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After more than 450 trainings for over 5,000 service providers, here's what we've learned.



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When compared with their younger counterparts, fewer older adults get tested for HIV or use condoms.

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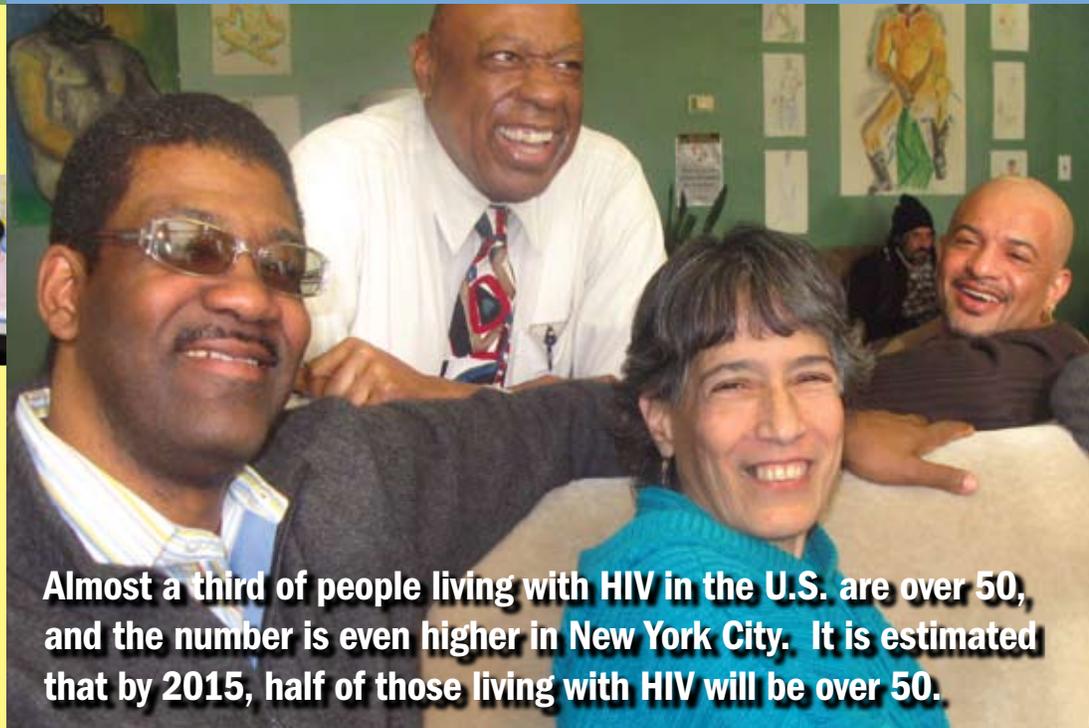
An overview of the aging process and what is seen in people with HIV.



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Achieve is a joint publication of
ACRIA and GMHC.



Almost a third of people living with HIV in the U.S. are over 50, and the number is even higher in New York City. It is estimated that by 2015, half of those living with HIV will be over 50.

Growing Older with HIV

by Sean Cahill and Alana Krivo-Kaufman

While many older adults with HIV are longtime survivors, others are newly infected. Among people over 50, new diagnoses increased by 25% from 2006 to 2007. Since 2003, the number of newly diagnosed women 50 and older has gone up by 40%. Overall, people over 50 made up 15% of newly diagnosed cases of HIV in 2007, and almost 17% in the first half of 2008.

We must address the unique complications and challenges of aging with HIV. The fact that people with HIV are living into their 50s, 60s, and 70s is testament to the amazing success of HIV treatment. It is critical that policies address the particular needs of HIV-positive older adults.

Epidemiology

First and foremost, we need to know more about this population. Targeted research and data collection must be increased. This information is necessary to guide the development of prevention, treatment, and care protocols. For programs funded by Congress, the numbers are essential to show that the need exists. The Older Americans Act could provide funding and services for HIV-positive older adults as a "vulnerable population."

The National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) need to develop and expand research. The CDC's epidemiological data track the transmission and spread of HIV. This information is vital to understanding how HIV is affecting older adults. But current CDC surveillance systems do

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ACRIA Trials in Progress

Pomegranate Juice

People who have not taken HIV meds for at least 90 days will drink pomegranate juice or placebo juice daily for 10 to 18 weeks to study its effect on the heart, quality of life, and HIV viral load.

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People 18 and older who have persistent diarrhea will take crofelemer (a new anti-diarrhea drug) or placebo tablets for 6 weeks. Then everyone will take crofelemer for 5 months.

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People who have taken HIV meds will take Intence with Reyataz and an NRTI for 48 weeks.

Isentress in Pregnant Women

Pregnant women who are already taking Isentress will give several blood samples on two separate days in order to find the optimum dose of the drug during pregnancy. Compensation is provided.

For more information on these trials, contact us at 212-924-3934, ext. 121.

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DESIGN

Tom Dolle

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LETTERS TO THE EDITOR

To the Editor:

I received your Summer 2009 publication of *Achieve*, and found it very useful. The article "When To Start: A Debate" was informative and pertinent to me. I appreciated your thorough and accessible review of the medications and different physician's opinions on when to start HIV treatment. I am currently incarcerated, so I don't have that access to the professional opinions of a whole panel of doctors. However, after reading the article I felt much more confident in managing my treatment plan and navigating all of the medical guidelines.

John

Photos used in *Achieve* imply nothing about the health status, sexual orientation, or life history of the models.

To The Editor:

Thank you for sending your publication. I've had the opportunity to read several of the articles in your last issue and have found them to be an invaluable source of information, presented in a super understandable manner.

Sergio Vásquez

Executive Director,
Asociación Gente Positiva
Guatemala

Achieve would love to hear from you!
Please send your comments to: Letters to the Editor, *Achieve*, 230 W. 38th St., 17th floor, New York, NY 10018
Or email them to: achieve@acria.org

not break down the data in ways that are specific enough. They should be modified so that all data are consistently broken down by five-year age intervals, up to age 65. Additionally, risk factors for infection must be tracked for older adults. Behavioral data on HIV-positive older adults should also be collected by the NIH to understand what interventions will be effective.

Clinical Research

More clinical research relevant to people over 50 with HIV is needed. The NIH must expand HIV treatment research to include older adults. It is critical that we gain a greater understanding of how treatments interact with aging bodies. Due to the high prevalence of comorbidities among older adults with HIV, they are often screened out of clinical trials. As a result, this research reports little on how medications will affect them.

Additional NIH research on non-AIDS-related cancers (NARCs) is also necessary. From 2000 to 2005 incidences of NARCs increased. Some of the most common NARCs include anal and cervical cancer, lung cancer, and liver cancer. People living with HIV may be at an increased risk for developing NARCs, particularly those associated with infections like HPV. More research needs to be done to increase our understanding of what risks older people with HIV face in developing NARCs.

Prevention

Most HIV prevention campaigns have been developed for people under 50, but programs must be developed that speak to older adults. CDC funding for prevention targeting older adults needs to be increased to meet their specific public health challenges. Increased funding is needed to develop social marketing campaigns, create additional Effective Behavioral Interventions (EBIs), and implement interventions addressing stigma among older adults.

Social marketing campaigns targeting older adults are necessary to spread knowledge of sexual health and encourage safer sex. Studies show that many people over 50 are sexually active, but that levels of sexual activity taper off with increased age and are lower for women than men. An AARP study asked adults between 45 and 59 about

recent sexual activity. Half of the women and 55% of the men reported sexual activity within the previous six months. Of those between 60 and 74, one-quarter of the women and 31% of the men reported sexual activity in the same period. Stark gender imbalances exist among older populations, with women outnumbering men. When there are many more women than men, older heterosexual women have less power, putting them at a disadvantage when negotiating condom use. Campaigns promoting

Behavioral Interventions (DEBI) program. But the CDC must also develop DEBI models tailored to older adults. DEBIs that have worked in other communities cannot simply be transferred. Strategies must be developed for older adults, and must address the disparities, stigmas, and power imbalances among older adults.

Alongside DEBIs, other interventions and structures must be developed to address HIV stigma and homophobia. Stigma related to homosexual behavior



condom use and the female condom could provide important tools for older women.

Many sexually active older adults take part in high-risk activities. ACRIA's *Research on Older Adults with HIV* (ROAH) study looked at older adults living with HIV in New York City. Of those who were sexually active, 47% used drugs or alcohol before sex. Another study found that 60% of older single women have had unprotected sex within the past decade. The CDC reports that over half of older African-American women living in rural areas have at least one risk factor for HIV, including unprotected sex. Many older adults lack sexual health knowledge and are unaware of the need to protect themselves.

Effective Interventions

The CDC currently supports proven HIV prevention models for use across the U.S. through its Diffusion of Effective

among men is likely a strong driver of HIV risk, including among older men who have sex with men (MSM). Data collected in New York City suggest that older men are underreporting MSM activity as a risk factor when compared with younger men (there is not a similar difference for women). If older men do not report their risk factors even in an anonymous survey, they are unlikely to talk about them in other contexts, such as with their doctors. This lessens their access to information that could help them practice lower-risk activities or know their HIV status. Addressing these issues requires culturally competent services for older people. Significant antigay bias has been found in senior centers and services, among both providers and clientele. Staff trainings and peer-to-peer outreach and education are needed to address these biases.

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Antigay bias and HIV stigma could be keeping older men from disclosing their sexual risk factors. A NYC Department of Health study looked at MSM of all ages. It found that 39% do not disclose their sexual orientation to their doctors. Black, Latino, and Asian MSM are much more likely than white MSM not to disclose homosexual behavior to health care providers. In general, doctors tend not to ask older patients about their sexual practices – this is common for older patients of all sexualities and genders. This silence keeps doctors from assessing their patients' risk factors, and can lead to serious health problems.

Geriatrics

Not enough medical professionals are trained in geriatrics (medical care for the elderly). As the country continues to age, this problem will worsen. As of 2002, there were only three geriatrics departments in medical schools nationwide. Only 10% of medical schools require that doctors in training take even a single geriatrics course. The programs that exist are understaffed and underfunded. Geriatrics programs in medical schools need to be supported and expanded. Retention in the workforce must also be supported to attract more doctors. Additionally, the current geriatrics workforce must be trained in the needs of HIV-positive older adults.

Medical and social service providers can be a key point of intervention if properly trained. Continuing education for medical professionals should emphasize the importance of assessing every patient's risk factors by asking them thorough questions – not making assumptions about sexual history or drug use based on age. HIV testing for all patients is a key prevention mechanism. Due to the fact that many older adults remain sexually active, the CDC should increase the recommended maximum age for annual HIV testing above the current age of 64.

HIV Disease in Older Adults

The U.S. government must also do better to monitor the conditions that people with HIV experience as HIV progresses with age. With better recognition of these conditions, we can modify standards of care. This will in turn help us better

understand how HIV and aging processes interact. Additionally, screening and prevention measures are available to reduce risk for NARCs, such as anal and vaginal pap smears, the hepatitis B vaccine, and reduced alcohol and tobacco intake. These measures should be broadly instituted and available for older adults with HIV.

Up to 91% of older adults with HIV deal with other medical conditions, including high blood pressure, nerve problems, hepatitis, arthritis, and depression. Many older adults receive some type of medical care for these conditions. So a significant portion of potentially affected older adults have a point of contact with a medical provider. This offers a unique opportunity for doctors and service providers to make a large impact on preventing HIV infections and assisting older adults in finding out their HIV status.

In general, doctors tend not to ask older patients about their sexual practices – this is common for older patients of all sexualities and genders.

Recommendations

GMHC and ACRIA, together with SAGE and GRIOT Circle, recently held a strategy planning meeting on HIV and older adults in Washington, D.C. Hosted by AARP, the meeting included advocates, policy experts, and federal officials. Funded by the MAC AIDS Fund, this was the first wide-ranging conversation among key players in both HIV and aging circles at the federal level, but it will not be the last. A key outcome was the agreement to come together again after the issuance of a policy paper on HIV and older adults in early 2010. Given the significant differences between aging and HIV providers, just understanding how best to approach prevention and services will require the commitment of all parties. A few important recommendations emerged from the meeting.

- Our understanding of older adults with HIV and those at risk is quite limited, making it difficult to know what is needed for prevention or services. A targeted research effort

should run the gamut from drug clinical trials to behavioral and psychosocial research to the development of evidence-based prevention initiatives targeted at older adults.

- More training and technical assistance for both HIV and older adults providers is needed to improve services in senior settings for those with HIV or at risk of infection. HIV providers need continuing education on what we know about older adults with HIV. Senior providers need education on HIV basics, stigma, discrimination, and other topics. A key training need is to increase the number of geriatricians generally and to increase the number with knowledge of HIV. We must also increase the number and competence of NPs, PAs, nurses, social workers, case managers, and others with regard to this population.

- There is a need for greater advocacy not only at the federal level, but at the state and local levels as well. This collaborative advocacy should be targeted at key HIV and aging allies among elected officials, as well as with the government agencies charged with funding and overseeing HIV and senior services.

In sum, legislation and funding aimed at older adults and people with HIV should focus on research, education, and collaboration, improving our understanding of this growing population and how best to meet their needs, given the realities and limitations of our existing service networks. As older adults will constitute more than one-half of all persons with HIV in the U.S. in the next ten years, the time to act is now. ■

Sean Cahill is Managing Director, Public Policy, Research and Community Health and Alana Krivo-Kaufman is the Community Organizing Coordinator at GMHC.

by Hanna Tessema, Lisa Frederick, Jack Denelsbeck, Cesar Angel and Karol Markosky

Myths die hard. Up until a few years ago, the idea that older people were at risk for HIV, or that younger people with HIV were living long enough to *become* older people, was generally dismissed or ignored. Even among service providers and medical professionals, the thought of grandma having an active sex life or doing drugs was uncomfortable. AIDS organizations clung to the youth-focused approach developed in the early days of the epidemic, even as some of their clients approached Social Security age.

Only recently, notably with the 2006 release of ACRIA's landmark *Research on Older Adults with HIV* (ROAH) study, has the issue of HIV and aging begun to receive serious attention. In New York City, with the support of the MAC AIDS Fund and the New York City Council, and working with a consortium that includes the Council on Senior Centers and Services, Gay Men's Health Crisis, GRIOT Circle, Services and Advocacy for GLBT Elders, the Hispanic AIDS Forum, and Una Sola Voz, ACRIA has provided training to HIV service providers, aging service providers, and faith-based organizations across the city and helped to build bridges between the organizations. Sessions ranged from two-hour trainings on HIV basics to comprehensive four-day trainings, technical assistance, and capacity-building.

Our efforts went national in 2008, again with MAC support for intensive technical assistance and capacity building assistance packages for aging and HIV service providers in Miami and New Orleans. In 2009, MAC supported similar efforts in San Francisco and Washington, D.C., and also brought together a national policy meeting of ACRIA, SAGE, GMHC, and GRIOT Circle.

Since 2007, ACRIA and its partners have conducted more than 450 trainings for over 5,000 HIV and aging service providers throughout New York City. In addition, we are conducting an ongoing prevention program called Community PROMISE that works directly with seniors. So far, over 60 seniors have created narratives to bring the prevention



Older Adults Trainings

Stories from the front lines

message to their peers. On the national level, we have provided training and technical assistance to over 80 HIV, aging, and faith-based organizations, sowing the seeds for a national network of providers interested in open and honest dialogue regarding sexual activity and drug use among adults over 50. Here's some of what we've learned.

Starting The Conversation

The first hurdle was that many aging service organizations were not ready to have any conversation about HIV. At the same time, many HIV service providers told us their caseloads were graying and that they had newly diagnosed clients who were over 50. Most reported having never seen any prevention messages for older adults.

It's easy to assume that HIV service providers know the basics of HIV, but we have found that that isn't necessarily the case. So we've learned to stack our building blocks carefully. We ask participants to rate their knowledge of HIV on a scale of 1-10. HIV service providers often respond with a resounding 9 or 10, and the senior service providers generally between 3 and 5. But during an exercise on HIV transmission, it often becomes clear that this topic is needed for

both groups – it gives the aging services providers a starting point, and for those who know more, it's often a wake-up call that there are grey areas when it comes to their knowledge.

Initially, there was a lot of resistance: "I can't talk to my grandma about sex!" or "Old people don't have sex or do drugs." We had to convince some providers that sexual desire and activity does not disappear with age. And most importantly, there is a serious HIV knowledge gap among many seniors.

At one of the first trainings, at a health center in the Bronx, the level of HIV knowledge was low and the stigma around older adults having sex high. The staff laughed about it, but also seemed bothered by the fact that their residents were having sex. They reported that on "check day" young girls would come to the center. Their dismissive attitude toward the residents' sex lives interfered with the learning process.

At one large city agency that provides financial assistance to people with HIV, a trainer was told he was being disrespectful and offensive because the audience was a mix of men and women. The staff felt that mentioning vaginal secretions and semen

continued on next page

was not acceptable in mixed company, that talking about safe sex was not in their job descriptions, and that talking to a senior about sex would be inappropriate. At a senior center in Queens, one staff member was unable to use the words “vagina” and “penis.” She used pet names instead, which made everyone uncomfortable.

Sometimes it was the clients who weren’t interested in hearing about the topic. One workshop was scheduled in place of bingo, which did not sit well with some of the seniors. After the training began, one angry participant announced that they all wanted the trainer to leave because the topic was unimportant and irrelevant, and what they really wanted was to play bingo!

But we also heard stories from senior service providers about clients that they knew were at risk. For example, one director shared the story of an older man at her center. He frequently paid for a prostitute, while still having sex with his wife. And he didn’t use condoms with either. Another director shared her experience on check days. “I often see a mattress outside the building when I know that they’ve gotten their checks.” Service providers also mentioned noticing used condoms around staircases in senior residential facilities, and many senior center directors reported being certain that their seniors were sexually active.

“Aha!” Moments

Sometimes participants shared very personal experiences. These most often related to the stigmas of age and HIV. At the end of one training, a woman said, “I have a new boyfriend. I’m 68 and he’s 72. He’s very nice to me and I am thinking about being intimate with him. I never thought safer sex was important, but after today I know that it is. But I don’t know how to start the condom conversation with him.” She looked at the rest of the women and asked, “What would you do?” Another woman stood up and addressed all of us. “This has been so helpful to me,” she said. “My niece recently told the family that she was HIV positive. I have to admit that I’ve been very nervous around her since then. Now I know that I can’t get HIV from her just by hugging her, eating with her, or talking with her. I am so happy that I got this information.”

One woman in her 60s said very somberly, “I think the best thing for us to do is to abstain.” Another woman, about the same age, turned to her and said “No, you abstain!”

Other “Aha!” moments had to do with how you can and can’t get HIV. The most notable moments came as we dispelled common myths about HIV, answering questions like “Can both men and women get it?” and “Can men get HIV from women?” The most common misconception was that you can get HIV from using a public restroom.

One of the funniest moments came at a peer training, when one woman in her late 70s commented on her sex life by saying, “I may be old, but I ain’t cold!” We found this to be a compelling statement, showing that many seniors want to discuss these issues but have not been given the opportunity.

At a nursing home in Queens, one woman in her 60s said very somberly, “I think the best thing for us to do is to abstain.” Another woman, about the same age, turned to her and said “No, you abstain!”

At a workshop at the LGBT center in Manhattan, groups were formed by age. The over-70 group was the most vocal and was clearly enjoying the topic of sex and seniors. When each group reported back on their discussions, the spokesperson for this particular group stood up and said, “There’s no expiration date on sex...sex ends when you die!” The group cheered.

One activity, “Forced Choices,” asked participants to agree or disagree anonymously with short statements like “70-somethings are sexy” or “older adults should encourage their HIV-positive children to have babies.” Participants then exchanged papers and were asked to defend each other’s responses, whether they agreed with them or not.

More than a few providers found it difficult to detach themselves from their opinions and beliefs – for example, that older adults don’t have sex or abuse drugs – but some were able to acknowledge how these beliefs may negatively affect the services they provide. The “How to Talk to Seniors about Sex” section gave participants the opportunity to define healthy sexuality along a broad spectrum of age groups, often coming to the conclusion that age is not an indicator of a person’s sexual desire or practices.

Overall, senior service providers in New York City have been fairly open to this issue, but some resistance does exist, most often due to cultural and religious reasons coupled with ageism. At some senior service providers, the subject of HIV and aging is initially greeted with shock, and sometimes avoidance and discomfort. But in others, directors have become very committed to the issue, scheduling sexuality education sessions and making condoms available at their centers. One director got tested for HIV in front of all the seniors, to make them more comfortable with the process and to encourage them to get tested.

When we’ve asked senior centers to host trainings, resistance hasn’t been solely about discomfort – often it is a logistical issue relating to a lack of space at the center. Many senior centers are small and don’t have a lot of extra space that can be used for the extended period of time that is required for some trainings. Another issue is that senior centers may share space with other organizations, which can cause logistical problems in setting up trainings.

Different Orgs, Different Approaches

Aging service organizations generally have fewer staff members than HIV services organizations. This became an issue when we tried to do full-day trainings at senior centers – most were not able to allow staff members to attend multiple-day trainings. As a result, we had to tailor the trainings and make them shorter. Sometimes senior centers would allow for multiple-day trainings as long as each did not last longer than two hours.

We also had to take the time to learn each other's language. HIV providers, for example, often use jargon and acronyms without considering that workers in the other field may not be familiar with them. Those working with seniors may assume that HIV providers have a greater knowledge of the ailments of aging than they actually do. Another significant difference is that in aging services, older adults are often defined as those 60 and older. In HIV services, an older adult is defined as a person who is over 50.

Aging service organizations tended to be more culturally conservative with regard to discussions about sex and HIV,



although this was not always the case – some did welcome the conversation. When they talked about health, it meant diet and nutrition, exercise, and preventing diabetes and hypertension, etc. – not HIV. Overall, it was more often the providers who were not ready to discuss sex and HIV transmission rather than the seniors themselves.

Highs and Lows

In the past three years, we've been able to create a strong group of trainers throughout New York City and to begin dispelling common myths about HIV transmission among aging services providers. Most importantly, we've created a national network of provid-

ers interested in increasing HIV health literacy and prevention among older adults.

Some service providers came into trainings saying things like “I don't buy bottled water on the street because I'm afraid that people inject HIV into the bottles before selling them” – revealing a great fear of HIV as well as a lack of knowledge about how HIV is transmitted. We have been able to have frank discussions about these concerns, which we hope will translate into better services to clients.

We found a real fear of HIV among some seniors, and some were unwilling to change their beliefs regarding HIV transmission. One woman claimed she had

been a nurse for many years and used that experience to try to convince the group that they should be concerned about getting HIV from a toilet seat.

What Have We Learned?

- Most older adult agencies do not provide adequate HIV services to the high-risk 50- to 65-year-old group, and many serve only clients who are over 60.
- Participants identified a need for more targeted prevention messages.
- Agencies that provide services to older adults are not convinced that those with HIV should use their services.
- Aging services organizations are largely unaware of the aging HIV population.

- Significant cultural differences between HIV and aging services organizations create barriers to needed collaboration.
- HIV stigma is significant among staff and clients at senior centers.

What Works?

- Targeting older adults service providers
- Partnerships between HIV service organizations and agencies serving older adults
- Encouraging networking between HIV service providers and older adult agencies, locally and nationally
- Increasing knowledge, changing attitudes and beliefs, and monitoring this with evaluation tools
- Addressing HIV stigma and ageism as two separate but related issues
- Mainstreaming HIV services into older adult services

Recommendations

- Provide the material in “bite-size” morsels that make it easy to digest. Busy senior service providers have to cover many aging issues, not just HIV.
- Give service providers activities and materials they can use with their clients directly.
- Start with the basics – it's astounding how many myths are still out there, even among people who have worked in HIV.
- Don't be crude – when working with people who are not in the HIV field, be sure to use language that they're comfortable with. They may not use “street” terms and may not respond to graphic descriptions of sexual acts.
- HIV service organizations must collaborate with aging service organizations and be willing to engage in open dialogue about the issues and ways to integrate services.
- Continue integration through creative methods, particularly in conservative senior centers that may not be open to candid dialogue about drug use, sexuality, and HIV. This is one of the most important factors in successfully running these types of programs. ■

The authors are trainers and consultants for ACRIA. Karol Markosky is HIV/AIDS Education Coordinator for CSCS.

Prevention Strategies for Older Adults

The popular belief that older persons rarely have sex or multiple partners has encouraged the belief that they are not vulnerable to HIV infection. Yet research shows that sexual behavior plays a significant role for most people throughout life and that many people in their 80s and 90s remain sexually active.

by Judith A. Levy and Theodore Hufstader

People of any age who have unprotected sex are at risk for HIV. When compared with their younger counterparts, however, fewer older adults get tested for HIV or use condoms. They also are less likely to perceive themselves to be at risk for HIV or to take action to protect themselves. Many take no preventive action.

Like their younger counterparts, many older people use dating services and other methods to find partners. The internet has become an inexpensive and ready means to “hook up” or to search for lifelong companionship. Jane Fowler, founder of HIV Wisdom for Older Adults, reminds us through her own experience that newly single older adults often have little experience navigating the contemporary dating scene, including negotiating safer sex or starting conversations about condoms. Meanwhile, drugs like Viagra have enhanced the sex lives of many older and even younger couples. But unless safer sex is practiced, it could fuel increases in HIV transmission.

Recreational drugs pose a second risk factor for older adults. For many years, people who use drugs were thought to either die or “mature out of the life” by the time they reached their 50s. This assumption proved false when early HIV street outreach programs designed to prevent HIV among injecting drug users (IDUs)

discovered unexpected numbers of older adults in the U.S. still shooting drugs. Most of these elderly IDUs began using heroin in their teens and early adulthood, followed by continuing careers of drug injection throughout their lives.

In contrast, late onset drug use is a relatively new drug behavior that has only recently been recognized as a source of HIV infection. In one of the few valid scientific studies of this trend, researchers at Emory University found that men and women who began using crack later in life differed by gender as to why they started drug use, number of sexual partners, and level of sexual activity. But both men and women had unprotected sex with high-risk partners.

Older Persons Are Not All The Same

Older men who have sex with men (MSM) face a unique set of challenges when it comes to HIV prevention. Having experienced stigma or discrimination at an earlier age, they now confront ageism as well as homophobia. Also, many gay men over 50 lost lovers and friends to the devastating effects of the AIDS epidemic in the 1980s and 90s. While some evidence suggests that this experience can enhance motivation to practice safer sex, current debates among gay men suggest that this norm may be changing due to such factors as “condom fatigue” and treatment optimism.

As they grow older, women who are sexually active also confront age-related factors that place them at special HIV risk.

At menopause, decreased lubrication during sex and general thinning of the vaginal wall due to lower circulating estrogen can lead to abrasions and tearing during intercourse that facilitate entry of the virus. The woman and her partner also may be less likely to use a condom for contraceptive purposes once she is past childbearing age.

Among drug users, the social isolation that often characterizes their lives as older adults has important implications for both HIV risk and the use of AIDS-related services. Research by Levy and Anderson has shown that as they age, street drug users tend to shift from active participation in the general drug scene to covert drug use along its margins. Here they form a hidden population often relegated to performing the socially lowest work within the drug-trafficking world in order to obtain drugs. Often injecting drugs alone or with “running bud-

THE RATE OF NEW HIV INFECTIONS FROM 2001 TO 2005 IN OLDER ADULTS WAS TWELVE TIMES HIGHER AMONG BLACKS AND FIVE TIMES AS HIGH AMONG LATINOS COMPARED WITH WHITES.

dies” of the same age, fear of possible street violence from younger users or unintentionally coming to the attention of the police hampers their likelihood of seeking testing or accessing HIV services. Unfortunately, there appears to be little to nothing known about the HIV risk of more affluent older drug users or that of occasional recreational users.

Considerable racial disparity exists among older adults in terms of contracting HIV. Linley and colleagues found that the rate of new HIV infections from 2001 to 2005 in older adults was twelve times higher among blacks and five times as high among Latinos compared with whites. Older gay men of color are at triple jeopardy for HIV due to risks related to the stigmas of age, same-sex behavior, and race. Research conducted by David Jimenez in Chicago found that 37% of older gay men in his sample had not disclosed their same-sex behavior to friends,



and 53% reported being “out” to less than half to none of their family members. CDC research shows that MSM of color are more likely to live outside of gay neighborhoods, beyond the reach of public health interventions directed at these areas. Minority older adults are also less likely in adulthood to have access to health care, if still working, or to qualify for Medicare, if retired.

HIV Screening and Diagnosis

People in their mid-70s and older grew up in a time when open discussion about sexual topics was considered inappropriate, and sexual norms differed considerably from those of today. This heritage of silence about sex can make it difficult for them to communicate with health care providers and others about HIV testing, prevention, or treatment. In contrast, those who came of age during the 1960s experienced a more permissive era. These youngest of older adults also have higher rates of drug use than previous generations. Nonetheless, research indicates that this age group seems just as reluctant to initiate discussions with health care providers or others about HIV.

Few physicians are taught to start conversations about sex with their patients or to recognize, diagnose, or treat HIV among older adults. As a result, they are less likely to test their patients over 50 for HIV. HIV disease can also mimic the normal conditions of aging, making it easy to miss the symptoms and signs that might be more readily recognized among younger adults.

Living with HIV as an Older Adult

Being older can have both positive and negative effects on living with HIV. As is true of taking medication in general, older adults tend to demonstrate greater adherence to HIV treatment than their younger people. In a National Institute of Aging study, Karolynn Siegel found that older adults with HIV felt that having had more life experiences made it easier for them to cope with the challenges and the psychological stresses of living with the virus. Yet, these same older adults also felt that age made them less physically resilient, more socially isolated, less likely to evoke sympathy, and too accepting of lesser social service and medical care.

Older people tend to have less social support in coping with HIV. In general, people’s social networks tend to shrink as they grow older, and many people over 50 live alone due to the death of a partner or spouse. Among older gay men, loss of network ties may partly reflect the death tolls of the epidemic. Studies also have shown that stress and depression due to HIV and other conditions can make it difficult to create and maintain supportive relationships. So adults may be less likely to have someone to call on for help when needed.

Interventions for Older Adults

Over 28 years have passed since the first AIDS case was reported in the U.S. While many successful programs and strategies have been developed for other high-risk populations, the needs of older adults have received little attention. Today’s young people may receive HIV education in school, but HIV was unknown during the years that today’s

older adults were in the classroom. Low testing rates among people over 50 prevent the effectiveness of using these services as a point of contact for HIV counseling and referral. The stigma of high-risk behavior and a general reluctance to talk about risk factors hinder attempts to reach older adults about HIV prevention, treatment and care. So does the belief on the part of both older adults and others that people over 50 are not at risk.

Some organizations are beginning to focus attention on providing HIV services to older clients. The Latino Community Services in Hartford, Connecticut, recently launched Project REACH (*Real Elders Achieving Community Health*). Funded by a five-year grant from the Substance Abuse and Mental Health Services Administration, the program is designed to serve heterosexual older Latino men, ages 50 to 69, living in senior housing complexes. The project’s main goals include working with substance abuse professionals, service providers, and key stakeholders to connect older adult Latino males to high quality substance abuse and HIV prevention services. In Detroit, Project S.H.A.P.E. at Adult Well-Being Services has been mobilized to address the needs of the older population in Southeast Michigan. In Chicago, *Aging as We Are* at Howard Brown Health Center aims to create a more comprehensive model of care for older gay, lesbian, bisexual, and transgender older adults.

Conclusion

Increased HIV prevention services to end transmission among adults of all ages are greatly needed as are special programs designed specifically for older adults. HIV education and training for service providers to improve prevention, diagnosis, and treatment for older adults also is vital. The number of older people with HIV is expected to increase dramatically—by 2015, half of all people with HIV in the USA will be over 50. HIV-related medical and social services for this age group must be expanded if we are to ensure that these older Americans have the treatment and care they need to enjoy long and productive lives. ■

Judith Levy is Associate Professor of Health Policy and Administration at the University of Illinois at Chicago. Theodore Hufstader coordinates the Social and Behavioral Sciences Core of the Chicago Developmental Center for AIDS Research.



HIV Prevention: Looking at the Research

by Timothy G. Heckman, PhD

Of the more than one million people in the U.S. who have been diagnosed with AIDS, over 12% were over 50 at the time of their AIDS diagnosis (19% of those diagnosed with AIDS in 2005 were over 50). Older African-Americans and Latinos are particularly vulnerable: Rates of HIV in persons over 50 years of age are 12 times higher among African-Americans and five times higher among Latinos than among whites.

Two factors account for much of the increase in AIDS cases in older adults. First, more effective HIV treatment has prolonged life, and second, there has been an increase in the number of new infections in people over 50, due primarily to unprotected sex. In 2001, 13% of newly infected people were over 50. By 2005, this had risen to 16%.

New Infections in Older Adults

The U.S. is not the only country seeing this increase. Similar trends have been documented in France, England, Italy, China, and elsewhere. Reasons for this include:

- High rates of divorce and separation that lead to new relationships
- Internet dating
- International travel
- Medications for erectile dysfunction (ED), like Viagra. As these meds enable more older men to remain sexually active, older women are not being offered risk reduction interventions.
- After menopause, women's vaginal tissues thin and natural lubrication decreases. This can increase the risk of microtears and of sexual transmission of certain diseases.
- Older people are less likely to use condoms because:
 - They don't consider themselves to be at risk for STDs.
 - They are no longer concerned about becoming pregnant.
 - Few older adults were educated that condoms should be part of their sex lives.
 - Physicians rarely talk to older patients about sex or other risk behaviors.

Research on Unsafe Sex

Four studies have examined sexual risk behavior in HIV-positive older adults.

ACRIA's 2006 *Research on Older Adults with HIV* (ROAH) study of 914 older adults with HIV in New York City found that half had been sexually active within the last three months. The type of sexual activity reflected their gender and sexual orientation, with oral sex being least common in heterosexual women (63%), vaginal sex being most common in heterosexual men (89%), and anal sex being most common in gay men (71%).

Of those who were sexually active, 39% had sex exclusively with HIV-positive partners. Fewer (29%) had sex only with partners who had a negative or unknown HIV status, and 32% had sex with HIV-positive and -negative partners or those of unknown HIV status. Most of those who had sexual partners reported having only one (77%), and 23% had more than one. Unprotected anal or vaginal sex occurred in 33% of those who were sexually active in the last three months, and in half of those instances, it occurred with a partner who was not known to have HIV.

A 2007 study of 356 men with HIV who were over 49 found that 42% of those who were sexually active had engaged in one or more sexual acts without a condom in the last six months. Those who had sex without a condom, multiple partners, or sex in exchange for money or drugs also reported more frequent alcohol use and the use of ED meds.

A 2008 study looked at sexual risk behaviors in 210 sexually active HIV-positive adults in Miami who were over 45. Of the men, 46% had had more than one sexual partner in the preceding six months and 60% had had at least one sexual encounter with someone who was HIV negative or whose HIV status was unknown. A lower percentage of women (14%) had more than one partner in the six months, and 61% of women who were sexually active had sex with a partner of negative or unknown HIV status. Twenty percent of all participants reported inconsistent condom use, and 17% of participants who reported sexual contact with a partner of negative or unknown HIV status used condoms inconsistently. Older adults who reported inconsistent condom use reported a more

negative mood, multiple sex partners, and more years of education. The researchers concluded that therapeutic interventions targeting mood state may improve condom use in older adults with HIV.

Another 2008 study looked at sexual activity and condom use in 290 HIV-positive adults over 50 living in New York City, Columbus, and Cincinnati. Of the 38% who had been sexually active in the past three months, 26% used condoms regularly, 7% used condoms irregularly but had sex with only HIV-positive partners, and 6% used condoms irregularly with at least one partner of HIV-negative or unknown status.

Rates of sexual activity, however, differed by sexual orientation and gender. While only 36% of gay/bisexual men and 21% of heterosexual women had had sex in the past three months, 72% of heterosexual men had been sexually active during this same time period. Among gay and bisexual men, inconsistent condom use was associated with being less knowledgeable about HIV transmission, having better cognitive functioning, and having lower annual incomes. Among older heterosexual men, inconsistent condom use was associated with increased loneliness. Among older heterosexual women, it was associated with being less knowledgeable about HIV transmission.

The research team highlighted the importance of not treating HIV-positive older adults as one large homogenous group when developing sexual risk reduction interventions.

Sexual Risk Reduction

While risky sexual behaviors in older adults with HIV have been studied, remarkably little research has attempted to develop interventions to help them refrain from high-risk behaviors. One study at the University of Pennsylvania examined an intervention to increase condom use in 60 older HIV-positive African-American men who have sex with men. Surveys were completed before the intervention, immediately after, and three months later.

The research team first conducted focus groups to develop an age-appropriate intervention, tested the survey, and then actually tested the intervention. The 60 participants were assigned to either

an HIV risk-reduction intervention or a health intervention. Each intervention consisted of four two-hour sessions delivered over four weeks in a classroom-like setting. After the intervention, men in the risk-reduction group were twice as likely to use condoms consistently as those in the health intervention.

Mental Health Interventions

The mental health needs of older adults with HIV are diverse and complex. Roughly 25% of people with HIV over 50 have “moderate” or “severe” depressive symptoms. One study of 113 people with HIV over age 45 found that 27 said they had suicidal thoughts in the previous week but would not carry them out. Two said they would like to kill themselves, but none said they would commit suicide if they had the chance. Unfortunately, very little research has aimed at developing age-appropriate interventions.

No interventions developed for older adults are available, and simply using another intervention not designed for older individuals is unlikely to be helpful.

At the Ohio University College of Osteopathic Medicine, we tested whether a 12-session group intervention delivered via teleconference could improve quality of life in 90 older adults with HIV. In this study, half participated in the intervention immediately and half after the first group finished. Compared with those who had not yet received the intervention, those in the first group reported fewer psychological symptoms, lower levels of stress, and improved skills to cope with stress.

Effective Interventions

As of 2009, no sexual risk reduction or mental health intervention that has been shown to be effective with HIV-positive older adults is available to AIDS service organizations or other agencies that work with

older adults. The Diffusion of Effective Behavioral Interventions (DEBI) program is a federal strategy that makes 26 different interventions available to state and community HIV/STD program staff (effectiveinterventions.org). The majority are designed for the African-American community, injection drug users, or adolescents. This is understandable given the extent to which these communities have been affected by HIV. But no interventions developed for older adults are available and simply using another intervention not designed for older individuals is unlikely to be helpful without first being specifically tailored and adapted.

One DEBI program (*Sister to Sister*) is a brief, 20-minute, individual risk-reduction intervention for African-American women 18 to 45 years of age. It is unclear why the original research did not include women over 45. Several programs have age limits associated with them. For example, TLC (*Together Learning Choices*) is for persons 13 to 29 years old, while SIHLE (*Sisters Informing, Healing, Living, and Empowering*) is a peer-led social skills training intervention for African-American teenage females. Clearly, interventions of this genre are unlikely to apply to older persons affected by HIV.

Conclusions

Older adults account for an increasing number of HIV infections and AIDS cases in the U.S. Indeed, approximately one in six people with HIV in the U.S. is over age 50. Sexual risk-reduction interventions are urgently needed that can prevent HIV-negative older adults from contracting HIV and enable older adults with HIV to remain safe.

Interventions are also needed to improve the quality of life of older adults with HIV. These interventions must carefully consider the unique physical, social, and emotional characteristics of older individuals. More research is needed on how to reduce risky sexual behaviors and improve psychological functioning in older adults with HIV. Finally, proven interventions are needed so that AIDS service and older adult organizations can offer these programs to their clients. ■

Timothy Heckman is a Professor of Geriatric Medicine/Gerontology and the Director of the Center for Telemedicine Research and Interventions (CENTRI).

Double Stigma

by Matt Sharp

I have fond memories of my July birthdays as a kid. Those hot Texas summer days were spent leisurely in my grandparents' backyard making homemade ice cream beside the plum tree weighted down with fruit. Now that I have become officially a "senior," I look back on those times with a mixture of sadness and longing. My time has passed so quickly it is hard to believe that I have had AIDS half of my life.

On turning 50 I was perplexed about exactly how I was supposed to feel. I struggled with the feelings that I am very lucky and privileged to have survived AIDS twenty years, but in reality I still just felt...old.

This time of my life has been thought-provoking yet confusing. Aging has sort of snuck up on me. It has been hard to accept growing older while living with HIV in our judgmental and antagonistic society. As an older person with HIV, I face the unknowns of a longer life with a virus that, despite successful treatment, continues to smolder within an aging body and immune system. There is really no precedent for the situation that many people, like myself, find themselves in. Yet, as the clock ticks on, I remain committed to my own fight against AIDS.

We are fortunate to be alive, especially when so many of us were unprepared to reach 40, let alone 50 or 60. Those of us who have gotten here wonder where all the time went.

My background in activism started in early adulthood when I wanted to speak out against social injustice. In the early eighties, when I had barely come out, I joined the gay liberation movement. One of my first protests was against the anti-sodomy laws. I remember massive protests in Greenwich Village following the U.S. Supreme Court's 1986 upholding of these laws in *Bowers v. Hardwick*. We marched through those muggy city streets blocking traffic on each avenue as we marched east across the city.

Gay coming-of-age coincided with my youth. Gay men partied and played before there was the PNP of today

(PNP means party and play — code in personal ads for using crystal methamphetamines). Bathhouses were a new revelation. We celebrated our post-Stonewall freedom with guiltless abandonment. Clinic visits for venereal diseases — as we called them then — were common. We took the shots or pills and were back in the mix as soon as the drip was gone.

Then the mirrored disco ball came crashing down. Before we knew it, the horror of AIDS hit us, many in the prime of our lives. There is no way to describe the horror of those times adequately, and all I can offer is my own perspective.

Having lived in New York City and Los Angeles in the late seventies, I was immediately aware of my own risk of contracting what was then called "the gay cancer." I moved to Dallas in 1981, and I remember Larry Kramer's first commentary on the growing numbers of this new rare illness striking gay men in major U.S. cities. A few of us mobilized by drawing chalk outlines on the city hall plaza to symbolize those who had died or would die, and staked white crosses in vacant lots in Oak Lawn, Dallas's gay neighborhood.

We were literally shaken to the core with sickness and death after the abandoned celebrations of sexual liberation and self-indulgence in the '70s. This was a complete shock to our collective being; one that I realize is hard for younger generations to comprehend. Our strategy quickly became learning how not to get infected, and how to find out anonymously if we were.

My own diagnosis was a surprise despite all the fear in the community. I drove home all the way home from the only anonymous test site in Oklahoma City in tears because of my deep denial. I assumed I would be negative but know now that gay men should anticipate a positive diagnosis and not assume otherwise.

We taught ourselves about clinical trials and drug development in order to fight for treatment, as we would wait nearly a decade and a half before the emergence of the effective HIV drugs we have today. People were trying anything they could get their hands on, even smuggling unproven, yet hopeful, drugs from Japan, Europe, and Mexico.

Tragically, so many are gone now. Yet some have survived and are thriving as we face the unexpected phenomenon of aging with HIV. We are fortunate to be alive, especially when so many of us were unprepared to reach 40, let alone 50 or 60. Those of us who have gotten here wonder where all the time went. Most likely it passed us by while we were fighting to save our friends' lives and worrying about our own survival.

Some in our community have simply lost perspective as the time has flown by, past the ACT UP protests, combination HIV therapy, and the "hit early, hit hard" era. We dealt with the scary body shape changes thought to be caused exclusively by protease inhibitors and partied through the crystal meth maze — losing even more friends and sometimes our livelihood. Then all of a sudden we realized that we had actually survived!

Many of us have regained our health, living on a strict schedule of popping HIV meds and seemingly constant blood draws. Others are less fortunate, often due to socioeconomic factors that limit or deny access to HIV health care delivery and severely curtail the quality of care.

Now we live, only to be stigmatized by our age. There is constant bombardment of cruelty against the aging population, HIV positive or not. Add an incurable, persistent virus to all the other layers of discrimination, and you have stigma on an overwhelming scale.

Older HIV-positive gay men face further and increased stigmatization within the gay culture where youth, good looks, and a perfect body are valued more than being whole. Gay hook-up sites are rife with the use of blatant language to separate us such as “18-45 ONLY,” or “disease-free.” Sadly, even HIV-positive men discriminate based on age. I have witnessed guys with lipodystrophy treated as freaks by younger poz men. It is sad. As a former dancer I watch as my misshaped belly grows as I age and remember the days I was younger, agile, and was probably joking about older “trolls.” It’s a vicious circle, I admit, and maybe our survival may teach us some humility.

Gay hook-up sites are rife with the use of blatant language to separate us such as “18-45 ONLY,” or “disease-free.” Sadly, even HIV-positive men discriminate based on age.

This stigma can only create further isolation and loneliness, leading to depression and substance abuse. We have to speak out and tell our community that this behavior by our own is offensive and should not be tolerated.

AIDS activism has led directly to the creation of entitlement programs to support our community. Many individuals depend on these programs to improve their quality of life or to have a safety net against further loss. And as we age with HIV, many more of us will need support. Also, thanks to the success of HIV treatment, some of us are able to participate in a range of social activities. Aging HIV-positive men must make sure to take care of themselves and engage with social networks. Being isolated and immobile creates loneliness and can have a negative impact on mental health. Being active and engaged after all the years of sickness and death will help us support each other through the many healing processes. We must build strong communities and develop the resources to ease many of the problems aging HIV-positive people now face.



Although we do not know all of the medical and social implications of aging and HIV, we must be as positive about the future as possible. We must work, collectively and individually, to change the status quo despite the unknown challenges. There is much hope for people living with HIV as we reach the third decade of the epidemic. Management of chronic HIV will become better understood as information continues to accumulate. HIV meds are becoming easier to take and more tolerable. There is ongoing “functional cure” research that offers the promise of enabling people with HIV to control their virus without the need for daily meds.

There is no question that by working together we can create solutions and break down the barriers that older people with HIV face. We can mobilize and demand the future we envision. That is what we did from the beginning of our movement, and we bring that dedication with us into a new age. ■

Exercise, Aging and HIV

by Sarah Robertson, RD, CDN and Margaret D. Swift, RD

As dietitians, we spend most of our time with clients talking about what they should eat. What some people might not realize is that dietitians are the first to admit diet alone doesn't cut it (shocking, we know). In the never-ending battle to lengthen life, exercise is essential.

As we age, our bodies' ability to get up and go can sometimes be impaired, leaving us with the question, "What's so 'golden' about the golden years?" If heart disease, osteoporosis, and declining mental status are in some cases inevitable, why are we working so hard? HIV researchers may be wondering the same thing.

Since HIV attacks the immune system, and older adults in general have a greater turnover of CD4 cells, we have to ask how the combination of the two affects immune health. Older adults with HIV have a greater CD4 cell loss than younger people. It remains to be seen if those infected in their youth will experience a greater rate of CD4 cell turnover as they age.

Heart disease (cardiovascular disease) is the number one cause of death for both older men and older women. Its risk increases with age, and our genes are still the most important factor in its development. Smoking, obesity, a poor diet, and inactivity also play a role. These risk factors can be eliminated by making certain lifestyle changes. But are those changes as effective in older adults with HIV?

There is very little known about how HIV treatments will affect the conditions commonly seen in aging. We know that HIV meds increase the risk of body fat complications. In an effort to combat these, doctors recommend behavior changes to improve cardiovascular health. Are these changes, such as exercise, as effective for an HIV-positive 65-year-old? The relationship is complex and the answer is still unclear.

While we are always learning more about treatment approaches for older adults with HIV, we don't have much to work with other than the methods used for HIV-negative older adults. Physical activity is key in the prevention and treatment of chronic illness. Even though we may not have all the answers, it is important to look at the facts and where we stand today in order.

Where are we today?

Twenty-seven percent of all people living with AIDS in the U.S. are over 50. In New York City this percentage jumps to over 36% for those over 50 and a whopping 74% over 40. We are currently experiencing a boom in the number HIV-positive older adults as prognosis and treatment of the virus improves.

At least 60% of adults in the U.S. are not regularly active at the level recommended for good health. Only 22% of those over 65 report that they are regularly physically active. Latinos and women are less active than non-Latinos and males. (These groups made up 26% and 17% respectively of the newly diagnosed HIV cases in 2006.) As we age, the time we set aside for leisure also increases. From the age of 55 it is estimated that adults in the U.S. spend up to 33% of their time engaging in leisure activities.

The amount of time dedicated to leisure time physical activity (LTPA) is often influenced by social networks and socioeconomic status. LTPA is defined as exercise, sports, recreation, or hobbies that are not associated with one's regular life duties. What specifically influences LTPA is not completely understood. A study published in *Epidemiologic Community Health* found that some barriers to activity were a

Exercise can help increase muscle mass, improve appetite, and increase the number of "feel-good" neurotransmitters in the brain.

lack of social support, access to exercise facilities or city sidewalks, education, care giving duties, a high-crime environment, lack of scenery, and age. It should also be noted that women, older adults, those of lower socioeconomic status, and people of color are the least active. Infection is highest among minority and lower income populations (nearly one in four African-Americans and one in five Latinos live in poverty).

It is likely that people who are HIV-positive, aging, and of low income are not engaging in regular physical activity as frequently as the U.S. population as a whole. Many AIDS organizations are taking on the changing and more complex needs of older adults, but offering LTPA for this population is a challenge.

The Physical Benefits of Exercise

Older people experience physiological and psychological changes over time, such as loss of lean body mass, poor appetite, and depression. Exercise can help increase muscle



mass, improve appetite, and increase the number of “feel-good” neurotransmitters in the brain. Additionally, exercise can combat fatigue by increasing energy and can improve immune function. While there are many physical benefits of exercise, one of the most important for the older people with HIV is the improvement and maintenance of muscle mass.

Muscle wasting is common in HIV, and as the muscles waste they lose their function. Strength training helps maintain muscle function and can increase lean body mass. Examples of strength training include weight lifting, yoga, tai chi, and calisthenics. A review of the effectiveness of resistance training among older adults with HIV was recently featured in *Clinical Science*. The study found that progressive resistance training increased strength, improved physical fitness, reduced upper and lower limb skin folds, and was associated with an improvement in CD4 counts.

Exercise can also play a vital role in controlling some of the long-term effects of HIV drugs. Metabolic complications such as high cholesterol, triglycerides, and blood sugar are common in people taking these meds. These are also a complication of aging,

so people who are over 50 and taking HIV drugs are at greater risk of them. Recommendations to combat these issues generally include a healthy diet and regular exercise, but it remains to be seen how effective that will be in older adults with HIV.

Long-term use of HIV medications can lead to changes in body composition, known as lipodystrophy and lipoatrophy. Lipodystrophy is defined as changes in the body’s fat, and is characterized by lipoatrophy (loss of fat from the arms, legs and face) and lipohypertrophy (increased fat in the abdomen or back of the neck). It is psychologically distressing and physiologically dangerous, as it may worsen metabolic complications.

A study of resistance exercise in adults with HIV was featured in *AIDS Care*. It found significant increases in weight, lean body mass, and sum of chest, arm, and thigh circumference among those who engaged in aerobic exercise and weight training compared with those who did not. Increasing arm and thigh circumference decreases the severity of lipoatrophy, as muscle is developing in areas where wasting may commonly occur. The study also noted that waist circumference was significantly decreased in those who exercised with weights. Evidently, resistance training combined with aerobic exercise is an effective way to prevent the side effects that can occur with HIV, its treatment, and aging.

The Psychological Benefits of Exercise

Aside from the physical benefits of exercise, research has shown there are significant psychological benefits as well. For one, exercise is an effective way to reduce stress, and chronic stress has been associated with suppression of immune function. Exercise reduces cortisol, which is frequently referred to as the “stress hormone.” Chronic stress and elevated cortisol levels may weaken the immune system over time, and can result in impaired inflammatory processes.

Depression is a concern, especially in those with HIV. The psychological demands of HIV medications and the stress of living with HIV can be overwhelming. While exercise is not a cure for depression, it can certainly improve it. Exercise raises the levels of “feel-good” neurotransmitters (such as serotonin), and an increased heart rate boosts the amount of endorphins circulating throughout the body. Exercise should not be substituted for antidepressant medications, but should be considered as an additional treatment.

Exercise is also a healthy coping mechanism. There are many studies linking emotional processes to immune function, showing a direct association between psychological processes and illness. Research shows that poor psychological defenses are associated with a weakened defense against HIV, and may result in greater numbers of opportunistic infections. Lower rates of depression and stress also lead to increased adherence to HIV meds.

Getting Started

The American Heart Association and the American College of Sports Medicine recommend that adults over 65 engage in at least 30 minutes of physical activity five days a week (which can

continued on next page

be broken into three 10-minute segments).

But most older adults do not get enough physical activity. Many feel that exercise is for the young. Additionally, they believe that it is costly and often associate exercise with extreme exertion. Their self-efficacy (the belief that they have the ability to achieve certain goals) can be low, and the perceived cost high. Those who do meet exercise recommendations are often well-educated on the benefits of physical exercise, have a high level of self-efficacy, and receive adequate social support.

In a study published in *The Journal of Medical Science Sports Exercise*, 208 individuals with HIV rated their “stages of change” for exercise: 48% were in the pre-contemplation stage, 25% in the contemplation stage, 70% in the preparation stage, and 63% in the maintenance stage. Remarkably, no one was in the action stage. The difference between the desire to exercise and actually starting an exercise program is profound. Considering the socioeconomic, ethnic, and psychosocial strains on older people with HIV, there is a risk of a rapid decline in their overall health over the next decade.

What Works

Health professionals know that exercise can improve body composition, mood, and immune strength. But we need to continue to educate HIV-positive older adults that moderate physical activity can be achieved at any age. A belief that exercise is possible in spite of barriers and constraints is associated with a greater chance of starting to exercise.

A major barrier to exercise is access to facilities and programs. But physical activity can be done at home, in parks, backyards, or even at the grocery store. Simple enjoyable activities like gardening, walking, or dancing can contribute to activity goals, as long as activities are moderate and last for at least ten minutes. Resistance exercise can be accomplished by lifting cans or other household objects.

Making a list of all the tasks that require physical activity can make remind people that chores like going to the store are part of one’s recommended exercise for the day. Activity goals should be small and measurable at first, such as walking or dancing for 10 minutes three times a day. Long-term goals can be ambitious, but make sure that they are realistic and flexible. Having a concrete plan is recommended.



According to the self-efficacy theory, there are four major areas that help older adults believe in their ability to perform specific tasks: accomplishments, learning by watching others, verbal encouragement, and physical and emotional responses. Creating a positive experience and support system for older adults is important. For example, observing other older adults exercise, receiving feedback from family or health care providers, or experiencing the benefits of walking outdoors on a sunny day can help increase the desire to engage in exercise.

Doing a little research to find exercise groups at local senior centers can be helpful. Internet access is not always available, so your community may benefit from having a printed list of centers to give to clients. Encouraging older adults to recruit an exercise buddy can also be a great way to help keep them going. Dietitians, doctors, nurses, social workers, and caregivers can also provide support for clients.

Conclusion

Advances in HIV treatment have made HIV a chronic disease for many, and while this is still a young disease, it is beginning to affect the old. The benefits of exercise for those with HIV are great, especially for those over 50. While the long-term benefits for older adults with HIV may not be known, we do know the benefits today. Exercise results in improved body composition, strength, heart health, mood, and life satisfaction. Adherence to HIV treatment is vital for longevity among this population – but optimizing health with good nutrition and physical activity is fundamental. ■

Sarah Robertson and Margaret Swift are HIV Nutrition Specialists at Gay Men’s Health Crisis.

Aging Before Your Time?

by Richard J. Havlik, MD, MPH and
Donna M. Kaminski

We are all aging, whether we are HIV positive or negative. It is part of the natural course of life. A small number of individuals live to 100 years of age with minimal disease and disability. Others seem to have accelerated aging with deterioration of multiple body systems, disability, and chronic diseases. Naturally, this brings us to wonder what factors account for this difference in aging.

To date, we've been able to identify a couple of factors. Resveratrol, a compound found to help fruit flies and yeast live longer, has been studied for its role in slowing down the aging process. Other studies have also looked at a gene called FOXO3A. People who have mutations in this gene seem to have a slower aging process. Studies are under way to see if these factors could be modified to help slow down the aging process, and to see what else seems to affect aging.

An Aging Epidemic

Fortunately for people with HIV, treatment has improved and people are living longer. It's estimated that by the year 2015, almost half of people with HIV will be over 50. In New York City, over 36% are over 50. By 2005, the number of people with AIDS in the U.S. who were over 50 was seven times higher than it was in 1990. Some of this may be due to greater testing efforts, but some of it is also due to improved access to HIV treatment.

But older adults are still getting diagnosed later in their disease than younger people. An Italian study looked at 1,977 people who received care from 1986 to 1998. About a third had a late diagnosis of AIDS, and the most significant factor linked with

that late diagnosis was age. People who were over 45 were more likely to be diagnosed at a later stage of HIV disease.

Another study found that more than half of newly diagnosed older adults developed AIDS in less than a year. A third study found that only 59% of HIV-positive adults over 65 survived more than three years, compared with 90% of adults aged 20 to 39. Despite earlier testing efforts and greater access to medications, people are getting diagnosed at later ages and are at risk of shorter survival times.

One study found that only 59% of HIV-positive adults over 65 survived more than three years, compared with 90% of adults aged 20 to 39.

In order to support people over 50, we need to have a better understanding of aging and HIV. This article will review what is known about the aging process and what is seen in people with HIV. Finally, it will review what needs to be better defined, and what might slow aging regardless of HIV status.

Common Manifestations of Aging

Aging is not a disease but a collection of changes in various body systems that occur as we age. These changes might be quite evident, such as graying hair, or may be subtle and detected only when an organ system is stressed. These changes should be separated from specific diseases, such as diabetes, which become more frequent with age. This is difficult to do, because there is usually an interaction between aging systems and diseases. Another

important principle is that different body parts or systems age or wear out at different rates in different people.

The Immune System: The thymus gland, located in the upper chest, produces CD4 and other immune cells. These cells fight infections either directly or by signaling B cells to produce antibodies. Shortly after birth, the thymus gland begins to shrink, and production of such cells is reduced. The total number of cells decreases as we age and they function less efficiently. This results in more infections in some older individuals.

CD4 cells are the first line of the body's defense against infections. In older adults, new CD4 and CD8 cells are created more slowly. The number of B cells is also reduced, so fewer antibodies are produced. These changes lead to immunosenescence, a general weakening of the immune system.

Skin and Body Shape: As we age, the skin thins in the arms, legs, and face due to loss of fat under the skin, making

it more vulnerable to injury. In addition, excessive sun exposure or lifelong smoking can lead to wrinkles and more frequent skin cancers. Also, there is a redistribution of fat to the organs in the belly area in men and to a certain extent also in women. Generally weight increases until well into middle age, but can then begin to decrease overall, along with the poor distribution of fat in the body.

Eyes and Ears: It is quite common for changes in the lens of the eye, such as cataracts, to occur with aging. In many cases this results in the need to use glasses for close work. Generally, there is a loss in the ability to hear higher tones, especially in a crowded room. Environmental noise over a lifetime can worsen this condition.

Muscle: Volume and strength of muscles are reduced with aging. Runners and other athletes do not compete as well against younger athletes because of

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Stepping Back, Looking Forward

by Ed Shaw

I have lived in Manhattan for 50 years. I was diagnosed with HIV in 1988, but I'm sure I was positive before then. During the first five years after my diagnosis I spent very little time thinking about HIV. I was healthy and had a good job and a fulfilling social life to keep me busy. I was doing administrative work at a job placement firm in the city and spent the majority of my time working or having fun.

When I was first diagnosed with HIV in 1988 at the age of 47, never in my wildest dreams did I expect to live past 48. As I grow older, HIV remains a top priority because of its virulent behavior. I always wonder how the disease will affect my life at the age of 70, 80, or even over 90. I also have to spend time thinking about the other issues that come with aging, such as affordable housing, access to health care, and, equally important, financial independence.

We all make decisions based on historical experiences – so it's important to look back in order to move forward. From living with HIV through the decades, volunteering with an incredible spectrum of people, and my experience as a social worker, I have a prism of experiences to share.

Prior to being diagnosed, HIV and AIDS were like foreign words to me. I never would have imagined how personal they would become. I worked in the social service field, lived in a co-op with full amenities, and drove a company car. My life was filled with joy and happiness – but that would change forever. Living with HIV brought new and unexpected health challenges, along with intense stigma and discrimination.

When I was first diagnosed in the summer of 1988, my life was turned upside down. I thought

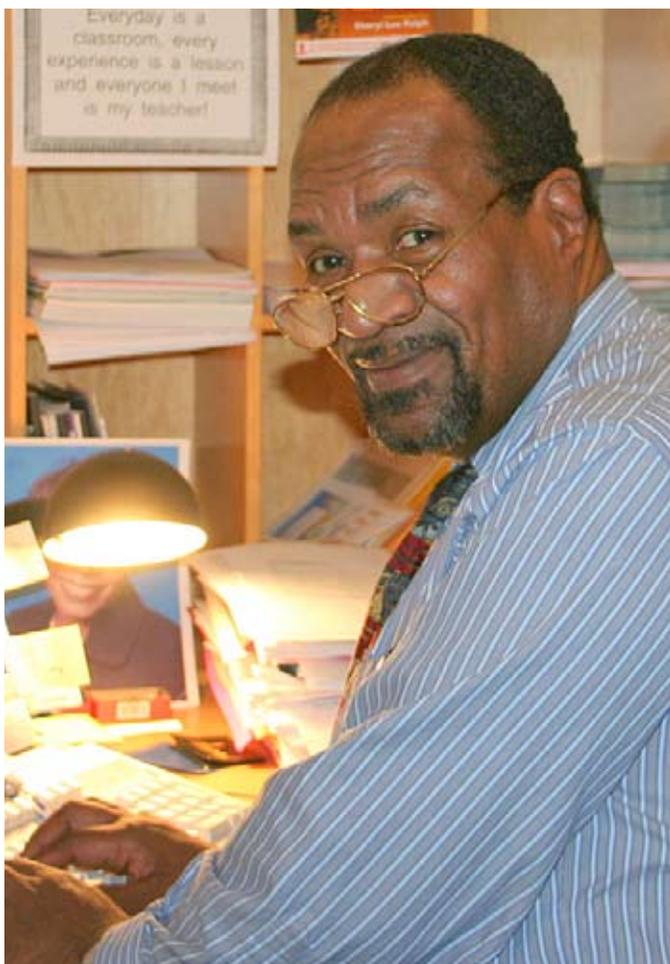
I was going to die instantly – we all did. From 1988 to 1993 I lived in denial and isolation. Those five years were driven by drug and alcohol use, promiscuity, and other ill-conceived plans. Many nights I was scared that if I went to sleep, I would not wake up in the morning. I gave up on life, spent all my savings, and wouldn't tell anyone about my HIV status. There was so much stigma about having “The Big A” – I felt like someone would beat me up if they found out.

It was also hard for me to overcome my fear of the medical establishment. Many of us were concerned about interacting with doctors because of the Tuskegee medical experiment. We were well aware of how the government-run project had denied treatment and information to black men used for syphilis research, up until 1972. Many of the people with AIDS I knew feared they might be subjected to this same type of “treatment.”

Many of us were concerned about interacting with doctors because of the Tuskegee medical experiment. Many of the people with AIDS I knew feared they might be subjected to this same type of “treatment.”

Then, in 1993, I had a mild heart attack and found myself in the hospital. Everything changed. I met with a counselor who told me straight up, “Mr. Shaw, you have AIDS.” I was petrified, but I took the bull by the horns and started asking questions. Though the process of building trust was slow at first, I can now say unequivocally that my reservations and fears of the medical establishment have disappeared. After all these years, I still have the same clinician. While we do not always agree, we work together to keep my T-cells high and my viral load undetectable, and so far we have managed to accomplish the task.

Living with HIV over the past twenty years has changed my life. The keys to my survival have been having support from my family and friends and staying politically active. Ever since I was asked to go to my first



HIV meeting back in 1993, activism has become a constant and sustaining part of my life. I take advantage of every opportunity to provide workshops and presentations, engage politicians, and speak to the issues. I also make sure to have a laugh every now and then.

Although I overcame many of the all-too-prevalent obstacles and barriers, it was a long process. While sometimes the challenges can feel insurmountable, it is important not to give up. In order to live a long life with this virus, you also have to make the right choices. That means not doing drugs, not drinking, and not having unsafe sex. Every time I see someone on a risky path I say, "I've been there, done that," and I let that person know that there are other ways to lead a healthy, fulfilling life.

For those of us who have been living with HIV for decades, it is important to take some time to enjoy

life. You have to find a range of new interests to replace the things you cannot do any more, either because of age or health. Go sit in the park, read the paper, play cards, treat yourself to a show. I play chess in the park every week, and have met many wonderful people there.

If you are new to the world of living with HIV, talk to someone. People call me Dr. Ed, because I am always on call, as are many other people who are ready and willing to offer support. Also, you cannot beat yourself up. Instead, reach out. There are many people and organizations dedicated to working with and for people living with HIV and AIDS.

For those of us who have been living with HIV for decades, it is important to take some time to enjoy life. You have to find a range of new interests to replace the things you cannot do any more, either because of age or health.

The more you learn, the more you can accomplish. Education is the key to advocacy. Never stop learning. Wisdom is elusive; just when you think you know it all another challenge presents itself and the process of education starts all over again. When you commit to continuously learning, it helps you and everyone around you.

Notwithstanding all the successes, there are constant challenges, such as the new rates of infection. I hope that one day the city, the country, and the world will take an approach outside the box and not just stick to the status quo. We need to get people of all generations conversing with one another. If we open up the conversation in this way we can get rid of stigmas about the virus and increase shared knowledge about prevention. We must reach across the ethnic and age barriers to get everyone talking. ■

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this and other issues that affect fitness. Increasing disuse of muscles and reduced physical activity, however, can also contribute to muscle loss.

Bone: Bone loses its density, accelerating over time, particularly in women after menopause, and its strength is reduced. This situation can lead to more frequent broken bones or fractures. This loss also occurs in men at older ages.

Liver: The detoxification function is maintained with age because liver cells can continue multiplying even at older ages, but with less efficiency than they do at younger ages. For example, the size of the liver can be reduced as we get older, and overall function can be challenged as we age. Liver function can also be impaired by drugs and excessive alcohol.

Kidneys: The cleaning function of the kidneys operates effectively until older ages, when clearing of waste products decreases. Among the many factors that affect kidney function are protein in the diet and other conditions such as high blood pressure and diabetes.

Lungs: The capacity of the lungs decreases with age, but this usually does not present a problem, unless factors like smoking have had a major impact.

Heart and Blood Vessels: The major blood vessels thicken due to fibers in the tissue of arteries solidifying and losing their elasticity. This is different from atherosclerosis, which results in hardening of the coronary arteries. The thickening of major arteries forces the heart to work harder to maintain its output. This can often result in enlargement of the heart muscle, sometime leading to heart failure after many years.

Blood Pressure: The thickening of the major arteries can also lead to the systolic blood pressure (the top number when recording blood pressure) becoming elevated. This can have a gender-specific effect in people over 55. For example, men have a higher risk of high blood pressure until age 45 than do women. From 45 to 54, men and women have an equal risk, and after 55 women have a greater risk. If untreated, this can increase cardiovascular risk and lead to a stroke.

Blood Fats (Lipids): Cholesterol, especially the low-density lipoprotein (LDL) type or “bad” cholesterol, tends to increase with age. This may also be caused by a lifelong fatty diet or bad genes or a combination of these factors. Diabetes and low levels of thyroid hormone can also be associated with higher levels of cholesterol and triglycerides.

Blood Sugar (Glucose): At older ages, the insulin needed to control glucose levels is not as well regulated and sugar levels tend to rise. Sometimes this leads to diabetes. This problem is often only revealed

temperature and other sensations and there may be reductions in sensitivity with age, but generally external factors, such as trauma or disease, diminish sensation.

Why do these various systems fail with aging? There are three theories as to the cause of aging. The first is programmed cell death, where destructive factors are genetic and built into the DNA of our cells. The second theory suggests that the inevitable wear and tear of life on our body systems, including the destructive effects of byproducts from the oxygen we breathe, results in cell death, especially



after a glucose test, taking a load of sugar by mouth, which can reveal poor regulation of glucose levels. Obesity, diet, and genetics can alter these relationships. Insulin resistance is common among individuals with later-onset diabetes, and is a central problem among our aging population.

Brain and Nerves: Aging can worsen mental function, when combined with other factors. Simple memory lapses, such as forgetting someone’s name, are quite common at older ages but do not signal serious disease. Special testing may be necessary to detect subtle changes. Peripheral nerves (such as those in the hands and feet) monitor pain, touch,

of the immune system. The third theory simply suggests that aging is a combination of known and unknown factors.

How Does HIV Affect Aging?

Among people over 50 with HIV we are seeing other conditions, commonly referred to as comorbidities. One study of 165 people with HIV over age 55 found that the most common comorbidities were high blood pressure (41%), chronic obstructive pulmonary disease (29%), and diabetes mellitus (22%). Softening of the bones (osteoporosis), cardiovascular disease, liver disease, and cancers like lymphoma and Kaposi’s sarcoma have also been

found to be more common. A key question is whether the virus itself or HIV treatment influences the aging process in a negative way. Here's a summary of the known possible effects of HIV on the body.

The Immune System: Of course, HIV damages the immune system by infecting and destroying the type of T cells known as CD4 cells. But it can also lead to a dysfunctional increase of certain T cell-related functions. This activation can have negative effects on the body, since inflammation, which usually helps to heal tissues, can get out of hand. The levels of cytokines, especially one called interleukin-6 (IL-6) may be increased to a level that adversely affects the body. In a long-term study of people with HIV, those with the highest IL-6 levels and high levels of markers known as C-reactive protein and D-dimer had a higher occurrence of cardiovascular disease and death.

People with HIV may also make less interleukin 2 (IL-2) and IL-2 receptors, causing CD4 cells not to work as well. This can cause the body to change the type of CD4 cells it makes, making fewer of the important "naïve" cells that have never encountered an infection. Older adults with HIV have significantly fewer naïve CD4 cells than younger people with HIV. One study showed that older adults whose HIV meds were lowering the amount of virus in their body were not seeing the same CD4 increases as younger people. It is thought that CD4 cells may not respond as robustly when HIV meds are started in people who are over 50. And smaller numbers of CD4 cells were found in the gut of older people with HIV, suggesting that immunity is not as strong as we age.

Eyes and Ears: In the early years, eye problems due to opportunistic infections were relatively common. Now, such acute infections are rare, although there may be old scars that can affect vision. Hearing level is not known to be affected by the virus or treatment.

Bone: A metabolic complication of HIV infection is reduction of bone mineral density (BMD). In one study of people taking HIV treatment, BMD was reported to be low in 52% of people, and an additional 10% had actual osteoporosis, a bone disease leading to increased risk of fractures. What's interesting is

that this effect doesn't seem to be affected by HIV treatment. One study found greater levels of osteopenia (which comes before osteoporosis) in people with HIV regardless of whether they were on HIV treatment. Older age was an important factor in these findings.

Studies in HIV-negative people have found a relationship between LDL cholesterol that has been distorted with too much oxygen and the production of a blood factor from T cells that destroys bone. If confirmed in people with HIV, this might be a partial explanation of their low BMD. Other risk factors, such as less physical activity, decreased intake of calcium and vitamin D, cigarette smoking, alcohol use, depression, cocaine and heroin use, and low testosterone levels are also seen in people with HIV.

Liver: Although HIV is found in liver cells, damage is more likely to be due to other liver infections or taking certain HIV medications. Both hepatitis B and hepatitis C are common among people with HIV. Viramune in women with

function over time. The condition, HIV-associated nephropathy, has been found to be more frequent in African-Americans with HIV and can lead to kidney failure in some cases. Viread can also lead to kidney problems in rare cases, and Crixivan must be taken with eight glasses of water a day to avoid kidney stones.

Lungs: Even after receiving HIV meds, people with HIV tend to be more vulnerable to pneumonia. This may be due to poor regulation of certain immune system proteins, especially the cytokine called TNF α (Tissue Necrosis Factor alpha) in the lung tissue. This deficiency is related to problems of immune function due to HIV infection. Also, studies have seen a reduction in the lung capacity of older men with HIV when performing a treadmill test. Although men could perform normal activities, the deficiency appeared when they were stressed with higher physical exertion. HIV-positive smokers seem to suffer more decline than HIV-negative smokers, suggesting some interaction of factors.

One study showed that older adults were not seeing the same CD4 increases as younger people. It is thought that CD4 cells may not respond as robustly when HIV meds are started in people who are over 50.

higher CD4 count can cause liver problems, as can other antiretrovirals, such as Zerit, Viread, Emtriva, Epzicom, Sustiva, Reyataz, and Aptivus.

It has also been found that people with liver disease and HIV are more likely to have diabetes than those who are HIV negative. One study of people with HIV and hepatitis C who were on HIV meds found higher rates of diabetes. When this study looked back to see if this effect was seen before HIV combination therapy became standard practice, they found that it wasn't. Therefore, this effect may be further associated with HIV medications and their effects on several metabolic pathways.

Kidneys: HIV has been incriminated in a relatively rare but specific kidney disorder that can compromise kidney

Heart: HIV does not have a direct effect on the heart muscle. But the blood vessels that feed the heart muscle may develop more atherosclerosis due to higher levels of virus and the inflammation seen in HIV disease. This is the conclusion of some experts based on the results of the SMART Study. This study compared two groups of people, one taking continuous HIV treatments and the other taking breaks based on their CD4 count. It was thought that breaks in treatment would minimize the rise in cardiovascular risk factors seen in people with HIV. But the study was stopped early because the continuously treated group did much better than the group that interrupted treatment. This led to current recommendations to avoid drug holidays to minimize cardiovascular risk.

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Another theory has looked into whether the HIV meds may be causing an increase in heart attacks among people over 50. One study showed a 26% increase in heart attacks among people on HIV drugs. Another study showed that one year after patients started HIV treatment, they had higher rates of high blood pressure. It's important that HIV patients and their doctors be aware of heart comorbidities.

Blood Pressure: High blood pressure, or hypertension, in people with HIV is most likely due to factors other than HIV. These would include the standard risk factors of obesity, salt intake, African-American race, and physical inactivity. The grouping of hypertension with abnormal blood fats and high blood sugar may, however, be higher in persons with HIV.

Blood Fats (Lipids): A study in otherwise healthy HIV patients receiving HAART found that elevated cholesterol was more common than expected. It is possible that HIV treatment resulted in individuals returning to their pre-illness cholesterol levels because of weight gain or increased fat intake. Some of the protease inhibitors have been incriminated in increasing lipid levels more than others. The choice of drugs might be modified to avoid such increases.

Blood Sugar (Glucose): The protease inhibitors have been shown to increase problems of regulating glucose by affecting insulin functions. People on HIV meds may be more vulnerable to multiple cardiovascular risk factors. Physicians are aware of this potential and either manipulate the drug regimen or add glucose-altering drugs.

Brain and Nerves: AIDS dementia has become quite uncommon with current treatments. But recent studies have suggested that certain mental functions might be adversely affected by HIV or its treatment. These are known as HIV-associated neurocognitive disorders (HAND). One study compared 106 people living with HIV who were over 50 to 96 people with HIV aged 20 to 39. After adjusting for education, race, CD4 count, and viral load, the study found that people with HIV who were over 50 were three times more likely to have neuro-

cognitive dementia than those under 40. Whether this finding is the result of the virus itself or inflammation has not been determined. Recent research has also suggested that there might be activation of biochemical products similar to those found in Alzheimer's disease. Fortunately, the abnormalities have been mild, but further research is necessary to understand the extent of such problems.

Another interesting finding is that there may be an association between HIV dementia and diabetes. In one study where over half of the patients were over 50, there was a link between dementia and diabetes among people with HIV. This effect wasn't seen among the patients over 50 who didn't also have HIV. (Other studies have suggested a relationship between abnormal glucose levels and dementia.)

It's not known whether the virus itself or the treatment might be speeding the aging process in some body systems or contributing to the onset of certain diseases.

Adverse effects on nerves in the hands and feet, called peripheral neuropathy, are quite common and can be debilitating. The symptoms vary from tingling in the legs to severe pain and difficulty walking. It is likely that HIV directly affects the nerves in the legs and spinal chord, although treatment with older HIV medications contributed to the problem. Treatment is mainly focused on minimizing the symptoms.

Does HIV Accelerate Aging?

The good news is that many people with HIV are living longer and better lives because of newer drugs. There is no doubt that mortality rates are down and life expectancy is increased. But whether the aging process is back to normal is still an open question. It's not known whether the virus itself or the treatment might be

speeding the aging process in some body systems or contributing to the onset of certain diseases. The immune system is the most likely target because of the fundamental effect of the virus on CD4 cells.

Body shape changes mimic the changes that occur in older persons. The softening of bones is frequent, and cognitive changes are possible. In some cases a combination of factors results in extreme physical frailty. Still, the jury is out on whether overall aging is increased in people with HIV. Fortunately, this is now becoming an active research area.

What Can You Do?

There is a great deal that can be done to achieve a longer and better life, even for those who are older and HIV positive, based on a large body of research on risk factors in older persons. The obvious things that can be done are stopping smoking, avoiding mind-altering drugs, and maintaining only modest alcohol intake. The cardio-protective effects of aspirin and the positive effects of antidepressants may suggest that, when indicated, these can both be helpful in helping people with HIV to live healthier, longer lives. Control of cardiovascular risk factors, including lowering blood pressure or lipids if elevated and maintaining appropriate body weight, makes good sense. One should take advantage of appropriate cancer screening to promote early detection and treatment. Psychologically, depressive symptoms are common and need to be addressed.

Those taking HIV treatment need to maintain good adherence and be aware of the advances that are occurring. HIV meds with a minimal risk of increasing blood fats or glucose should be used to reduce cardiovascular risk. Such a strategy will go a long way to improve quality of life and increase longevity. As further research is completed, it is highly likely that more specific approaches will become available to assist the older person with HIV age more gracefully. ■

Richard Havlik is a medical epidemiologist, formerly with the National Institute on Aging.

Donna M. Kaminski is a fourth-year medical student and ACRIA's former Associate Director of Treatment Education.

Ted Kennedy: Leader and Ally

After decades of leadership in American politics, Senator Ted Kennedy succumbed to brain cancer in September of 2009. Throughout his career, Senator Kennedy demonstrated a passion, ability, and dedication to utilizing his privileged position on behalf of the underdogs of the American political system. He worked since the 1960s to build the foundation for health care reform, was at the forefront of civil rights and fair housing advances, stood side by side with immigrant rights groups, created cornerstone HIV legislation at the height of AIDS hysteria, and supported expanding LGBT rights. His staunch progressive leadership earned him the title “Lion of the Senate,” while his ability to work across the aisle is evidenced by his legislative accomplishments. He will be remembered as a consistent ally to many.

Since he was elected to the Senate in 1962, Kennedy took on the tough, meaningful issues that shaped the country we live in today. In advocating for the 1964 Civil Rights act, he said, “We should use our powers not to create conditions of oppression that lead to violence, but conditions of freedom that lead to peace.” He worked to abolish poll taxes in 1964, to pass the Voting Rights Act of 1965, and to enact the Fair Housing laws in 1968. He took the lead on eliminating racist and anti-Semitic immigration quotas, a victory realized in the 1965 Harts-Sellers Immigration Act. In his work on health care, he recognized the geographic and economic barriers to crucial services. In 1966 he championed community health centers in low-income neighborhoods, and he has fought for comprehensive national health insurance since 1969. As an advocate for women’s equal access to education and employment, he worked to make Title IX of the 1972 Civil Rights Act a reality.

In the arena of health care policy, which he called the “cause of my life,” he connected the personal to the political, and authored foundational legislation. He recognized that the health plan available to members of Congress protected him and his colleagues from the tough decisions often forced on the middle class and from the lack of access faced by the poor and working class. In Senate committee hearings, he shared the struggles of those with whom he sat in hospital waiting rooms, and brought the funeral processions of people who died from AIDS to the Senate floor. He spoke on behalf of those who had no voice in the Senate.

In 1987, when he became chair of the Health committee, the AIDS crisis was in full force, accompanied by a federal policy of deliberate neglect. Senator Kennedy used his position to

secure much needed, though belated, funding for the AIDS epidemic. He introduced legislation that in 1990 became the Ryan White CARE Act, the federal program that provides access to the lifesaving care needed by people with HIV and AIDS. In addition, he fought against the barrage of anti-gay amendments promoted by former Senator Jesse Helms, who epitomized the homophobic political climate of the time.

Senator Kennedy sided with smart immigration policy and supported alternatives to the HIV travel ban. Instituted in 1987, the ban promoted unsound public health policy and discriminated against HIV-positive people attempting to immigrate or even visit the U.S. In response to attempts to strengthen the ban, Kennedy noted that these “unfair” policies stemmed from “a past where people feared HIV as a contagious disease.” We know he would be proud that the ban will finally be lifted on January 1, 2010.

Senator Kennedy’s leadership did not waver over time. His more recent achievements in the area of health care included safeguards for the unemployed, women, people of color, children, and people with special needs. He ensured that NIH grants included women and racial minorities in all new medical testing and development, thanks to a bill passed in 1993 and reauthorized a decade later. He succeeded in expanding his 1985 COBRA legislation (a law ensuring temporary health insurance extensions when people lose their jobs), to even more people in 1995. The passage of the

State Child Health Insurance Program (SCHIP) in 1997, and its reauthorization in 2007, brought medical care to poor children across the country. Senator Kennedy also labored to expand Medicaid coverage to include people with special needs.

Senator Kennedy was a staunch defender of civil rights, and sought to expand them to include LGBT equality and protection from hate crimes. He was a strong supporter of marriage equality, opposing “civil laws to deny any American the basic right to be part of a family.” He worked on the recently passed Matthew Sheppard Hate Crimes Bill, as well as the Employment Non-Discrimination Act, which would provide critical protections to LGBT Americans.

Ted Kennedy leaves a legacy of working for racial justice, workers and immigrants’ rights, civil liberties, and health care access. His leadership and courage will be missed, and his legacy must be carried on by our political leaders. This is a moment of opportunity to honor his memory by securing the progressive priorities – such as providing health care to all Americans – that he kept at the forefront of American politics for decades. ■



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Marjorie H. Cantor

1921 - 2009

MENTOR, TEACHER, AND FRIEND

Nearly a decade ago the issue of HIV and aging was joined by a luminary in the field of aging: Marjorie H. Cantor, Professor Emerita and Brookdale Distinguished Scholar of Fordham University's Graduate School of Social Service. Still actively engaged at the age of 88, Marjorie passed away in October. She guided ACRIA's seminal research on older adults and HIV and chaired the Research on Older Adults and HIV (ROAH) Advisory Group. Marjorie's last academic publication is the upcoming book on ROAH: *Older Adults with HIV: An In-depth Examination of an Emerging Population* (Brennan, Karpiak, Cantor, Shippy, Eds.).

A past President of the Gerontological Society of America, Professor Cantor was the first Director of Research for the NYC Department for the Aging, a Senior Fellow of the Brookdale Foundation, and a participant in White House Conferences on Aging.

Marjorie has been a mentor, teacher, and friend who has touched the lives of countless individuals both here and abroad. She has influenced the issue of HIV and aging profoundly, and her legacy will not soon be forgotten.