References:
A surge of evidence supports treating HIV earlier

- **DHHS guidelines**:¹
  - HAART is recommended for patients with a CD4 cell count of 350–500 cells/mm³¹
  - Half of the Panel favors initiating HAART for patients with a CD4 cell count >500 cells/mm³¹ while the remainder views HAART as an option
  - As part of the consideration for earlier initiation of HAART, the Panel cites both the benefits and potential limitations

- **Significant improvement in patient survival**²
- **Better long-term CD4 cell count**³
- **Significant reduction in the probability of morbidity**⁴
- **Lower probability of HIV transmission**¹

▶ Talk to your patients and help them understand the potential of earlier initiation of HAART.

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¹DHHS=Department of Health and Human Services.

²59% increase in relative risk of death when treatment was deferred until CD4 cell count was ≤350 cells/mm³ (versus initiating at 351–500 cells/mm³; P<0.001) and 94% increase in relative risk of death when treatment was deferred until CD4 cell count was ≤350 cells/mm³ (versus initiating at >500 cells/mm³; P<0.0001), based on the NAPRAGG study.²

³After 6 years, patients with a baseline CD4 cell count >500 cells/mm³ achieved and maintained nearly normal CD4 levels with HAART (versus ≤350 cells/mm³) in an observational analysis.³

⁴Earlier initiation (>350 cells/mm³) was associated with significantly reduced probability of opportunistic disease (OD), serious non-AIDS events, and non-OD deaths in an analysis of the SMART study.⁴
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In the Beginning
And What’s New in 2011

In recognition of the 30th anniversary of the first reported AIDS cases in the US, this issue of the HIV Specialist looks at the history of the epidemic and the enormous progress we have made through the eyes of activists, providers and policy makers. As the Acting Deputy Assistant Secretary for Health (Policy and Evaluation) and/or the Deputy Director of that office during all of the 1980s, I had a bird’s eye view of, and some influence on, the U.S. Public Health Service’s struggle to meet the challenges of this new deadly epidemic. Though some historians may disagree with me, I saw dedicated government physicians and scientists do everything in their power to address the epidemic, while navigating a very complicated bureaucracy. But the real story here is how far we have come in the past 30 years—both from a societal and medical perspective. We have not yet found a vaccine or an adequate way to shrink incidence. But we have found a variety of ways to effectively treat HIV—so much so that one of AAHIVM’s 2011 initiatives is focusing on providing medical guidance on how best to treat the elderly HIV patient.

The aging initiative is an example of how AAHIVM recognizes the needs and advances in HIV care over the last three decades. While we celebrate advances in medical care each day, we also remain diligent in addressing the challenges our Members face. Much of the work that the Academy Board and staff have done over the past year will become increasingly evident over the next several months. In each of our areas of focus — education, credentialing and advocacy — we will be making substantial upgrades for our Members and the patients you serve.

At the end of February, we launched our new interactive website. With features such as a state legislative tracking tool, daily HIV news service, discussion boards and an improved job bank, we hope the new aahivm.org will become a daily destination for you. In addition, the Referral Link pilot program we developed with the CDC will become national in scope—now including all AAHIVM Members and Credentialed Providers throughout the country. This will facilitate the referral of those newly diagnosed patients in generalist routine testing sites to local HIV Specialists™ and practitioners.

Later this spring, AAHIVM, the American Geriatrics Society and ACRIA, will publish the first-ever report on clinical guidance for HIV and aging. Presentations on the report will be made at the ACT HIV conference in April and at the American Geriatrics Society meetings in May. Thanks go out to the leadership of the co-principle investigators, Drs. Jon Appelbaum and Wayne McCormick, the 14 member expert panel, and to Ken South of our staff, who manages the entire process.

Also coming this year will be a broader array of online CME sponsored by the Academy, as well as two surveys that will enlighten the practice of HIV medicine.

Later this year, we will announce the details of a new partnership with the Institute for Technology in Health Care and the presentation of a $20,000 award for the use of innovative technology in HIV practices. The award will be presented at our annual Membership Reception in conjunction with CROI in 2012. This award will highlight and stimulate the adoption of new technologies (broadly defined) in the practice of HIV medicine.

And finally, due to the popularity of the HIV pharmacist credentialing pilot program, we will develop a separate credentialing exam for HIV pharmacists for the 2011 cycle. This has been done to better recognize the expertise of the HIV pharmacist community, while continuing to maintain the integrity of the Academy’s highly regarded Credentialing program headed by Peter Fox of our staff. Further, as a reflection of the increased membership of HIV pharmacists, the Academy Board of Directors has created a Pharmacist Committee—with the chair of that Committee to become a member of the National Board of Directors.

2011 will be an exciting year for AAHIVM. We hope that through these initiatives, we will continue to better serve you and provide additional benefits to your membership. As always, we want to hear from you regarding new ideas on how we can best support you in the coming years. Write to me at jfriedman@aahivm.org.

James Friedman
THE EVOLUTION OF

Viral Load Technologies

What are the implications for HIV patient management?

BY BRUCE J. PACKETT, II

MEASURING VIRAL LOAD COUNTS IN INDIVIDUAL PATIENTS has been a key indicator for determining the efficacy of various ARV treatment regimens since the late 1990s. In recent years, rapid advances have been made with the development of new, more sensitive viral load assays based on RealTime PCR technology. Different strategies have been employed by manufacturers in the design of these new RealTime viral load assays, and the assays vary in their limits of detection and quantification.

A new survey of AAHIVM providers (n=233) shows significant uncertainty among many clinicians regarding the management of low-level viremia in their HIV patients, especially regarding these new viral load assays. Interestingly, respondents indicated that the Roche Amplicor 1.5 assay, which is based on an older “end-point PCR” technology, is still the most widely used. Of the new RealTime PCR assays, the Abbott RealTime and Roche Taqman were the most commonly used among respondents; however 42 percent of respondents were actually unsure of which assay was being used by their practice.

Both the Abbott and Roche assays have the ability to detect (with strong confidence) viral load levels below 50 copies/mL. Siemens, the manufacturer of the bDNA assay (8 percent of respondents indicated they used this assay), is currently developing a RealTime PCR-based assay to replace their older technology. (If providers are uncertain, the lower limit of detection will provide a significant clue as to which assay is being utilized, e.g., Siemens/bDNA < 75 copies, Roche Amplicor < 50 copies, Roche CTM, Version 1 < 48 copies, Roche CTM Version 2.0 < 20 copies and Abbott RealTime < 40 copies, respectively.)

As with all change, evolutions in HIV viral load technologies is not without its controversies. A phenomenon known as “blips,” or detectable viral load counts in previously suppressed patients, has been introduced into the care of HIV. This phenomenon has been widely reported in the literature and has prompted changes to the DHHS guidelines (Jan. 10, 2011 www.aidsinfo.nih.gov), defining a virologic failure as a confirmed viral load greater than 200 copies/mL.

The new guidelines also state: “In addition, low level positive viral load results (typically < 200 copies/mL) appear to be more associated with some viral load assays than others.” In light of these new DHHS guidelines and the emergence of the “blips” issue with certain viral load assays, there appears to be a dichotomy in the field of HIV medicine: If virologic failure is defined as a confirmed viral load greater than 200 copies/mL, why is there continued pressure from manufacturers to lower the limit of detection even further below 50 copies/mL?

The majority of the survey respondents put the threshold for blips as 200 copies/mL (in accordance with guidelines), but 35 percent still defined a blip as greater than 200 copies/mL, perhaps indicating an educational gap vis-à-vis the new DHHS guidelines. Regardless of how blips are defined by respondents, it is clear from this survey that they are resulting in an increase in physician/patient “concern,” with about 80 percent of respondents noting some degree of perceived anxiety in the patient, and 72 percent indicating they would order repeat viral load testing. In a survey question regarding the threshold for repeat testing, 36 percent said they would repeat for viral loads less than 200 copies/mL, and nearly 20 percent said they would repeat for less than 400 copies/mL, with an additional 37 percent ordering resistance testing. When asked about non-resolving blips on follow-up viral load testing, there were still 28 percent of the survey-takers who would repeat again.
These responses suggest unnecessary follow-up, repeat (often costly) diagnostic testing (including resistance) and additional scrutiny of drug interactions – all of which place a huge burden on an already stretched health care system. There is some suggestion from these numbers that targeted education on viral load technologies and the management of low level viremia for HIV care providers may have a palpable impact on economy and quality of care. Certain care-management activities like checking treatment adherence (as was documented in some of the individual survey responses) may be appropriate and economically sound avenues for follow-up on blips.

Worth noting is a recent study by Willig and colleagues at the University of Alabama-Birmingham 1917 Clinic, which found a significant number of viral blips when their clinic switched to the TaqMan HIV-1 v.1.0 assay. The study estimated that the costs of repeat testing, including the ordering of HIV genotypes, is more than $20,000. They also noted the “psychological stress impacting patients and providers who must face an apparent loss of virologic control.”

Brad Hare, MD, AAHIVS, Medical Director at the University of California-San Francisco’s Positive Health Program at San Francisco General Hospital, underscored the importance for providers to be familiar with the performance characteristics of diagnostic assays. “The results directly affect the decisions we make when managing patients; reliability and precision are key attributes of any assay,” Dr. Hare noted when interviewed on this topic. “In the case of viral load testing, reliable and accurate results can eliminate unnecessary additional tests due to transient elevations.”

Many individual comments in the AAHIVM survey indicated that the communication, context, and cues from the provider were powerful factors influencing the level of patient anxiety. One respondent summed up the variability on this point nicely: “Some patients are extremely anxious and require a lot of explanation and demand repeat testing; others are satisfied with a brief explanation and some reassurance (which I provide if the blips are low). Higher blips make the patients, and me, a lot more anxious.”

Most respondents (74 percent) concurred that the specific ARV regimen did not play a factor in reordering viral load tests. In addition, 88 percent did not change the viral load assay when testing a series or clustering of blips, perhaps because it isn’t an option in their clinical settings.

One clinical scenario presented by the survey related to a clustering of blips and queried as to whether the viral load needs to return from blip status to undetectable within four weeks for it to require no further clinical action. Fifty-five percent of respondents agreed with this premise, but individual responses varied.

There also was a varied response regarding how to clinically manage stable, low-level viremia, although 88 percent of respondents agreed that subsequent testing showing the viral load increasing would indicate early treatment failure and would be cause to consider ordering an HIV genotype and/or changing the regimen. Many reiterated the need for adherence checking and counseling. Some respondents suggested an intensification of therapy, which is generally not recommended by current HIV treatment guidelines. Most (87 percent) suggested staying the course with existing regimens for stable, low-level viremia.

Overall, it is clear from the survey results that the “blips” phenomenon is a source for concern and undermines confidence in viral load results as an indicator of treatment success/failure. The issue on differences in viral load technologies and their impact on the clinical management of HIV/AIDS warrants further discussion and targeted education. Many providers taking the survey were unabashedly open about the need for new educational initiatives on
What viral load assay do you use?

- Don’t know: 42%
- Roche Amplicor 1.5: 21%
- Roche Cobas TaqMan Ver 2.0: 18%
- Abbott Real Time HIV-1: 18%
- Siemens Versant bDNA: 14%
- Other viral load assay: 8%
- Roche Cobas RaqMan Ver 1.0: 6%
- Roche Cobas TaqMan Ver 1.0: 6%
- Roche Cobas TqMan Ver 2.0: 6%
- Roche Cobas TqMan Ver 1.0: 6%

What viral load assay do you use? (Hospital Lab Only)

- Don’t know: 45%
- Roche Amplicor 1.5: 21%
- Roche Cobas TaqMan Ver 2.0: 17%
- Abbott Real Time HIV-1: 15%
- Siemens Versant bDNA: 6%
- Other viral load assay: 6%
- Roche Cobas RaqMan Ver 1.0: 5%
- Roche Cobas RaqMan Ver 1.0: 5%

Do you order a resistance test for blips?

- Yes: 63%
- No: 37%

What is your viral load threshold?

- >1,000 copies: 49%
- >500 copies: 41%
- <500 copies: 10%

To define a blip that would require no further action, do you believe it has to return to undetectable on a repeat test within 4 weeks?

- Unsure: 12%
- No: 31%
- Yes: 55%

The AAHIVM survey was supported in part by an unrestricted educational grant from Abbott Molecular.

The topics of new HIV diagnostic technologies, viral load testing and blips. Seventeen percent asked for follow-ups directly from scientific affairs liaisons from diagnostic/molecular companies (Roche, Abbott, Siemens), and about half of all respondents suggested there could be useful educational activities on these topics, with a strong bent toward venues such as online CME, webinars and live CME workshops.

“It seems clear from the survey that there are varying ideas and perhaps even some confusion on how to clinically manage viral blips and low-level viremia in the context of new and more sensitive diagnostic tools,” noted AAHIVM Communications Chair Jeffrey T. Kirchner, DO. “We would do well to offer provider education and CME focused on these issues.”

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**Passing the Torch**

Doctor/priest treats body, mind & spirit. His potential successor plans to do the same.

**BY BOB GATTY**

**Dr. Drew A. Kovach is a physician and the go-to doc in all of Hawaii for HIV patients, as well as many gay and lesbian non-HIV patients who crowd his clinic every day seeking care for all manner of ailments.**

But as much as Dr. Kovach is in demand as both a family doc and HIV physician, he is much more. The Very Reverend Father Drew A. Kovach, M.D., M.Div., ABFM, AAHIVS, is a healer of the body, yes, but also of the mind and spirit. For the past 35 years, he has been an ordained Episcopal priest, and more recently an Orthodox Archpriest in the Inclusive Orthodox Church.

“In my mind,” he said, “medicine is ministry and ministry is medicine.”

For 30 years, Dr. Kovach has treated HIV/AIDS patients, starting with a young man who came to St. Mary’s Hospital in Grand Junction, CO with lesions on his face. “We didn’t know what was wrong, but we eventually found that he had AIDS. He tried to commit suicide, and I took care of him. But eventually he died from the disease.”

Dr. Kovach’s career has taken him from that post as the assistant director, family medicine residency at St. Mary’s through many positions that included private practice in family medicine, culminating with his current directorship of HIV services at a large corporate medical delivery system in Hawaii.

His approach is one of comprehensive care, one of treating the whole person. Now, at age 63, he is preparing for the day when he will retire and pass the torch to someone new. Fortunately, he has found someone—a young man who shares his dedication to HIV care and his philosophy of treating the total person. He is Robert John Matyas, II, MS, DO, a former U.S. Navy flight surgeon served in Iraq, who has done two two-week rotations in Dr. Kovach’s clinic and who has worked with him on a retreat for family medicine specialists.

**Trinity of Man**

“Here I am, a man taking care of people living with HIV for now over 20 years with a multi-level view of health, wholeness and wellness,” Dr. Kovach wrote in an article for *New Catholic Communion*. “Ministering to them as whole people to make them whole and holy. I often speak of the ‘trinity of man’—three parts: mind, body and spirit. Three intersecting spheres each overlapping the other in perfect balance. Each always influencing the other two. Imbalance or disease or pain in any one always affects the other two.”
And so, Dr. Kovach toils every day, treating, ministering, and caring. His goal is to help patients be healthy, yes, but also to live a good and happy life.

“Good health is just part of good life,” he said. “A balance of mind, body and spirit to live a good life is what I have always wanted for my patients, as well as my parishioners, since the beginning of my dual ministries.”

Dr. Kovach explained: “So often the traditional medical approach focuses on the physical body with tests and procedures. Sometimes, the emotional elements of the patient are dealt with, but usually it’s by different practitioners. Their spiritual wellbeing is never considered. ‘That is what the clergy do,’ they say.”

Not at Dr. Kovach’s clinic. There, the total patient is treated and comprehensive care means being concerned about every aspect of a patient’s life.

“Over the many years of my work with HIV/AIDS patients, by God’s grace, I have had the opportunity to put my various skill sets together on a continuing basis,” Dr. Kovach said. “In the early days of the pandemic, supportive and pastoral care was all that we had to offer people living and dying with this most comprehensive disease. It is one of the only illnesses that I know of in medicine that affects every aspect of a person’s life. Mind, body and spirit are affected. And so, I take a cosmic view of medicine.”

Since the early days, Dr. Kovach has believed that treating symptoms and opportunistic infections was only part of the treatment. “I felt at that time that it was 50 percent dealing with the virus and infections and 50 percent the ‘rest of the stuff of life.”

“Now, we have 30 different medications to treat and suppress the HIV virus. I now believe it is about 25 percent keeping the virus under control and 75 percent the ‘rest of the stuff of life,’” he explained. “I was then doing pastoral care, getting people ready to die. Now, I continue to do pastoral care getting people ready to live with this chronic disease.”

**A Clinic Opens; Patients Come**

Dr. Kovach moved to Hawaii from Colorado, with his partner, in 1992, and was hired by the corporate health care group as a family physician. It was not long, however, before the word got around that there was a gay doctor who knew about HIV. “And, so,” he said, “they began to come.”

The clinic was opened in 1995, and Dr. Kovach convinced his bosses to allow him to create a comprehensive care clinic much like the one he had run in Denver, and within a year, HIV was his fulltime work. Today, the clinic is the largest in Hawaii and serves some 600 patients from four islands, with Dr. Kovach, a nurse coordinator and a medical assistant.

“They come in with gall bladders and appendicitis and everything else,” he said. “The majority of my day is HIV, but with about 400 additional patients being gay, lesbian and transgender who are HIV negative, we do everything.”

Dr. Kovach’s clinic is popular among providers who want to learn about his approach to care. “People come to study with me;” he explained. “My approach is different, and if they want to see HIV patients, this is where the mother lode is.”

He also is in demand as a speaker, and teaches at the John A. Burns School of Medicine at the University of Hawaii.
“I use any opportunity that I have,” he said, “to always discuss my belief that a mind, body, spirit approach needs to be used to help people heal and achieve wholeness.”

“Because I lecture all over the world,” he explained, “everybody knows about this HIV doctor who is also a priest. Everybody I have taught in my clinic, I have planted seeds of interest in HIV. Some have taken sprout, some have not.”

One of those that sprouted was Dr. Matyas.

**Called to Do the Work**

“He is the most passionate person about HIV medicine, besides myself, that I have ever met,” Dr. Kovach said. “He told me that as a gay man, he felt called to do this work.”

It was an answer to Dr. Kovach’s prayers, because he had been concerned about who would continue his work once he retires. At 63, he knows that soon he will need to step aside, as will many others of his generation.

“I had pretty much given up hope that anyone else would want to do it the way I do it,” Dr. Kovach admitted. “But R.J. is a family practice doc. He told me, ‘I want to become you. I want to become like you. I want you to teach me as much as you can.’”

Today, Dr. Matyas is under contract with the same company as Dr. Kovach, and some day he may well be in charge of the clinic there.

“I feel Dr. Kovach came into my life for a special reason,” Dr. Matyas said thoughtfully. “The first day I met him, I looked into his eyes and I felt a sense of connection, that I was meant to meet this man.”

While Dr. Matyas is not a priest, he believes, as a DO, in the importance of treating the total person, including mind and spirit. “I know I can continue God’s work in many ways,” he explained. “I don’t have to be a man of the cloth to do that.”

As a gay man who struggled with his sexual identity during grad school, when he finally “came out” and then served in the military, Dr. Matyas believes he can bring life experiences to his work at Dr. Kovach’s clinic, helping HIV patients cope with their disease and their struggles with life. “It is amazing to me to think that I can help them and make them understand that this is not a death sentence. If they maintain their balance with mind, body and spirit, I can help them live a happy and healthy life even though they are HIV positive.”

“This is an extraordinary opportunity that is in front of me,” Dr. Matyas acknowledged.

“Dr. Kovach clearly has had a profound impact on his patients and on HIV medicine all over the world. I want to have that same impact. It will not be easy to achieve. But I want to take advantage of whatever he’s willing to do and become the best HIV physician that I can be.”

“We are both immensely excited about this,” said Dr. Kovach. “This is probably the best thing that’s happened to me in years. I was very fearful that the model of care here would change. But now it will continue when I retire. I want to be sure R.J. is a very good family doctor and a very good HIV specialist before I hand over the practice to him. I have set a retirement date for the end of 2013. It is a soft date, because it depends on how things go over the next few years.”

But now, Dr. Kovach is confident he can pass the torch to someone who will carry on and continue to provide the comprehensive care about which he is so passionate.

“God is working his purposes out,” he said. “I have been blessed in so many ways by this combined ministry. Medicine is ministry and ministry is medicine. I pray that God will sustain me to continue for many more years. It is God’s doing, and it is marvelous in our eyes.”

**HIV**
“We likened the spreading AIDS situation to the arrival and spread of smallpox and the bubonic plague in Europe several centuries ago. But despite an aggressive research effort, progress was slow. Five years into the crisis, AIDS remained a mystery.”

– Dr. C. Everett Koop

“Through his report and his many speeches and interviews on AIDS, (former U.S. Surgeon General C. Everett) Koop did more than any other public official to shift the terms of the public debate over AIDS from the moral politics of homosexuality, sexual promiscuity, and intravenous drug use...to concern with the medical care, economic position and civil rights of AIDS sufferers.”

THIS PAST NOVEMBER, the man who served as U.S. Surgeon General during the beginning and gestation of the AIDS epidemic in America, C. Everett Koop, MD, ScD, issued what may be one of his last calls to the public: Understand that “HIV is contagious and it can kill you.”

Speaking at the National Press Club in Washington, DC, Dr. Koop said the “most important lesson from the past 30 years is that the nation must remain aware and knowledgeable about HIV/AIDS.” He urged the public health community to be “vigilant in its prevention and early detection efforts.”

At the time of Dr. Koop’s address, at the age of 94, reporters were told it is likely that this will be his last major address on HIV. Dr. Koop spoke just prior to the Forum For Collaborative HIV Research’s 2010 National Summit on HIV Diagnosis Prevention and Access to Care.

“With the rapid spread of HIV/AIDS (with 30,000 cases in 1987), we knew we were fighting a contagion,” Dr. Koop recalled. “We likened the spreading AIDS situation to the arrival and spread of smallpox and the bubonic plague in Europe several centuries ago. But despite an aggressive research effort, progress was slow. Five years into the crisis, AIDS remained a mystery.”

However, one important fact was known, he said: The virus that causes AIDS is transmitted from one person to another in blood or semen, explaining why in the beginning AIDS was so prevalent among homosexual and bisexual men and intravenous drug users.

“It was also a warning sign of what is now commonplace in the U.S. and around the world – cases of HIV/AIDS in heterosexual men and women.”

Fighting Fear
But at the same time, a related battle was being fought, Dr. Koop said. It was the fight to overcome public fear.

“This was a time when the country was rife with rumors and misinformation about HIV/AIDS. Americans worried about contagion through casual contact in schools, restaurants and public lavatories. There was also a pervasive bias against the people most affected by HIV/AIDS, which severely hampered our ability to respond. Politicians called for a quarantine of AIDS patients. And AIDS activists took to the streets.”

Dr. Koop said he saw his job “as waging all-out war against disease—not people,” realizing that unless every adult and adolescent was informed and knowledgeable, the HIV contagion would continue to spread.

Where there is a deadly disease, he stressed, “It is vital to give Americans the facts – and do it in plain English.”

Rumors had to be dispelled and the public needed to be informed about how the disease is transmitted, who is at risk, and how people can protect themselves. It also meant having “a frank and open discussion about the subjects of sex, sexual practices, and homosexuality.”

That is what his 1986 Report of the Surgeon General sought to achieve, as it concentrated on two key messages:

- The risk of infection increases with the number of sexual partners, male or female.
- The best protection against infection, barring abstinence, is the use of a condom.

Twenty million copies of the report were distributed through Congressional offices, the public health community, and parent-teacher associations. Then, in 1988, Dr. Koop turned the report into an eight-page pamphlet that was sent to every American household – all 107 million of them. It was the first time, he said, that the federal government provided explicit sex information to the public.

In 1986, Dr. Koop said, antiretroviral therapy changed the course of AIDS from a deadly disease to a chronic condition. Now, he observed, there are significant advances in developing a vaccine against HIV.

“But it is not time to declare victory,” he warned. “The war against HIV/AIDS is far from over.”

Continueing Concerns
More than 1.1 million Americans are living with an HIV infection, he pointed out, noting that despite the best efforts of medical science and public health, new infections continue at “far too high a level,” more than 56,000 each year in the U.S., with more than 14,000 deaths – usually gay and bisexual men.

Those statistics are troubling to Dr. Koop because of the continued high prevalence of HIV/AIDS in this country, and specifically because HIV infections among gay and bisexual men have been increasing since the 1990s. He also expressed his concern that “we are falling short in reducing the incidence of HIV/AIDS in injection drug users, African Americans, and Hispanics/Latinos.”

Currently, almost half of all people living with HIV are African Americans, accounting for nearly half of new infections every year.

Another reason for Dr. Koop’s concern, he said, is “a growing sense of complacency...that is as dangerous as the irrational fear in the early days of the AIDS controversy.”

“If there is a new front in our war against HIV/AIDS, it is ignorance and complacency,” he declared. “Simply put, HIV is no longer on the public’s radar screen. And the result is deadly serious.”

Anthony S. Fauci, MD, director of the National Institute of Allergy and Infectious Diseases, presents Dr. Koop with the first C. Everett Koop HIV/AIDS Public Health Leadership Award.

“But it is not time to declare victory. The war against HIV/AIDS is far from over.”

– Dr. C. Everett Koop

Dr. Koop pointed out that 21 percent of people with HIV do not know they are infected, and that the number is higher among gay and bisexual men and infected teens. And so, they are not getting treatment and are not protecting others from getting the disease.

“The HIV/AIDS epidemic is still very real in this country,” Dr. Koop warned. “Putting an end to the suffering requires ending the complacency and making sure that people who need effective prevention interventions have access to them.”

ABOUT THE AUTHOR. Editor of HIV Specialist, Bob Gatty is a Washington, DC-area health policy writer and publications professional. He is founder of G-Net Strategic Communications and can be reached at bob@gattyedits.com.
“Our war against HIV/AIDS started exactly 30 years ago,” C. Everett Koop, MD, ScD, told a gathering at the National Press Club in Washington, DC last November 17. Dr. Koop served two terms as U.S. Surgeon General during a period that coincided with the rise of the AIDS epidemic in the U.S. and in 1986 issued the first Surgeon General’s report on AIDS.

“It was June, 1981, when we heard about five cases of homosexual men in Los Angeles who were dying from pneumocystis carinii pneumonia,” he recalled, pointing out that the disease was so rare “that a handful of cases in a single year was like an epidemic.”

Then, he added, a month later the Centers for Disease Control (CDC) reported 26 cases of homosexual men diagnosed with Kaposi’s Sarcoma (KS), an equally rare skin cancer.

“Those first cases were ground zero in the fight against HIV/AIDS,” Dr. Koop said. “In two short months, we were witnessing a rash of deaths from very rare diseases and no one knew why. It appeared that some kind of ‘bug’ – a virus, most likely – was attacking and destroying the natural immune systems of otherwise healthy adults.”

By 1983, the epidemic had a name – Human Immune Deficiency Virus, and by then, the battle against what was now seen as a disease with one certain outcome – death – was underway. By 1987, there were 30,000 reported cases.

That battle, however, has been unlike any other health-related campaign in the history of mankind, largely because of its victims: predominately gay men. So not only have the challenges been difficult scientifically, but fraught with roadblocks caused by prejudice, fear and misunderstanding.

Nevertheless, brave, committed souls have fought the fight, and today the outlook for patients is much brighter. HIV and AIDS still exist. But today’s medical treatments have greatly lengthened, and improved, the lives of patients to the point where there are now efforts underway to better understand how to treat the aging HIV patient.

Some of those leaders have shared their thoughts, recollections and impressions with HIV Specialist as we look back, through their eyes, at the fight that has been waged. All were asked the same set of questions. Here, in their words, are their stories:
What are some of your most vivid memories during the first decade of the epidemic?

My earliest memories are of emotions, the first ones being alarm and anxiety. In the initial days, the origins, causative agent and means of transmission of what would later be called HIV, were unknown. Young men were presenting with a mysterious new syndrome, and I was fearful, not knowing who might be at risk, how widely and rapidly it would spread, and how we could contain it. San Francisco was an early epicenter, and as Director of Health, I had to make decisions without this important scientific information.

As more and more infected patients were quickly moving through the stages of this new disease and were dying, anxiety gave way to dread. A state of depression enveloped many of us, and like the effects of HIV itself, spread across the country to front line providers, and friends, relatives and acquaintances of infected individuals. Nationally, along with the understandable public fear, there were elements of discrimination and hysteria that grew, filling up the gaps in knowledge.

In San Francisco, there was a prompt outpouring of support, in the community, in city government, and by some health care providers, that gave comfort in the midst of these difficult times. That rallying and cooperation, the identification of the organism and its means of spread, and the development of some early treatments, provided some encouragement and even excitement in this heartrending situation. It became clear we were dealing with the quintessential public health problem, with all of its political, social, epidemiological and medical dynamics.

What was the environment (social, political, personal, etc) around you as you responded to the demands of the epidemic?

As Director of Health in San Francisco, I was fortunate to have support from the Mayor, the Board of Supervisors, and much of the public, in meeting the challenges of this new epidemic. My requests for funds were never rejected. The medical community was proactive and integral in meeting the growing demand for services.

Out of a close, collaborative approach by the city and the medical staff at San Francisco General Hospital grew what was to become known as the San Francisco Model: a case-managed continuum of care with emphasis on outpatient services. Socially, new alliances were formed for the purpose of aiding those affected by the epidemic.

There developed a close feeling; a strong sense that we were all in this together. We worked together, and we mourned together as wonderful friends began to die and memorial services became all too common. A dark pall descended over the earlier atmosphere of gusto in an era of gay liberation.

By contrast, at the national level, the seeming lack of concern in the White House not only bred apathy and adversely influenced public opinion, but also affected the ability of the important federal agencies to respond to the growing crisis.

Locally, the bathhouses became
symbolic of the public health dilemmas presented by this epidemic. Though only a small percentage of gay men were regular customers, these settings had represented a safe social and sexual haven. When it became evident that such businesses were profiting from sponsoring high-risk, even lethal, activities, I was faced with some tough decisions. Could the bathhouses become centers for health education and information? If not, should we close them unilaterally, or could we enlist the support of the gay community as allies? Would closure create a schism between the Department and the people it was serving, diminishing our work with the community on prevention? How should we address the legal requirements, and the possibility that closures would be overturned in court, sending the wrong message to bathhouse clientele? Would closure send the risky behaviors underground?

Almost from the beginning there were politicians and citizens, primarily outside the gay community, who felt the problem was simple: the bathhouses should be closed immediately. I disagreed. However, after failing to get support from the gay community or the cooperation of bathhouse owners to create a safe environment, I had no choice but to close them down.

When and where did the first “PWA” come into your life?

It is difficult to remember when I met the first “PWA.” Bobbi Campbell was, I believe, the first person living with AIDS to come out publicly, and was known as the “poster boy” for Kaposi’s Scarcoma. We met at the Health Department.

How was your personal life affected by your work in those years?

I feel blessed to have been the Director of Health for San Francisco during this incredibly challenging time. I had the opportunity to work with a completely dedicated medical team, outstanding individuals and groups within the lesbian and gay communities, and wonderful people both in the San Francisco government and in the community at large. The courage and commitment I witnessed was an inspiration to me, and will always remain so. I made some lifelong friends. I also received support and counsel from my wife and children, who appreciated both the gravity of the situation, and the long process that would be required to resolve it. It is always a privilege to serve at a time of need, to use one’s training at the cutting edge of a challenge. To my mind, HIV/AIDS is the archetypal public health problem for our time, so professionally as well as personally, I could not have had a more rewarding and transformative experience.

How would you characterize the first decade in terms of the status of the three voices? Medicine, Government, HIV Community?

Although many people do not realize it, we have learned more about HIV/AIDS in a shorter period of time than any other disease. Even though medical science has not come up with a cure or vaccine at this time, it has made amazing advances, the foundation of which was laid in those initial years. I am gratified to see among the newer physicians and researchers many who were there from the beginning and who are still active today. And we should not forget the many other healthcare workers who, in the chaos and uncertainty of that first decade, showed dedication far beyond the call of duty.

Many local governments, San Francisco, for example, did, and continue to do, a great job dealing with the epidemic. Nationally, the Administrations of Ronald Reagan and George H. W. Bush were utter failures, demonstrating little compassion and taking even less positive action to deal with this terrible epidemic.

The HIV Community was courageous, caring, supportive, and outspoken. They created a new brand of activism, which got governments to listen and respond, doctors to partner with them, and the pharmaceutical industry to not only reduce the price of anti-virals, but include community input into their decision-making.

Who were your heroes during this time?

Drs. Paul Volberding, Donald Abrams and Connie Wofsy were on the front lines when no one knew what was causing this syndrome and how it was being spread. They never retreated from the bedside or the clinic to protect themselves (and possibly) their families.

Drs. Mathilde Krim, and Joseph Sonnabend started the first foundation to deal with this new epidemic and Mathilde went on to co-found amfAR with Michael Gottlieb.

Hank Wilson, Cleve Jones, and others too numerous to mention who were some of the early activists and served as mentors for me.
“Fortunately the patients with HIV themselves had become my support system. I had witnessed the bravery of young men confronted with the lack of any prospect of survival, continuing their lives as best they could, sometimes assisted by their families and partners, some of them afflicted with HIV themselves.”

— Dr. Cesar A. Caceres

Cesar A. Caceres, MD
Internal Medicine & HIV Disease,
Washington, DC
Saw the first GRID case in Washington

When and where did the first “PWA” come into your life?
The first encounter was in early 1982. A bisexual patient, heavily into the gay fast track scene, came to my office with pneumocystis carinii pneumonia. That extremely rare pneumonia had begun to be reported in New York City in the late 70’s in patients with depressed immune systems.

What was the environment (social, political, personal, etc) around you as you responded to the demands of the epidemic?
Gay patients were concerned and curious about what they had heard about in New York City. The National Institutes of Health (NIH) established significant research interest in the area. The Bethesda Naval Medical Center realized the problem early and began testing extensively. The pharmaceutical houses had sulfa drugs for Pneumocystis. Trials began to test AZT and through many interesting lobbying techniques, AZT received an accelerated approval. Other medication followed rapidly. It was a time of exciting new developments medically.

How was your personal life affected by your work in those years?
After internship and residencies, I trained nine years to be a cardiologist. But my practice rapidly changed to HIV and the concerns of my gay patients.

In the second half of my first decade in HIV practice, reality struck when a regular number of patients began to die weekly. The realization? AZT was not a cure and that there was more to come, without relief. This reality led me to consider leaving the medical field.

Who were your heroes during this time?
Fortunately the patients with HIV themselves had become my support system. I had witnessed the bravery of young men confronted with the lack of any prospect of survival, continuing their lives as best they could, sometimes assisted by their families and partners, some of them afflicted with HIV themselves.

Being among such heroes has been an honor that now, 29 years later, continues to be my inspiration in life.
Paula Van Ness
Executive Director
Los Angeles AIDS Project
Recently chief operating officer,
Peter G. Peterson Foundation

What are some of your most vivid memories during the first decade of the epidemic?
My first encounter with AIDS Project LA (APLA) in late 1984/early 1985 came when I was asked to do a “board development training needs survey.” I met the most incredible group of people, heard their stories, and was instantly hooked. I needed to do something to help out; it just wasn’t right that the general public didn’t seem to be paying attention and people were so scared of people with AIDS. Soon after that session, I joined the board and became treasurer. I think the budget was a few hundred thousand and the staff was seven extraordinary people.

I vividly remember when Mathilde Krim and Elizabeth Taylor recruited Bill Misenhimer (then the executive of APLA) to join them in starting AmFAR. He turned to me and said, “I can only do this if I leave APLA in good hands. Will you do it?” I knew at that moment that if the board would have me, I would have to do it. I had the most amazing tenure there—and in short order we grew the budget tenfold, expanded services, and took care of more and more people.

The first AIDS Walk—I remember thinking, “No way will we raise the expected $50,000.” I was so wrong. We raised maybe $350,000. I don’t remember for sure.

The first Commitment to Life event—Elizabeth Taylor was so hands on. She called everybody she knew and asked them to get involved. We honored Betty Ford. There was no way I thought we’d raise a million bucks on one night, but we did. The program was amazing—the star-power was stunning.

I was privileged to be one of two non-government people at a strategic planning retreat to coordinate across governmental departments. I was there to represent community interests and make sure community-based organizations were included as real “partners” and that money would start to flow to those organizations.

I really connected with several key governmental leaders and learned how hard they also were working to make a difference.

Leaving APLA to join the staff at the Centers for Disease Control was a monumental step for me. So many of my friends in the AIDS community saw it as “selling out,” but I saw it as a chance to make a real difference. It was an incredible experience, but I was bruised and battered by running into brick walls. I only lasted about a year-and-a-half, but in that time we started the first national public service awareness campaign, started the AIDS Clearinghouse, expanded the National Hotline, created and sent out a mailing to every household in America, and designed and implemented an initiative to make grants to community-based organizations, particularly those serving minority communities. We partnered with a diverse cross-section of national and local organizations, and I was told, we changed the way CDC did its work forever.

Then in 1987, I had the opportunity to start National Community AIDS Partnership, which later became the National AIDS Fund and merged with the National Leadership Coalition on AIDS at the behest of The Ford Foundation. I will never forget my first meeting with the great Dr. David Rogers, who had agreed to chair that new initiative that would be housed at the National AIDS Fund.

It was a terrific experience. Again, I worked with incredible people and we
were the catalyst for engaging community leaders, particularly those in philanthropy, in planning for and responding to AIDS in their communities. I am proud of how we leveraged a relatively small amount of money to provide technical assistance to a number of communities so they could qualify for HRSA planning grants (pre Ryan White CARE Act).

Along the way I was blessed to know and work with my counterparts at organizations of all sizes in cities across the nation and deeply committed heroes in government.

And then there is Elton John, who with John Scott came to National AIDS Fund, where we created a partnership that funneled money to communities in a very significant way. I'll never forget Elton making a multi-million dollar commitment to this work and for allowing some of those resources to be used for prevention, not just care.

*When and where did the first “PWA” come into your life?*

At that first meeting with APLA, a young man living with AIDS told me his story, including an anecdote that will stay with me forever. He had been invited to the home of friends, where the table was set with beautiful crystal, china, exquisite silverware, and amazing flowers. But at his place was a paper plate with plastic utensils and a paper cup. The hosts, his dear friends, were afraid. My heart broke for him, just getting a glimpse of how PWAs were marginalized, and isolated, and feared. It wasn't right. I met and worked closely with, and admired so many others along the way, and always my work was inspired by knowing that they deserved better; that their AIDS diagnosis was not their fault.

*How was your personal life affected by your work in those years?*

I put my personal life on hold. My friendships were mostly with other warriors in the fight against AIDS. I never thought I would know and love so many gay men! I didn't date. I put my hopes of doing a single parent adoption aside. I felt like I had to give the cause everything I had and more. I felt privileged to do that and driven to make a real difference.

*How would you characterize the first decade in terms of the status of the three voices? Medicine, Government, HIV Community?*

Medicine: There were plenty of heroes in medicine and research. Doctors weren't always seen as reliable voices when it came to the subject of contagion. People like Michael Gottlieb, who I'd been privileged to know since that first meeting at APLA, kept plugging along, doing whatever they could.

Government: Moving the bureaucracy was extremely difficult, but some of were able to create miracles. Sometimes people in government were part of the problem, but in my experience, I saw incredible commitment and strength.

HIV Community: People accomplishing so much against all odds. Think of how people with little or no background in the nonprofit sector started organizations built a parallel service system to serve their clients, and created new fundraising tools that have been used again and again by others. People gave so generously of their time and talent. And particularly in the gay community, people gave generously, digging deeply into their pockets again and again.

And then there is Elton John, who with John Scott came to National AIDS Fund, where we created a partnership that funneled money to communities in a very significant way.

*Who were your heroes during this time?*

The people living with AIDS, their support systems and caring family members; the doctors, nurses, social workers; the researchers looking for cures and vaccines; the volunteers, board members and the staff members of CBOs; the government leaders and workers who gave it their all; the celebrities who modeled for others the generosity and compassion that was needed; the brave corporate sponsors and foundation leaders who funded programs. On my personal list: Ryan White, Richard Dunne, Elizabeth Taylor, Elton John, Bill Misenhimer, Steve Pieters, David Rogers, BJ Stiles and Larry Kramer.
(for his relentless loud voice and masterpiece, *The Normal Heart*).

What struck me most at the time was that people we did not know and would never meet were the reason why we were doing this work. It was the right thing to do. I knew it in my heart.

There is one other poignant memory that I want to share. When Rock Hudson died, the TV crews all wanted to do stories, but they didn’t want to enter the APLA office because of the fear of contagion. So we did interviews outside or at the park across the street.

I was so frustrated during one of those press events with the questions about “getting AIDS from being close to or kissing people with AIDS” that I gave a big smackeroo on the lips to the man sitting next to me who happened to be living with AIDS. I just wanted to demonstrate that you didn’t have to live in fear of “those people” and that with severely compromised immune systems, they probably had more to fear from the rest of us, than we had to fear about them.

I don’t know if I convinced anybody, but just hearing that loud, big kiss on the radio and seeing it on TV are among my fond memories of trying to harness the power of the media to touch peoples’ minds and hearts.

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**Paul Kawata**

the first executive director of the National AIDS Network, and now executive director, National Minority AIDS Council, Washington, DC

**When and where did the first “PWA” come into your life?**

In the early 80s, I owned a chic and trendy hair salon in Seattle, WA. We were a relatively small operation, with about 20 fabulous employees. But between 1983 and 1985, I lost six of them to AIDS — about a quarter of my staff!

Each death absolutely broke my heart. At the time, I was serving as LGBT liaison to Seattle’s mayor, and I tried to express the sense of urgency and despair that I was feeling to him. This need to do something, to make a difference, was the impetus for my move to Washington, DC.

**What was the environment (social, political, personal, etc) around you as you responded to the demands of the epidemic?**

In the early days, our lives revolved around hospital visits, funerals and mourning our friends. We would habitually read the obituaries because they always contained notices of someone we knew or loved. You would schedule your entire life around hospital visitation hours and memorial service times. It was absolutely devastating.

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**How was your personal life affected by your work in those years?**

Through the years, I’ve lost countless friends and even partners to this epidemic. There really wasn’t any way to escape unscathed.

It screwed with all of our emotions — the entire community. On the one hand, it made you shut down, and limited your capacity to be vulnerable. On the other, the sense of urgency and fear forced us to become very close, very quickly. Some of those first losses...it took me years to get over them.

**How would you characterize the first decade in terms of the status of the three voices? Medicine, Government, HIV Community?**

That first decade was probably the most frustrating for medicine. There was so little that those on the front lines could do. The nurses that I knew were amazing. But there really was no treatment at the beginning. All they could do was try to make their patients comfortable. For the government, it was a period of deafening silence. Most of our elected officials were hesitant to even acknowledge the epidemic. And for the community, it was a mad scramble to create an infrastructure that could respond to the crisis.

**Who were your heroes during this time?**

I had so many heroes during those early years. Probably the biggest were the nurses. They were incredible, tough, amazing people who fought so hard for my friends. I was also proud of the way the lesbian community stepped up. Until that point, in the broader gay rights movement, gay men and lesbians hadn’t really come together to form a unified voice.

But with the emergence of AIDS, all that changed. We shared a common purpose, and it was amazing to see. And lastly, I was so proud of the dignity gay men showed under unimaginable circumstances. With as much dignity as possible, we buried the dead and with as much courage as we could muster, we stood up and demanded action.

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**EDITOR’S NOTE:** According to UNAIDS estimates, there are now 33.3 million people living with HIV, including 2.5 million children. During 2009 some 2.6 million people became newly infected with the virus and an estimated 1.8 million people died from AIDS.
A Personal Story

In 1983, I was living in Hartford, CT, running a small community center by day and volunteering with several friends to create the Hartford Gay & Lesbian Health Collective in the evenings. Our main goal was to do outreach in the gay community to stem the tide of sexually transmitted disease through counseling and testing. The Hartford Gay & Lesbian Health Collective evolved into the present day’s AIDS Project Hartford service agency.

While doing this work, I met my first person with AIDS. He had returned from San Francisco to his parent’s home in West Hartford to face imminent death. I never will forget meeting him in his old bedroom, still decorated for a teenager. Here was a 30 year-old man, again depending on his mom to feed, dress and comfort him.

This first experience helped me to start to crush my denial about the disease. I, like many of my peers, had all kinds of theories about this strange disease targeting gay men, my brothers. I actually said at a party around that time, that this “thing is not a problem in Hartford, because it’s something that those guys who play around in the trucks on 9th street in the Village” get. I was now faced with a killer that was after me, because I was a gay man!

In 1984 I moved south to become the second director of AID Atlanta. During the summer of 1985 the First International AIDS Conference, sponsored by the Centers for Disease Control (CDC), was held at the Georgia World Conference Center.

I lobbied CDC to provide six eight-foot tables so community groups could display their information in what became the first “exhibit hall” for that 1985 inaugural event. In contrast, the last IAC’s exhibit hall used acres of space, a vivid indication of progress that has occurred.

We also received permission to produce, Atlanta native Rebecca Ranson’s 1984 play, “Warren”, one of the two plays widely regarded as the first to address AIDS on stage. Rebecca wrote the play in honor of her friend, Warren Johnston, who died of AIDS in San Francisco General Hospital’s Ward 5B.

Later, at the first presentation of the AIDS Quilt in Washington on October 11, 1987, I had the honor of reading Warren’s name to the crowd. I also had the dubious honor of appearing on the Sally Jessie Raphael show in Macon, GA about “AIDS testing”, where I actually needed an escort to leave the auditorium in safety after a very heated debate with Georgia State Representative “Billy” McKinney, who wanted people’s HIV test results posted on their driver’s license.

I moved to Washington, DC at the end of 1987.
hired by a consortium of community-based AIDS organizations led by Gay Men’s Health Crisis, to provide staff support for Dr. Frank Lilly, a GMHC board member in his role as a commissioner on President Ronald Reagan’s Commission on the HIV Epidemic. Apart from helping Dr. Lilly, I was to be a “mole” inside a commission that the AIDS community seriously distrusted. As it turned out, under the considerable leadership of Admiral James D. Watkins, the commission performed some valuable work.

Until the middle of 1988, I was director of the Koba AIDS Institute and Principle Investigator of a National Institute on Drug Abuse (NIDA) demonstration project to study and change the high-risk behaviors of intravenous-drug users (IVDUs) and their sex partners in Washington, DC; San Juan, Puerto Rico; Laredo, TX; and San Diego, CA.

I saw firsthand the effects that poverty and addiction have on the spread of life threatening diseases. I witnessed IV drug users line up morning and evening at the edge of San Juan’s municipal landfill, having ridden there on garbage trucks so they could scour piles of trash for scraps of metal. On their way out, they would stop at little shacks along the road to sell the metal so they could pay for their day’s fix.

I also experienced how cruel the opposition could be thanks to the ongoing rhetoric of some ignorant and fearful Senators and Congressmen as they consistently demonized Americans suffering from AIDS.

– Ken South

From 1989 to the end of the first AIDS decade in 1991, I served as Public Policy Director for the AIDS National Interfaith Network, where I worked on both the authorization of the Ryan White AIDS CARE bill and the Americans with Disabilities Act (ADA). I learned how working together in dedicated coalitions can make a huge difference in Washington.

A highlight for me was standing inches away from Dame Elizabeth Taylor in Senator Ted Kennedy’s hearing room for the rollout of the Ryan White AIDS CARE Act. I also experienced how cruel the opposition could be thanks to the ongoing rhetoric of some ignorant and fearful Senators and Congressmen as they consistently demonized Americans suffering from AIDS.

Throughout my career, I experienced the horrors of friends dying because of no treatment options, despicable levels of homophobia and bigotry, the fear of the unknown, as well as the amazing response of an AIDS community dedicated to creating a vast support system from scratch.

Today, I serve HIV/AIDS care providers as the director of membership services at the American Academy of HIV Medicine.

I’m proud that I have been fighting the good fight from the beginning and will continue to work for progress in the care and treatment of men and women with HIV.

ABOUT THE AUTHOR: Ken South is director of membership services at AAHIVM.
World AIDS Day
Looking Back: Seasons of Love

Based on Puccini’s ‘La Boheme’, the blockbuster Broadway musical Rent told the story of one year in the lives of friends living the Bohemian life in modern day East Village, New York City, around 1989-1990. In the course of the play, we learn that the friends are facing a number of challenges, including poverty, eviction and HIV infection at a time when AZT was the only available treatment option. In the hit song “Seasons of Love,” the cast confronts the age-old question, “How do we measure a year in the life?” According to the song, one obvious suggested answer is “Five hundred twenty-five thousand, six hundred minutes.”

By that accounting, over 15,500,000 minutes have passed since June 5, 1981 when the U.S. Centers for Disease Control and Prevention (CDC) issued its first report of five young men treated in Los Angeles for a relatively rare form of opportunistic pneumonia known as pneumocystis carinii (PCP). This isolated report in the CDC’s Morbidity and Mortality Weekly Reports was the first signal of the emergence of a global pandemic of what was to become known one year later as the Acquired Immune Deficiency Syndrome (AIDS). Looking back over the twenty-seven and one-half years since then, it is natural that we reflect upon all that we have experienced. How can we account for what we have learned in those 14 million, four hundred fifty-four thousand minutes?

Recognizing almost immediately the severity of this syndrome, the community-based Gay Mens Health Crisis was founded in New York City in 1982. One year later, in 1983, Drs. Luc Montagnier and Francoise Barre-Sinoussi isolated a virus that they named the lymphadenopathy-associated virus (LAV) at the Pasteur Institute in Paris, seminal work for which they were this year awarded the Nobel Prize in Physiology or Medicine.

Shortly thereafter, in 1984, this virus, which was also referred to as Human T-cell Lymphotrophic Virus-III (HTLV-III), and still later renamed Human Immunodeficiency Virus-1 (HIV-1), was recognized by Dr. Robert Gallo of the U.S. National Cancer Institute as the cause of AIDS. Later molecular analysis of tissue specimens would reveal that this bloodborne virus had been associated with previously unrecognized disease at least as far back as 1959, and was probably around for decades earlier.

1985 saw the approval of the first HIV antibody test, the founding of the American Foundation for AIDS Research, and the death of film legend Rock Hudson. But it was not until 1986 that President Ronald Regan first mentioned the word “AIDS” in public.

Other landmark events included clinical trials of AZT and the beginning of widespread promotion of AIDS education directed at prevention by condom use and distribution of clean needles. The births of community advocacy group, Act Up, the AIDS Memorial Quilt, the Global Programme on AIDS, and FDA approval of AZT occurred in 1987, as did the publication of Randy Shilts’ history of the early years, And the Band Played On..., and the deaths of entertainer Liberace and Chorus Line director, Michael Bennett.

1988 witnessed the births of the International AIDS Society and the AIDS Clinical Trials Group (ACTG), as well as the declaration of the first World AIDS Day on December 1. The following 525,600 minutes brought the deaths of choreographer Alvin Ailey and photographer Robert Mapplethorpe, major protests concerning AIDS drugs from the Golden Gate Bridge to the New...
York Stock Exchange, and the endorsement of the parallel track policy for making new HIV drugs available to individuals who did not qualify for clinical trials.

In 1990 the Ryan White CARE Act was established by Congress. Named in honor of this brave young man who passed away at age 18 in April of that year, the Act provided federal funds for community-based care and treatment. Also that year, the Americans with Disabilities Act prohibited discrimination against people living with HIV/AIDS.

1991 saw further advances in AIDS awareness with the introduction of the Red Ribbon, the passing of rock singer Freddie Mercury, and the announcement by Magic Johnson that he is HIV positive. The tenth anniversary of the first case reports found over 10 million HIV infected persons worldwide, roughly 1 million in the U.S.

By tennis legend Arthur Ashe’s announcement of his AIDS diagnosis in 1992, the illness had become the number one cause of death for U.S. men ages 25-44. Ashe passed away the following year, as did ballet performer Rudolf Nureyev.

The landmark ACTG 076 study, published in 1994, demonstrated that a regimen consisting of AZT given ante partum and intra partum to the mother and to the newborn for six weeks reduced the risk of maternal-infant HIV transmission by approximately two thirds. But, the joy of that victory was dimmed by the passing of Elizabeth Glaser, co-founder of the Elizabeth Glaser Pediatric AIDS Foundation.

The approval in 1995 of the first protease inhibitor, saquinavir, and in 1996 of indinavir and ritonavir, the non-nucleoside reverse transcriptase inhibitor nevirapine, as well as viral load testing, ushered in a new period of optimism, as antiretroviral combinations composed of different drug classes could be combined to demonstrably impact HIV replication and the progression of associated disease.

For the first time in the history of the epidemic, the number of new AIDS cases declined. As Time magazine named AIDS researcher David Ho its “Man of the Year,” the journal Science proclaimed the new Highly Active Antiretroviral Therapy (HAART) for HIV its “Breakthrough of the Year.”

By 1997, as the U.S Department of Health and Human Services issued its first national guidelines for the use of antiretroviral therapy, AIDS-related deaths in the U.S. declined by over 40 percent.

Yet it was clear that many critical challenges remained, including growing signs of treatment failure and side effects from HAART, and the daunting challenge of supplying medications to those in desperate need throughout the world. By 2000, the U.S. and U.N. stepped up their HIV efforts, declaring the disease a threat to global security, forming a Global AIDS Program, and authorizing hundreds of millions of dollars for global HIV prevention and treatment activities.

Despite all of these advances, by 2002 HIV became the leading cause of death among individuals aged 15-59 worldwide. The Global Fund to Fight AIDS began that year; and, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) took form in 2003. By 2006, with the passing of the first quarter century since the first AIDS case reports, the CDC dealt perhaps a final blow to AIDS exceptionalism, by revising HIV testing guidelines for health care settings, to recommend routine screening for all aged 13-64, and yearly screening for those at high risk.

We have come so far these last 14,454,000 minutes; yet, we clear-
ly have so much farther to go. Latest estimates indicate that 33 million people, including 2 million children, are now living with HIV/AIDS worldwide; and, despite all efforts, 2.7 million new infections and 2 million deaths occurred in 2007 alone, bringing the total death toll to 25 million since 1981. Disturbingly, in developing nations, only roughly one third of individuals in immediate need of HIV therapy are receiving it.


However, what I will remember most is how partnerships, persistence, patience and kindness can conquer alienation, anger and fear. As the theme from Rent concludes, “Though the story never ends, let’s celebrate. Remember a year in the life of friends. Remember the love. Measure your life in love.”

**About the Author:** Dr. Joseph S. Cervia is clinical professor of Medicine and Pediatrics at the Albert Einstein College of Medicine. He is Attending Physician at the Center for AIDS Research and Treatment and the North Shore/Long Island Jewish Health System, and Medical Director and Senior Vice-President at Pall Medical in Port Washington, NY. Contact: cervia@lij.edu, joe_cervia@pall.com.
Focus on the Future
Second Decade Campaign is Launched

2011 MARKS THE 10TH ANNIVERSARY of the American Academy of HIV Medicine. While we celebrate our past, our focus remains on the future. To better serve our membership, the HIV patient and the HIV community, AAHIVM will launch its Second Decade Campaign with a series of new programs and updated communications tools. These include a new website, a major report on HIV and aging, a new HIV pharmacist credentialing program, a HIV medical technology award.

The core of the Second Decade Campaign is the re-launch of the Academy’s website, www.aahivm.org. The new site offers visitors a variety of services and information. Here are some feature highlights:

- **Daily HIV News Feed** This daily news feed is available on the homepage for all visitors. The feed will be updated each day with relevant news articles on HIV research and advocacy.

- **Provider Discussion Forums** These members-only forums will give providers across the country the ability to communicate with each other on treatment dilemmas, clinical trial opportunities, patient protocols and local advocacy initiatives.

- **Job Bank** Whether looking for a job or posting an opening in your clinic, the job bank with showcase the leading job opportunities for HIV practitioners.

**Referral Link National Database** AAHIVM’s nationwide resource database, known as Referral Link, began as a pilot online referral network developed in conjunction with the Centers for Disease Control and Prevention (CDC). Referral Link launched to assist general practitioners in identifying HIV providers and other resources in their geographic areas for their newly-diagnosed HIV patients. The directory also serves to verify the Academy-certified status of HIV care providers.

**State Bill Tracker** Another new addition to the AAHIVM website is a comprehensive state legislation tracking tool that will allow AAHIVM members to stay updated and get involved on HIV-relevant bills pending in their state government.

“We are excited to provide our members and visitors a dynamic, interactive online experience,” said James M. Friedman, executive director of AAHIVM. “The goal of the new website is to create a robust daily destination for current HIV news, resources and networking opportunities.”

To provide your thoughts or ideas on the new site, please email us at websitefeedback@aahivm.org.

Haven’t visited the new AAHIVM website? Here are a few tips to help you get started

**Brand New to AAHIVM?**
While not required to browse the AAHIVM website, we invite you to create a basic profile for free by visiting www.aahivm.org. You may then proceed with joining AAHIVM as a full Member if you wish, or availing yourself of our many other services. Your profile provides ongoing access to your public and private information, your Membership and Credentialing status, and your activity history with AAHIVM. Please note that many key features of the new AAHIVM website are for Members only.

**Current AAHIVM Members and Credentiallees**
Current and recent AAHIVM Members and Credentiallees have been automatically enrolled with an online profile (a log in account), and have been emailed with their new log-in information (all former passwords have been reset).

Please log in to verify or augment your professional contact information, update your directory display settings, change your password, verify your Member or Credentialing status, join or renew your Membership, enroll in Credentialing services, order publications, register for a workshop, or utilize other services. If you have not received your new username and password by email, please contact us at websitefeedback@aahivm.org.

**NOTE:** Member and Credentiallees profiles that have an institutional affiliation on file with the Academy (i.e., a clinic, hospital or work address) have been automatically published in the new public directory. If you wish to remain active with AAHIVM but keep your information unpublished, please select the appropriate option from within your profile (this will not deactivate your Membership or any other service).

**Former AAHIVM Members and Credentiallees**
If you are a former AAHIVM Member or Credentiallee, your profile is active but has not been posted in the public directory. Your user name has been set as the most recent email address on file for you at AAHIVM. To obtain your password, please use the “Forgot Password” feature on the log in screen. You will be emailed your temporary password at which time you can log-in to view and update your profile.

You will note there are several new Members-only areas of the website; we welcome you to join as a Member by clicking JOIN under the membership tab (while logged in). It is important to note that having an updated or published profile does NOT indicate active AAHIVM membership.
New at the Academy in 2011

*HIV & Aging* clinical guidance, to be released in the Spring

A new HIV Pharmacist (AAHIVP) Credentialing program

$20,000 award for innovative technology in HIV practices

An all-new, interactive Website, featuring:

- *Provider Discussion Forum and Job Bank*
- *National Expansion of Referral Link, our HIV care provider resource directory*
- *The AAHIVM State Legislation Tracker for your state*
- *Daily News Feed of the top national HIV news*
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