them as well as antiretroviral therapy and treatment and prophylaxis for opportunistic infections. However, only 29 states cover both pegylated IFN and ribavirin, although several states carry one or the other. People living in states that do not cover pegylated IFN and/or ribavirin can apply to patient assistance programs from Roche and Schering Plough (below).

Roche Patient Assistance Foundation 1-877-75ROCHE (877-757-6243)
www.schering-plough.com/binaries/Commitment-to-Care.pdf

State	PEG-IFN	Ribavirin	SSRIs	Epoetin-Alfa	Filagrastim	HAV/HBV vax
Alabama		●		●		
Alaska	●	●				●
Arizona	●	●	●	●	●	●
Arkansas						
California	● also standard IFN	●	●	●	●	●
Colorado	●	●	●	●	●	●
Connecticut	●	●	●	●	●	
Delaware	● also standard IFN	●	●	●	●	●
District of Columbia	● also standard IFN	●	●		●	
Florida	● also standard IFN	●	●	●	●	●
Georgia			●			●
Hawaii	●	●	●	●	●	
Idaho						
Illinois	●	●	●		●	●
Indiana			●			
Iowa		●	●		●	
Kansas			●			
Kentucky						
Louisiana		●				
Maine	●	●	●	●	●	
Maryland	●	●	●	●	●	
Massachusetts	Open formulary					
Michigan	●	●	●			●
Minnesota			●		●	
Mississippi	●	●	●			
Missouri	●	●	●		●	●
Montana			●		●	
Nebraska			●		●	
Nevada			●	●		
New Hampshire	Open formulary					
New Jersey	Open formulary					
New Mexico			●		●	●
New York	●	●	●	●	●	
North Carolina	●	●	●	●	●	●
North Dakota			●		●	
Ohio	● also standard IFN		●			●
Oklahoma			●			
Oregon	●	●				
Pennsylvania	●	●	●			
Puerto Rico		●		●	●	
Rhode Island		●	●	●		
South Carolina			●			
South Dakota			●		●	
Tennessee		●	●			
Texas	●	●				
Utah	●	●				
Vermont	Standard IFN only		●			●
U.S. Virgin Islands	●	●				
Virginia	●	●	●			
Washington	● also standard IFN	●	●	●	●	●
West Virginia			●			●
Wisconsin	● also standard IFN	●	●		●	
Wyoming	●	●	●			●

Source: Henry J. Kaiser Family Foundation, National Alliance of State and Territorial AIDS Directors (NASTAD). National ADAP Monitoring Project, Annual Report, April 2009. ADAP Formularies. Available online at: http://www.kff.org/hivaids/7861.cfm

Special thanks to Britten Ginsburg and colleagues at NASTAD.

Two New TAG Publications
Research Funding Gaps Revealed

Two new reports from TAG detail shortfalls in medical research funding for HIV, viral hepatitis, and tuberculosis.

Treatment Action Group has published two new reports on the crisis in national and international funding for scientific research on AIDS, tuberculosis (TB), and viral hepatitis. TB and hepatitis are diseases that affect hundreds of millions of people worldwide. They are particularly deadly coinfections for people with HIV.

Flat-Lined, authored by Lydia Guterman and edited by Mark Harrington, examines the current overall state of research investment after five years of flat funding at the National Institutes of Health (NIH) from 2004 to 2009, and focuses on HIV/AIDS and its three most common coinfections, hepatitis B virus (HBV), hepatitis C virus (HCV), and tuberculosis. The report finds that overall funding for the NIH during this period has failed to keep up with inflation, resulting in a net decline in research investment for all diseases. TAG recommends that NIH funding increase by 15% per year for the next five years in order to get back on track.

TAG also published the third in its series of yearly reports evaluating worldwide funding trends for tuberculosis research and development. *A Critical Analysis of Funding Trends: 2005-2007*, authored by Neha Agarwal, finds that while TB research has increased modestly year-to-year, funding is expected to fall far short of the target set by the World Health Organization (WHO) if tuberculosis is to be brought under control during the next decade.

Mark Harrington, executive director of TAG, said, "Research funding for TB and hepatitis has fallen far short of the need, and the results are tragic. Despite the millions of lives at risk, worldwide support for TB research is well below the level of commitment recommended by the WHO. And support for hepatitis research barely registers at the NIH here in the United States."

The U.S. government's NIH is the world's preeminent medical research body, and has historically been a powerhouse in generating new discoveries to treat cancer, heart disease, and infectious diseases such as HIV/AIDS.

Both reports can be found at TAG's website: www.treatmentactiongroup.org/newpubs2009.aspx

TAG BE INVOLVED

About TAG

Treatment Action Group is an independent AIDS research and policy think tank fighting for better treatment, a vaccine, and a cure for AIDS. TAG works to ensure that all people with HIV receive lifesaving treatment, care, and information. We are science-based treatment activists working to expand and accelerate vital research and effective community engagement with research and policy institutions. TAG catalyzes open collective action by all affected communities, scientists, and policy makers to end AIDS.

Program areas include antiretroviral treatments, basic science, vaccines, prevention, hepatitis, and tuberculosis.

Join TAG's Board

TAG is always seeking new board members. If you are looking for a great place to invest your time and talents, please call Barbara Hughes, TAG board president, to learn more about board opportunities with TAG.

Call 212.253.7922 or email: barbara.hughes@treatmentactiongroup.org

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