Presidential Advisory Council on HIV/AIDS
Twenty-Eighth Meeting
Hubert Humphrey Building
200 Independence Avenue, S.W.
Room 800
Washington, DC 20201

November 14, 2005

Council Members—Present
Anita Smith, Co-Chair, Presidential Advisory Council on HIV/AIDS (PACHA)
Abner Mason, Chair, International Subcommittee
David Reznik, D.D.S., Chair, Treatment and Care Subcommittee
M. Monica Sweeney, M.D., M.P.H., Chair, Prevention Subcommittee
Rosa M. Biaggi, M.P.H., M.P.A.
Cheryll Bowers-Stephens, M.D., M.B.A.
Jacqueline S. Clements
Mildred Freeman
John F. Galbraith
Edward C. Green, Ph.D.
Cheryl-Anne Hall
Jane Hu, Ph.D.
Karen Ivantic-Doucette, M.S.N., FNP, ACRN
Deborah Jacobs-Rock
Rashida Jolley
Sandra McDonald
Joe McIlhaney, M.D.
Jose Montero, M.D., FACP
Dandrick Moton
Beny Primm, M.D.
Reverend Edwin Sanders
Ram Yogev, M.D.

Council Members—Absent
Louis Sullivan, M.D., Co-Chair, PACHA
Franklyn N. Judson, M.D.
Henry McKinnell, Jr., Ph.D.
Prem Sharma, D.D.S., M.S.
Lisa Mai Shoemaker

Council Staff—Present
Joseph Grogan, Esq., Executive Director, PACHA
Dana Ceasar, U.S. Department of Health and Human Services (HHS)

Welcome Remarks

PACHA Co-Chair Ms. Anita Smith welcomed members to the full Council meeting and thanked them for their heavy involvement in and commitment to the draft report entitled *Achieving an HIV-Free Generation: Recommendations for a New American HIV Strategy* to be discussed and voted on today. She noted members had devoted more time to the report than their schedules permitted, but without that level of participation, the report draft would not be ready for consideration.

Ms. Smith thanked Mr. Joseph Grogan and his staff, particularly Ms. Dana Ceasar, for the amazing amount of work they had done on the report as well, which met with a round of applause from members. She asked Mr. Grogan for his remarks.

Executive Director Remarks

Mr. Grogan thanked members for their graciousness and patience with the report's numerous drafts. He expressed gratitude for the members' input and time. He noted that mockups of what the report could look like are currently available. He noted that all the report's graphics are in the public domain, as published by the Centers for Disease Control and Prevention (CDC).

Mr. Grogan noted the unavoidable absences of PACHA Co-Chair Dr. Louis Sullivan, Dr. Prem Sharma, Dr. Franklyn N. Judson, Ms. Lisa Mai Shoemaker, and Dr. Henry McKinnell, Jr. Mr. Grogan noted that Ms. Shoemaker would not be able to attend this, her last meeting, due to high winds in her home State. He relayed her best regards to the Council and her prayers that the meeting would go well. Mr. Grogan noted that Dr. McKinnell would be absent for this, his last meeting, because President George W. Bush had asked him to go to Pakistan to help with earthquake relief.

Mr. Grogan then read a letter from Dr. McKinnell expressing regret that he could not attend. Dr. McKinnell wrote that his experience with the Council was a "life-affirming experience." He expressed respect for all the members and gratitude for all the years of open and candid discussion, as well as trust. He believes the Council report recommendations will act as a catalyst for action by the Administration. He expressed strong support for the domestic and international goals of the report and hope that the Council would adopt, in particular, the recommendations of the International Subcommittee, of which he is a member. He noted progress and reason for hope in the fight against the pandemic.

Structuring Council Work on the Draft Report

Ms. Smith said Dr. McKinnell's letter was a fitting segue for discussion of the draft report, which all members have now seen. Work on the report will proceed as follows: Subcommittee Chairs will summarize their Subcommittees' sections of the draft, then lead and moderate Council discussion of their sections. Ms. Smith asked members to confine their remarks to the section at hand. At the end of the day, members will discuss and vote on the report's Preface and Introduction.

Ms. Smith asked members who wish to speak to the report to consolidate their thoughts and try to speak only once. She asked Subcommittee Chairs to recognize each member

one time. If a member who has already been recognized wishes to speak again, that person will be placed on a list.

Ms. Smith asked members to focus on the larger issues in the report and to avoid wordsmithing. She noted that each Subcommittee has voted to move the draft forward and that a great deal of editorial work has already been done. Time limits will not be placed on member comments; rather, members should impose time limits on themselves. A full Council vote will be taken after presentation and discussion of each Subcommittee section.

International Subcommittee Motion
Ms. Smith noted that, after lunch, the full Council will consider a motion proposed by the International Subcommittee entitled "Resolution on HIV/AIDS and Prostitution and Trafficking of Women."

Public Comment and Presentation by Ms. Carol Thompson, Director, Office of National AIDS Policy
Ms. Smith noted that public comment will be taken after lunch, and, at the end of the day, Ms. Thompson will address the Council, in part to recognize members rotating off of the Council.

Treatment and Care Subcommittee Presentation
Treatment and Care Subcommittee Chair Dr. David Reznik presented the Subcommittee's section of the draft report.

Dr. Reznik began by acknowledging the team effort of the Subcommittee members and thanked each one for their compassion and wisdom: Dr. Cheryll Bower-Stephens, Assistant Secretary of the Office of Mental Health in the State of Louisiana; Ms. Jacqueline S. Clements, of the Lincoln Community Health Center, in Durham, North Carolina; Ms. Sandra McDonald, President and Founder of OUTREACH, Inc., in Atlanta, Georgia; Dr. Jose Montero, of the Infectious Disease Center, Tampa General Hospital, and Associate Professor of Medicine at the University of South Florida; "living legend" Dr. Beny Primm, Executive Director, The Addiction Research and Treatment Corporation, New York City, New York; and Rev. Edwin Sanders, Senior Servant, Metropolitan Interdenominational Church, and Executive Director, the First Response Center, in Nashville, Tennessee.

Dr. Reznik used slides to provide background on the Subcommittee's recommendations. He also provided printouts of graphics to be incorporated into the Subcommittee's section of the report regarding the estimated number of AIDS cases and rates for male adults and adolescents by race and ethnicity, 2003, for all the States and the District of Columbia; the estimated number of AIDS cases and rates for female adults and adolescents by race and ethnicity, 2003, for all the States and the District of Columbia; the estimated number of persons living with AIDS by race and ethnicity, 1993-2003, in the United States; and the proportion of AIDS cases among adults and adolescents by race and ethnicity and year of diagnosis, 1985-2003, in the United States.

Historical Context: Dr. Reznik asked members to step back in time and remember when we first learned about AIDS:

- The first cases of what would become known as AIDS were reported in the United States in June 1981. Since that time, more than 1.5 million people in the United States have been infected with HIV, including 500,000 who have died.
- Of the first five young men identified as infected, two died. All were treated for biopsy-confirmed pneumocystis carinii and had confirmed previous or current cytomegalovirus (CMV) and candidal mucosal infection. Subsequently, 26 cases of Kaposi's sarcoma were reported among gay males, and 8 died, all within 24 months of diagnosis.
- In 1982, the CDC links the new disease to blood, and the term AIDS is coined. Two years later, the virus that causes AIDS is discovered.
- In 1985, the U.S. Food and Drug Administration (FDA) approves the first HIV antibody test.
- In 1987, FDA approves the first anti-HIV medication—AZT (zidovudine, Retrovir).
- In 1988, the United States bans discrimination against Federal workers with HIV.
- In 1988, 107 million copies of the Surgeon General's "Understanding AIDS" booklet are distributed.
- In 1990, the Americans with Disabilities Act and the Ryan White CARE Act (RWCA) are signed into law, the latter named for an Indiana teenager suffering from HIV/AIDS.
- In 1993, the CDC revises its definition of AIDS to include new opportunistic infections, and researchers in Europe show that AZT has no benefits to patients in the early stage of the disease.
- In 1995, the first protease inhibitor is approved for use in the United States (Saquinavir).
- In 1998, the U.S. Supreme Court decides its first case related to HIV/AIDS and the Americans with Disabilities Act.
- Through 2003, nearly 930,000 cases of AIDS have been diagnosed in the United States, including 43,171 cases in 2003 alone—a 4.6 percent increase over AIDS cases diagnosed in 2002.
- Up to 2003, some 524,060 people with AIDS have died, including 18,017 in 2003 alone.
- In 2003, the CDC estimates that more than a million people are living with HIV or AIDS in the United States, including nearly 406,000 in the most advanced stages of the disease.

Impact on Racial and Ethnic Minority Americans: Today, African Americans have the highest AIDS case rates of any racial/ethnic group, followed by Latinos, American Indian/Alaska Natives, whites, and Asian/Pacific Islanders. In 2003, the AIDS case rate per 100,000 population for African Americans was 9.5 times that of whites. In addition, African Americans accounted for 55 percent of all deaths due to HIV in 2002, with

Latinos accounting for 13 percent. Survival after diagnosis is lower for African Americans than for other racial/ethnic groups.

Other specifics about the disproportionate impact of HIV/AIDS on racial/ethnic minorities are:

- In 2003, minority Americans represented 71 percent of new AIDS cases and 64 percent of those estimated to be living with AIDS. African Americans alone account for almost half of all those living with HIV/AIDS in the United States.
- In 2003, African American women accounted for 67 percent of estimated new AIDS diagnoses among women.
- In 2002, teenage girls represented about half of HIV cases reported among 13-19-year-olds, with young African Americans representing 65 percent of AIDS cases reported among 13-19-year-olds.
- In 2002, some 60 percent of children born to HIV-infected mothers were African American.

Treatment and Care Subcommittee Recommendations

Given the data and the current trends of the epidemic, the Subcommittee decided that its first recommendation should address resource allocation and the disproportionate impact of HIV disease on African American and other communities of color.

Recommendation 1:"Programmatic initiatives and resource allocations should follow the epidemic and address the devastating and disproportionate impact HIV disease currently has among African Americans and other communities of color."

Because early diagnosis and getting patients into effective treatment and care programs are vital to stopping the spread of HIV and prevention, and treatment programs cannot be conceived and executed in isolation, the Subcommittee's second recommendation links prevention and treatment.

Recommendation 2: "Treatment and care should be integrated into prevention efforts."

The Subcommittee's third recommendation addresses the need for HIV testing to become a routine part of medical care in the United States, acknowledging that early diagnosis of HIV not only prolongs healthy productive lives but also increases the effectiveness of antiretroviral medication and is cost-effective over time.

Recommendation 3: "Because HIV testing is the gateway to HIV treatment and care, testing should be encouraged wherever possible."

Because life-sustaining antiretroviral medications should be available for all those who qualify for treatment and services under RWCA and yet, in some States, RWCA AIDS Drug Assistance Program (ADAP) funding shortfalls have led to waiting lists and broken drug therapy regimens, the Subcommittee's fourth recommendation addresses the need for more effective distribution of ADAP funds.

Recommendation 4 “Funds distributed under ADAP of the Ryan White CARE Act need to be distributed more effectively.”

Dr. Reznik elaborated on the background of the Subcommittee’s fifth recommendation, regarding core medical services. The Subcommittee agreed that these services should be provided in a culturally sensitive and linguistically appropriate manner and include:

- Physician and other medical provider visits, such as for adherence, subspecialty care related to HIV, and/or HIV treatments related to HIV, such as obstetric and gynecological and pediatric services
- Medically necessary medications
- Laboratory tests to monitor effectiveness and safety of treatment prior to initiating and during therapy
- Oral health services
- Mental health services
- Substance abuse treatment
- Prevention counseling in HIV clinical settings
- Nutrition counseling
- Hospice care
- Essential support services that enable people living with HIV disease to access and stay in care.

Recommendation 5: “The core medical service model should include a range of services to keep those needing HIV care in treatment, adhering to HIV medications, and leading healthy, productive lives.”

In its sixth recommendation, the Subcommittee addressed mental health because depression frequently accompanies initial diagnosis and can hinder access to and retention in care, complicated HIV medication regimens require stringent adherence, and mental health screening and comprehensive care, including access to mental health medications, must be included in any definition of core medical services.

Recommendation 6: “Mental health services need to be included in the core medical services of the Ryan White CARE Act.”

The Subcommittee agreed in its seventh recommendation that substance abuse treatment and counseling are essential for people living with HIV to help patients stay in care and to adhere to complicated medication regimens. Substance abuse treatment and counseling also play a significant role in secondary prevention.

Recommendation 7: “Substance abuse treatment must be part of core medical services available under the Ryan White CARE Act.”

The Subcommittee’s eighth recommendation addresses the need for treatment of comorbidities such as hepatitis C (HCV). Dr. Reznik noted that HIV is a cofactor that

accelerates HCV progression, leading to more rapid fibrosis and cirrhosis as well as other sequelae of end-stage liver disease. He also noted that whereas the effects of HCV on the natural history of HIV remain under investigation, there may be an impact on the management of HIV infection due to the risk of hepatotoxicity, more rapid progression of HIV-related disease, and impaired CD4+ cell recovery while on antiretrovirals. Access to core medical services should include treatments for comorbidities such as HCV in order to increase survival and allow for effective responses to HIV medications for a large subset of those HIV-infected.

Recommendation 8: "Treatment of comorbid conditions accompanying HIV infection, such as hepatitis B and C, must be covered under core medical services."

Dr. Reznik emphasized Ms. Clements' contribution to the Subcommittee's ninth recommendation, the essence of which is that HIV/AIDS patients should become independent, not dependent. The goal of HIV case management specifically should be to educate and empower patients to adhere to treatment regimens and follow up with medical visits. In addition, people are healthier when empowered.

Recommendation 9: "Medical case management and adherence counseling must be covered under core medical services."

The Subcommittee's tenth recommendation addresses oral health. Dr. Reznik emphasized that oral manifestations of HIV disease, such as thrush, warts, rapidly progressing dental decay, and periodontal disease, occur in a very high percentage of people living with HIV/AIDS. Unchecked oral diseases can lead to malnutrition and the inability to adhere to HIV medication regimens, yet access to oral health services for those receiving care and services through RWCA "remains a top unmet need nationwide."

Recommendation 10: "Oral health care must be a part of core medical services available under the Ryan White CARE Act."

In its eleventh recommendation, the Subcommittee emphasized the need for a reinvigorated communication campaign on domestic HIV/AIDS, specifically a public service awareness campaign to promote prevention that will also serve to increase HIV testing and reduce stigma associated with the disease. Americans must be reminded that HIV is life-threatening yet infection is preventable.

Recommendation 11: "The Federal Government needs a comprehensive, invigorated communication campaign of our domestic HIV/AIDS policies."

The Subcommittee's twelfth recommendation, which addresses incarcerated populations, emphasizes that the link between care while incarcerated and care upon release should not be broken. There should be HIV testing of inmates upon incarceration and upon release. Access to care must be available for those who test positive.
Recommendation 12: "Prisons should have intensive HIV education and counseling programs to protect inmates and the communities they return to."

The Subcommittee's thirteenth recommendation addresses the need to ensure the availability of more medical professionals willing and able to treat HIV/AIDS patients, because HIV/AIDS patients have better outcomes when they receive health care from providers and facilities with experience in treating HIV-positive patients. At present, there is a shortage of such providers, in part because HIV medicine is not a lucrative profession. Potential solutions could include:

- Providing reimbursement for health care workers who choose HIV care in medically underserved areas
- Encouraging the recognition of HIV care as a medical specialty
- Providing incentives for more medical health care professionals to be certified through their respective associations
- Ensuring adequate reimbursement for HIV care
- Promoting programs to increase the diversity of HIV health care professionals.

Recommendation 13: "Creative solutions must be found to encourage more doctors, physician assistants, and advanced practice nurses to choose to develop the skills necessary to treat HIV."

The Subcommittee's fourteenth recommendation addresses the need to maintain quality care while expanding care capacity. Specifically, outcome measures should be adopted to ensure that mainstream care is effective and competent, and continuing medical education should be provided and—if necessary—subsidized by Federal and State Governments to effect dissemination of the latest HIV medical knowledge.

Recommendation 14: "As we attempt to expand our capacity to treat HIV-positive Americans, we must not forget quality."

The Subcommittee's last recommendation focuses on research. Specifically, research must focus on limiting toxicities and metabolic abnormalities associated with existing therapies, and specific incentives should be provided for development of treatments that assist small-patient groups, as well as incentives to encourage the development of new medicines for broader HIV/AIDS management.

Recommendation 15: "Research into new and novel pharmaceutical agents to better manage HIV infection is of vital importance and must be encouraged."

Treatment and Care Subcommittee Section Discussion: Ms. Smith asked for and received a motion and a second to discuss the Treatment and Care Subcommittee's section.

Dr. Ram Yogev asked for more emphasis on rapid testing and mention, in Recommendation 8, of tuberculosis (TB). In terms of Recommendation 15, pharmaceutical companies will need strong incentives to do the necessary research.

Dr. Edward C. Green noted the domestic focus of the Treatment and Care Subcommittee's recommendations and asked whether some of them apply internationally as well, such as treating comorbidities.

Dr. Reznik expressed the hope that the Treatment and Care and International Subcommittees could work together more closely in the future.

Ms. Deborah Jacobs-Rock asked for more emphasis on peer counseling and outreach workers. Perhaps those living with the disease could be credentialed, for example, as substance abuse counselors.

Dr. Reznik said he would take that into consideration.

Dr. Beny Primm said the Subcommittee's draft is very complete and that many of the recommendations are applicable to the Caribbean.

Proposed Amendments to the Section and Adoption: It was proposed that Dr. Yogev's recommendations regarding rapid testing and TB be added to the Subcommittee's section. It was proposed that the section also include some discussion of the effectiveness of outreach workers in promoting case management.

Ms. Smith entertained both of these proposals as amendments to her motion to adopt the draft, which was seconded, and the Subcommittee's section was unanimously adopted by a show of hands.

Break

Reconvening

Ms. Smith noted that the intention of the report before the Council today is to reflect the Council's work over the past 4 years. She noted that this would be the last meeting of about half the Council's members. Remaining members and new will in the future consider a number of other issues raised today that are outside the scope of the current report. Ms. Smith assured those waiting to provide public comment that their comments would be taken into consideration as Subcommittee Chairs finalize the report in the days to come.

Prevention Subcommittee Presentation

Prevention Subcommittee Chair Dr. M. Monica Sweeney thanked Subcommittee members for all their hard work: Ms. Smith, Ms. Rosa M. Biaggi, Ms. Lisa Mai Shoemaker, Dr. Franklyn N. Judson, Ms. Rashida Jolley, Dr. Joe McIlhaney, Mr. Dandrick Moton, Ms. Mildred Freeman, and Ms. Deborah Jacobs-Rock. She also thanked Treatment and Care Subcommittee members Dr. Reznik and Dr. Primm for their input. Dr. Sweeney noted extensive discussion has already occurred on key aspects of the Subcommittee's draft. She emphasized that one way to view the Subcommittee's recommendations is to recognize that it costs $10,000-$20,000 per year to treat each newly diagnosed case of HIV. If there are at least 20,000 new cases each year, we will

need $400 million each year to treat just those coming onto the treatment rolls. In short, we cannot treat our way out of this disease. We have to focus on prevention. All of the Subcommittee's recommendations are designed to recognize this.

Additional facts include that 22 States now have or are preparing waiting lists for those in need of HIV/AIDS medication. When the Council last considered this issue, there were only 10. Also, the number of professionals prepared or preparing to treat people with HIV is decreasing. Just this morning, a Council member mentioned that a large clinic in a major city in the United States has closed, stranding 450 HIV/AIDS patients. One reason for these trends is that the epidemic has shifted. Those previously infected were middle- or upper-class white males, who were well educated for the most part and who had resources. Now those who are becoming infected at an increasing rate are dependent on public insurance. They are poor and poorly educated. And professionals who were previously willing to treat HIV/AIDS patients are no longer willing to treat them.

Recommendations and Background: Dr. Sweeney thanked Dr. McKinnell for his hard work on the Subcommittee's draft and acknowledged him as the originator of the concept of an HIV-free generation. She noted other infections that were thought to be unbeatable, such as smallpox. But when someone articulated the goal of eradication, many efforts were made to achieve it. While HIV/AIDS is a greater challenge than smallpox, an HIV-free generation is still possible.

Therefore, the Subcommittee's Recommendation 1 is: "The goal of United States domestic HIV prevention policy should be to have zero new infections, and all our prevention policies should be targeted to achieve that goal."

Dr. Sweeney noted another theme of the Subcommittee's draft: routinizing HIV testing. Here, medical health professionals need to catch up with the public, which assumes that if their blood has been drawn, they have been tested, even if they have not signed a consent form or subsequently been contacted about results. What is needed is a general consent form that will include HIV testing. New York State is making advances in this area, where all pregnant women are counseled about the need to know their status. The exceptionalism that has existed around HIV/AIDS needs to end.

Therefore, the Subcommittee's Recommendations 2, 3, and 4, respectively, are: "Every pregnant woman in the United States should be tested for HIV"; "HIV testing should be a routine part of primary care in the United States"; and "We must seek out opportunities to get people tested."

Dr. Sweeney said other general themes in the Subcommittee's section are:

- The need for science-based solutions

- The need for notification of partners to be part of public health policies everywhere, including in jails and prisons
- The need for HIV testing in jails and in prisons upon entry and exit
- The need for leadership at every level and the involvement in solutions of everyone infected and affected ("HIV stops with me" is an attitude that will greatly assist secondary prevention)
- The need for name-based reporting to be the standard of data collection and care and for appropriately reported data from all 50 states and territories
- The need for funding to follow the epidemic
- The need to tie mental health and substance abuse treatment to prevention
- The need to acknowledge and address in prevention programs and with appropriate messages the disparity of the infection rate among minority communities
- The need for adolescents to be involved in planning and targeting prevention programs
- The need for pharmaceutical advertising to be truthful and appropriate and for media treatment of HIV/AIDS to be more truthful and appropriate
- The need for all those infected to be treated with dignity and to be able to access care
- The need to reduce the stigma associated with the disease and with care of those infected (treatment needs to be mainstreamed so all those infected and affected can freely access care)
- The need for private sector partners to continue to invest in new treatments
- The need to end anonymous testing.

Dr. Sweeney continued to provide brief background for the Subcommittee's Recommendations 5-25, which are as follows:

Recommendation 5: "Contact tracing and partner notification should be standard."

Recommendation 6: "Anonymous testing should be eliminated."

Recommendation 7: "The Federal Government needs a major HIV prevention initiative in America's prisons and correctional systems."

Recommendation 8: "States accepting Federal dollars should demonstrate to the Department of Health and Human Services that they have developed a prevention action plan to combat new infections."

Recommendation 9: "The Health Resources and Services Administration (HRSA) and CDC need to fully integrate their treatment and prevention efforts."

Recommendation 10: "Those in HIV treatment and care must have access to mental health and substance abuse treatment."

Recommendation 11: “The links between depression, isolation, substance abuse, and risky behaviors must be confronted wherever possible.” (All those fighting HIV watch with increasing foreboding the rise in methamphetamine use accompanied by a rise in risky behaviors. Illegal drugs and alcohol abuse decrease inhibitions and compound mental illness, fueling the HIV epidemic. We must integrate HIV treatment and prevention campaigns with substance abuse prevention and treatment campaigns.)

Recommendation 12: “The Federal Government needs a comprehensive, multimedia HIV prevention campaign.” (…Media elites and television stars should be enlisted to help relay important HIV prevention messages.…)

Recommendation 13: “A particular emphasis in any prevention effort is needed for the African American, Hispanic, and minority communities.”

Recommendation 14: “In all messages to the public, we need to be honest, focusing on the realities of HIV.”

Recommendation 15: “An HIV prevention campaign must be appropriate to age, culture, and risk behavior.” (…Behaviors that put people at risk are found in every demographic group, regardless of age, race, ethnicity, or socioeconomic status. We must strive to make prevention messages culturally relevant….Many people in the United States are at risk and do not know it because they perceive HIV as a problem that only affects “other” people. HIV is now moving to affect people who did not think they were at risk. The recent data showing a dramatic increase of infections among women, particularly African American women, and an increase in HIV infections among young men who have sex with men [MSM], make it all too clear that stopping the spread of HIV is everyone’s responsibility.)

Recommendation 16: “People of good will working to control the spread of HIV must be respected.” (Parents who choose to educate their children that abstinence until marriage should be their first line of defense should be respected. In the same way, those who choose to make frequent testing and condoms their primary prevention approach should be respected. But every American should be aware of the risks associated with various sexual and drug-using behaviors, as well as the consequences should their prevention approach fail. Every American must be confronted with messages portraying the reality of HIV in America and the risk behaviors that lead to transmission.)

Recommendation 17: “Care should be taken to ensure the dignity and humanity of those infected with HIV.” (The recommended prevention campaign must confront difficult issues, but it must reaffirm our commitment to Americans infected with HIV. Done well, this campaign would galvanize Americans to fight HIV together while we care for those who need help.)

Recommendation 18: “Government officials should work with pharmaceutical companies to ensure continued caution and responsibility in the marketing of HIV pharmaceuticals.”

Recommendation 19: “Schools and parents must be challenged to tackle discussions of HIV prevention with youth.” (Federal officials must use the bully pulpit to reinforce the efforts of parents and teachers to help children make healthy choices.…We must deliver messages they can relate to, messages that are relevant to their experience, and real.…)

Recommendation 20: “Young people should be educated about the importance of delaying sexual debut and reducing the number of lifetime partners.” (Young people should be encouraged and educated to make the choice to delay sexual activity until adulthood and to remain faithful to one’s sexual partner. It is the number of lifetime partners that is the greatest indicator of HIV risk through sexual activity. The data are increasingly clear that delaying sexual debut drastically reduces the chances of HIV transmission.

Recommendation 21: “HIV education should be a part of an overall program to reduce risky behaviors.” (We must encourage young people to make healthy choices whenever possible and make it clear that healthy choices convey freedom, while unhealthy choices can ensnare someone for life.)

Recommendation 22: “More research is needed on adolescent brain functioning, specifically as it relates to addiction and risk-taking behaviors.”

Recommendation 23: “We need to have one standard and CDC-compatible data system.” (Confidential HIV name-reporting must be in place in every State and jurisdiction accepting Federal dollars.…At present, the CDC accepts data from only 36 States because it deems data from 14 States unreliable. We have been in the fight against HIV for 25 years, yet we still do not have reliable data… [which] are essential to deploy resources intelligently.…)

Recommendation 24: “Those States that refuse to adopt reliable, confidential, name-based systems should be required to surrender dollars to States that use sound policies in fighting this disease.” (We note that RWCA requires States to have reliable data systems in place in time for appropriations to be disbursed for 2007. Many States will not meet that deadline. These States must be held accountable. States without reliable, confidential, name-based systems…have had 25 years to build these systems, and the RWCA statutory deadline has been in place for 7 years….)

Recommendation 25: “The President and the Executive Branch should encourage States to pass health laws that advance sound HIV policies.” (One of the complicating factors in developing a comprehensive national HIV strategy is that health policies and laws are primarily the province of State Governments….The Federal Government should give serious consideration to creating a task force of experts from HHS and the U.S. Department of Justice to develop and promote model public health laws.)

Prevention Subcommittee Section Discussion and Adoption

Ms. Smith asked for and received a motion and a second for discussion of the Subcommittee's section of the draft report. By a show of hands, Council members approved the motion.

Dr. Bowers-Stephens asked that community mental health clinics and institutes for mental diseases be added to Recommendation 4. She asked that language stating that mental health and risky behaviors must be confronted whenever possible be added to Recommendation 11.

Dr. Sweeney said these suggestions are good. She noted that rapid testing is already conducted in nontraditional medical settings. Now it must be offered in traditional medical settings as well, and that point should also be made in the Subcommittee's section.

Dr. Yogev commented that Recommendation 2 is not specific enough. Second, he agreed we need to advance rapid testing because, at present, people are not returning to get their results. He suggested that rapid testing be mentioned in any recommendation regarding partner notification. Testing should be offered "on the spot," after counseling. Third, commenting on Recommendation 12, he suggested that the Subcommittee propose specific mechanisms to get the private sector involved, and he suggested that messages to adolescents be emphasized. Specifically, he suggested that we need to do more than simply "enlist" the help of media elites and movie and television stars in a prevention campaign.

Ms. Karen Ivantic-Doucette commented that Recommendation 9's background text statement—"Every health care provider treating a patient should pledge to do everything in their power to make sure that 'HIV stops with my patient'"—is excellent. She proposed additional language on training and providing incentives to medical providers for integrated treatment.

Rev. Edwin Sanders proposed that support for continued funding of the Minority AIDS Initiative (MAI) be specifically addressed in the draft report, in both the Prevention Subcommittee and Treatment and Care sections. He commented that MAI has been the single most significant source of support for increasing capacity and resources to fight the disproportionate impact of HIV/AIDS in minority communities. He noted the Administration had supported growth of the initiative; therefore, PACHA should do so as well.

It was agreed that Dr. Sweeney will discuss specific language with Reverend Sanders after the meeting.

Ms. Cheryl-Anne Hall recommended that the mention of 25 years be stricken from the background text of Recommendation 24. There seemed to be consensus for that. There was further discussion of the accuracy of the text. Ms. Ivantic-Doucette suggested that the text simply mention that States need to meet the statutory deadline imposed by

RWCA. It was agreed that the background would be restructured to deflect arguments that imposing such a deadline on States is an unexpected and unfunded mandate.

Dr. Green made a broad comment about the need for the draft report to make distinctions between generalized and other types of epidemics because strategies to address them differ to a certain extent. In addition, the President's Emergency Plan for AIDS Relief (PEPFAR) addresses this and the need for avoidance as a primary strategy.

Dr.Yogev responded that now that the disease trend is more heavily heterosexual, special efforts should be tailored to special populations. Second, he stated that we need to protect the status of those found to be positive so that they don't lose their medical health insurance, for example. Third, he asked if what is recommended for prevention domestically will differ from what is recommended for prevention abroad. Last, he commented that if circumcision is referenced, such references should be cross-referenced in the draft report.

Dr. Sweeney responded to Drs. Green and Yogev. She noted concern about special populations who think they are not at risk and, therefore, may not accept the concept of risk-based testing. She added that the goal of normalizing testing is to encourage testing. She noted that circumcision is addressed in the International Subcommittee's section of the report. She asked the Council if the report should address concern over the loss of insurance due to positive test results.

To the last point, Mr. Grogan noted that this issue has not been discussed fully to date nor has the Council received a presentation on it. He suggested the topic be addressed at a later meeting. Questions to be explored could include how big the problem is and whether loss of insurance is a barrier to testing.

Dr. Sweeney agreed the topic should be explored in the future.

Dr. McIlhaney apologized for having been out of the country without access to e-mail. He proposed that the draft more strongly emphasize behavior change, particularly to encourage no sexual behavior among young adults.

Dr. Sweeney noted that delay of sexual debut is discussed in the background text of Recommendation 20. Mr. Mason noted that behavioral change as a social vaccine is addressed in the International Subcommittee section of the report.

Rev. Sanders commented that he appreciated Dr. McIlhaney's and Dr. Green's statements, but that consensus seems to have been reached already on the topic of behavior change, as addressed in the draft report. It is difficult to create a hierarchy of risk. We have to say we're all at risk and make it clear that one of the ways that risk could be addressed and even eliminated is through behavior change.

Dr. Green commented that the epidemiological truth is that we're not all at equal risk. Those partners who are tested and who are monogamous and faithful to each other are at

zero risk. Either we tailor our message to the groups at risk and the behaviors that need to be changed or we don't. He proposed changing the background text for Recommendation 20 for youth so that it calls for a decrease in casual, multipartners sex. He proposed that a new, similar recommendation be added for adults.

Discussion ensued on how the majority of new infections are among MSM and how that kind of issue needs to be addressed, particularly in communities of color, where the infection rates are high. Dr. Reznik commented that he knows from his work that reducing partners works. Our prevention messages should be two-fold: we need a general message for our country, along the lines of delaying sexual debut, but we also need messages targeted to those who are at risk.

It was agreed that Dr. Sweeney would work on the issue with Dr. McIlhaney and Mr. Grogan.

Mr. Grogan clarified questions about process regarding the draft report and issues to be discussed in the future in the Prevention Subcommittee. He noted the number of member terms expiring today. After today, he expects further wordsmithing of the report and double-checking of data. He will not make any changes not approved by the Council Co-Chairs. He noted that the process to date has been collaborative and has proceeded on the basis of consensus.

Ms. Smith proposed that the Council reread Recommendation 15, suggesting that some of the issues under discussion were either addressed there or could be addressed there. Dr. Yogev suggested that condoms be mentioned in Recommendation 20. It was noted that the intention of Recommendation 16 was to mention different prevention messages that are felt to be appropriate in different settings.

Ms. Mildred Freeman suggested that Recommendations 20 and 21 could be combined. She added that, if condoms are mentioned, the message should be for them to be used each and every time.

Discussion ensued on whether the document states often enough that HIV is 100 percent preventable. It was noted that the Preface states this.

Discussion ensued about whether to add language to the Prevention Subcommittee section regarding casual, multipartners sex and consistent and correct use of condoms. Dr. McIlhaney proposed that Recommendation 20 for youth state that youth should be encouraged to make best choices, which are abstinence and, after sexual debut, lifelong or long-term faithfulness. He proposed not mentioning condoms in Recommendation 20.

Further discussion ensued on what can reasonably be expected of youth.

Dr. Sweeney clarified that unanimous votes are not necessary for changes to the draft. Ms. Smith noted that votes will be taken, and members who wish to vote against a motion or abstain are within their rights.

Ms. Smith asked and received a motion and a second for a vote on adding consistent and correct condom use to Recommendation 20. By a show of hands, the Council agreed to add language of this kind to the recommendation. The vote was 14 for; 5 against; and 1 abstaining.

Further discussion ensued on whether casual, multipartners sex and consistent and correct condom use would be added to Recommendation 15.

The Council then took up Ms. Ivantic-Doucette's proposed changes to Recommendation 9. It was agreed that there was general consensus in favor of the changes and that specific language would be crafted and shown to the Co-Chairs and the Subcommittee Chairs.

The Council then took up a proposal by Rev. Sanders to add the word "jails" to Recommendation 7. There seemed to be consensus to do so.

Ms. Smith and Mr. Grogan then summarized Council action on the Prevention Subcommittee's section of the draft report:

- Recommendation 2 will be changed to reflect Dr. Yogev's concern.
- Recommendation 3 will refer to rapid testing.
- Recommendation 4 will be changed to reflect Dr. Bowers-Stephens' proposals.
- Recommendation 5 will make clear that contact tracing and partner notification should be the standard, and partners who have not been tested should be encouraged to do so.
- Recommendation 7—the word "jails" will be inserted.
- Recommendation 9—training incentives will be mentioned.
- Recommendation 11—Mr. Grogan will work with Dr. Bowers-Stephens on specific language to insert here.
- Recommendation 12—a stronger word than "enlist" will be inserted.
- Recommendation 13 will refer to MAI.
- Recommendation 15 will be altered to reflect Dr. Green's and Dr. Yogev's concerns.
- Recommendation 20—condom use will be mentioned as voted on.
- Recommendation 24—the reference to 25 years will be removed and something else substituted for it, and the reference to the deadline under the RWCA will be checked.

Ms. Smith asked for and received a motion and a second for a vote to adopt the Prevention Subcommittee section of the draft report as amended. By a show of hands, the vote was unanimous to adopt.

Ms. Jacobs-Rock asked that the record reflect her concern about over-the-counter testing, as it could compromise the benefits of pre- and post-test counseling and the possibility that those who test positive would seek care. In addition, those who test positive could be subject to domestic violence.

The issue was placed on a list of issues for the Council to take up in the future.

Working Lunch

Ms. Smith acknowledged members who are rotating off of the Council after today's meeting. She noted many of them were members of the Prevention Subcommittee. She said all will be missed. She asked those present to state their top three issues for the Council to take up in the future.

Mr. Dandrick Moton responded that the hope of the young in the African American community is a top issue for him. Knowing what a healthy relationship feels and looks like is not as simple as choosing to have sex or not. It must be understood on a holistic level, and it requires a sense of hope.

Ms. Rashida Jolley thanked the Council for all the friends she has made. Her top issue is for young people to realize they have a purpose, that brighter days are to come. She noted that if we believe in them, eventually they will believe in themselves.

Ms. Jacobs-Rock thanked the Council and said her top issue is the need to work with parents. At present, there are so many children raising each other. She also hopes Council dialogue will impact policies that merge education and economics—that recognize and support HIV/AIDS patients who are living longer who want to return to school and work, in order to be productive citizens again.

Ms. Freeman said her experience on the Council was an honor and a pleasure. She noted she is a strong believer in prevention and in the ABC model of prevention. A top issue is that we can't treat our way out of this disease. But with budget cuts being proposed by the Administration, minorities will not be able to afford treatment when it is needed. With decisions like that, it will be difficult to send realistic messages to young people about delaying sex.

Rev. Sanders expressed the certainty that relationships built over the years on the Council will continue. A top issue for him is that the Council continues to be willing to deal with the tough issues surrounding this disease. He said he's convinced that the President doesn't choose members to be "yes" people. Therefore, the Council should deal specifically with issues such as injection drug use and needle exchange. While a great deal of scientific research has been done on this issue, it is also a political issue, like condoms. The Council needs to represents all sides of the dialogue on such issues, against the tide of "harm reduction." Last, the Council needs to continue to advance the day the disease is no longer stigmatized.

Mr. John Galbraith, who has just returned from 2 weeks in Africa, said the United States should be proud for having instilled a tremendous sense of hope in the developing world, through PEPFAR. While prevention is critical, he hopes we will continue to treat people because he found that treatment has been very successful in places he visited, such as Zambia. A year ago, hospices were critical for the dying. That has changed. On his trip a

Zambian asked him what to call hospices when people don't go there to die anymore. A top question for him and our partners abroad is, what will happen with PEPFAR.

Ms. Cheryl-Anne Hall commented that it was important for her, as a Caribbean, to be on the Council because to PEPFAR, the region is composed only of Haiti and Guyana. She now hopes that, someday, the Caribbean will be viewed as an entire region, not just two countries. She thanked the Council for helping her to do a better job working on HIV/AIDS in the Caribbean through a grant she received shortly after coming to the Council.

Ms. Ivantic-Doucette noted that when she first came to the Council she had some assumptions and fears about how the Council might work, based on her ideology and the fact that she is a field person and an activist. But she learned a great deal, including about building bridges and achieving consensus, and she is grateful for that mentoring. She believes that progress against the disease will be achieved through consensus, which is needed in order to be able to ask the hard questions. She very much admires the HIV-free generation paradigm. Hard work and finding a common language will be necessary to achieve it. The report represents a good start. Now she will be working closer to home, at the local, State, and city scene to try to get HIV/AIDS patients back into care.

Mr. Abner Mason thanked the Council and its staff for a wonderful experience. He enjoyed working with the International Subcommittee, the other Subcommittee Chairs, and the Co-Chairs. He commented that his fellow Subcommittee members are incredibly talented, have strong opinions, and are not easily led. Nonetheless, each member always wanted to end up in the right place. His reason for hope is the passion of people like his fellow Subcommittee members.

World AIDS Day Presentation

Mr. Miguel Gomez of HHS gave a brief presentation about World AIDS Day for members to take back to their communities. He asked everyone to get involved, as a major issue facing the event is that not everyone is as involved as in the past. Mr. Gomez noted that World AIDS Day events have been held for nearly 18 years. Women and girls will be specifically recognized and honored in March, and Native Americans in May.

For World AIDS Day, HHS will be demonstrating what is hoped will be replicated elsewhere, such as testing HHS employees. There will be employee education events across the Department, as well as an HHS-wide conference call to provide examples of what others can do to recognize the day, the lives lost, and the need for awareness. Key issues will be focused on, such as changes to Medicare Part D. In addition, Secretary Michael Leavitt is sending all HHS employees an e-mail about the day, providing updated statistics on HIV/AIDS and urging individuals to get tested.

Key events will include faith and civic events. This year an event will be held in Salt Lake City, Utah. Mr. Gomez noted that the metropolitan region has two mayors, one at the county level and one at the city level. Other participants will be Buddhist, Baptist, Episcopalian, Catholic, and Latter Day Saints churches, the last of which has never been

involved in an AIDS event. In Detroit, Michigan, a report will be released in partnership with the Arab Muslim and Christian communities. It will address silence in those communities about HIV/AIDS. In Kansas City, 300 female students will conduct assemblies in their school systems challenging their peers to become more aware of the HIV/AIDS epidemic.

Mr. Gomez provided to members a sample e-mail and downloadable posters for use in members' communities. He noted that key officials will travel across the country, possibly announcing news about PEPFAR.

Mr. Gomez emphasized the need for World AIDS Day to get more exposure, and he proposed a joint marketing venture with PACHA and its new goal and supporting report on achieving an HIV-free generation. He noted that it would be particularly effective to provide mixed cultural messages, which is what American youth and young adults seem to prefer. He noted a Web page where members can download facts and tools.

Public Comment
Ms. Smith announced the opening of public comment. She said she would read the names on the list of speakers, then Mr. Grogan would inform speakers of their 3-minute time limit at 1 minute left, then 30 seconds left, then time.

Ms. Smith read the following names. None of the speakers named appeared when called:

Mr. William Arnold
Mr. Terrence McDonald
Ms. Laura Hannon
Ms. Jennifer Johnson
Ms. Janice Sykes
Ms. Genevieve Grabman

Ms. Smith then read the name of Dr. Gene Copello.

Dr. Copello, Executive Director, The AIDS Institute, commended the Council for imagining an HIV-free generation as a common hope of many advocates. He agreed that ending HIV/AIDS will require new strategies by the United States and other countries around the world. Continued U.S. leadership is crucial to ending the domestic epidemic and global pandemic. Dr. Copello asked the Council to consider the following core principles as it finalizes its recommendations:

- HIV prevention efforts must be based on public health science that leads to a reduction in HIV infection.
- High-quality medical treatment and care must be provided to all Americans living with HIV/AIDS regardless of where they reside in the United States, including the availability of trained HIV medical providers in all jurisdictions.

- Research to find better medical treatments and, ultimately, an HIV preventative vaccine and curative therapies is an essential component of any strategy to end HIV/AIDS.
- HIV medical comorbidities, including hepatitis B, HVC, TB, and STDs, must be addressed as part of the overall plan to provide adequate medical treatment of HIV/AIDS.
- A number of factors contributing to HIV infection and disease progression must be addressed, including cultural issues, socioeconomic factors—particularly the relationship between HIV infection and poverty; and stigma and discrimination.
- Internationally, barriers to the provision of HIV prevention, treatment, and care must be overcome. These include lack of infrastructure, trading regulations that impede the donation of medications and medical supplies, and alarming rates of other infectious diseases, such as malaria.
- Adequate Government funding will be required to achieve an HIV-free generation.

Dr. Copello asked the Council to consider the following factors in finalizing its recommendations:

- Emphasis should be placed on strategies to reduce HIV infection in MSM, as 47 percent of all new cases are MSM and half of those are among African Americans. Strategies to reduce HIV infection of this kind are a key component in controlling the domestic epidemic.
- Several jurisdictions in the United States have legal needle exchange programs that are not funded by Federal sources. These programs should be noted as part of the domestic effort to curb HIV infection.
- Rapid testing in public health and community settings should be made widely available and legal and funding barriers removed. Over-the-counter HIV test kits should be piloted and the results assessed.
- Generally, The AIDS Institute supports the treatment and care principles articulated by the Administration regarding reauthorization of RWCA. The Institute strongly recommends that language be added to discuss the relationships between Medicaid and Medicare and RWCA at both systems and client levels and how those relationships can be improved.

Ms. Smith called Ms. Donna Sabatino.

Ms. Sabatino spoke on behalf of the Association of Nurses in AIDS Care (ANAC). Ms. Sabatino stated ANAC support for full funding reauthorization of RWCA. She attributed success of HIV/AIDS care and treatment in the United States as related to RWCA's comprehensive services programs. She said the Administration's principles regarding reauthorization are based on a flawed assumption;—that there are adequate resources/funding for HIV/AIDS care and treatment and that funding streams simply need to be restructured. Unfortunately, at least 150,000 more Americans are living with HIV/AIDS than when President Bush took office in 2001. The problem is not that we are

spending funds unwisely but that there is not enough funding to meet the continually increasing need.

Other principles not addressed by the Administration when addressing the needs of people living with HIV/AIDS include:

- There is a need to recognize that quality HIV/AIDS care and treatment involves more than a narrow definition of medical care. Support services, such as case management, adherence counseling, and mental health and substance use/abuse programs, enhance appropriate care and contribute to the decrease of disease exacerbation. Disease exacerbation leads to poorer outcomes with increases in morbidity and mortality.
- There is a direct relationship between medical outcomes and regular participation in care. Success of care and treatment is jeopardized when there is not access to services. Health disparities are the manifestation of not getting into care in a timely manner or not being able to stay in care due to lack of access to and availability of vital services.
- Treatment and effective secondary prevention have well-defined links. Those in routine care can get prevention counseling, education, and support to help curb further transmission. Therefore, secondary prevention strategies should be integrated into primary care and treatment programs and settings. Decreasing funding for services not currently considered "core" would be short-sighted and could potentially lead to higher costs.
- Providers of care, services, and treatment must be highly qualified to provide an appropriate level of care and treatment. There must also be a sufficient supply of qualified providers. Ongoing education and training is needed to maintain adequate skill levels and to ensure knowledge of the latest treatment and care information.
- Nurses are essential to care and treatment of those living with HIV/AIDS. They provide services in all areas of care. As nurse practitioners, they provide front-line HIV primary care, and are often case managers as well as caregivers. They also work in community-based clinics and organizations, educate and train other providers, are educators in schools and communities, and provide prevention counseling, substance abuse counseling, and palliative care. They are involved in program planning and development, are expert consultants to national programs, and serve on many Federal advisory councils and boards. Many nurses work in RWCA programs and therefore have a unique perspective on the critical role of RWCA programs.
- HIV/AIDS is expanding primarily into low-income and poor communities, communities of color, and increasingly among women. These are the same citizens who are bearing the brunt of cutbacks in Federal assistance programs such as Medicaid. If we are honest about our commitment to address HIV/AIDs in the United States, the need for appropriate care and treatment of those living with HIV/AIDS must be addressed.

Ms. Smith called Ms. Diana Bruce.

Ms. Bruce introduced herself as the manager of government affairs at AIDS Alliance for Children, Youth, and Families (AIDS Alliance). She thanked PACHA for including the needs of pregnant women and their children in the Prevention Subcommittee section of the draft report.

AIDS Alliance supports universal, routine HIV testing, with informed consent and pretest counseling, for all pregnant women. It also supports routine offering of HIV testing for newborns. In addition, it supports additional clinical research on the elimination of MTCT. The Alliance recommends that the draft report acknowledge that existing treatment of MTCT is highly effective. This fact can best be built on by making sure that all pregnant women have access to this treatment.

In addition to testing and research, the Alliance urges PACHA to focus on supporting additional resources for programs that work. For example, increased funding is needed for HRSA and the CDC to engage in intensive case management for pregnant women, in order to identify, reach, and serve the remaining 200 U.S. women annually who give birth to HIV-positive babies. If $10 million was devoted to this purpose, we could come closer to MTCT elimination.

Ms. Smith called Mr. Jeff Tomhave.

Mr. Tomhave spoke on behalf of the National Native American AIDS Prevention Center (NNAAPC) in Oakland, California. He noted that RWCA excludes the Indian Health Service from any direct AIDS treatment funding. The Indian Health Service has no line item within its annual budget for HIV/AIDS treatment for American Indians and Alaska Natives, despite CDC estimates that American Indians and Alaska Natives have the third highest rate of AIDS diagnosis. CDC also estimates that the AIDS infection rate among American Indians is 40 percent higher than among whites.

Two weeks ago in Tulsa, Oklahoma, NNAAPC convened a group of grassroots direct-service AIDS treatment providers, known as the Policy Advisory Committee, to promulgate recommendations to be forwarded to the U.S. Senate and House Health Committees as they consider reauthorization of RWCA. Among the recommendations are provisions for: a comprehensive, coordinated system of care for Native peoples; elimination of current obstacles to funding that bar Tribal providers from access to existing RWCA funds; culturally competent treatment and care; and mandatory Tribal representation on all Federal advisory committees, such as PACHA.

Mr. Tomhave offered NNAAPC assistance to PACHA and expressed hope that PACHA will seek to remedy the stated disparities.

Ms. Smith called Ms. Genevieve Grabman again.

Ms. Grabman is a legislative and policy associate with the Center for Health and Gender Equity. She said the Center notes with concern PACHA's International Subcommittee's proposed resolution on HIV/AIDS and prostitution and trafficking of women. She said current U. S. international AIDS policy and PEPFAR programs bar funding groups from working with sex workers to protect them from violence. Such groups are accused of facilitating prostitution. At present, relevant U. S. policy and implementing regulations are being challenged in Federal Courts in two districts (the District of Columbia and New York).

Ms. Grabman said PEPFAR is encouraging short-term programs to move sex workers out of prostitution, such as rescue and restore, as opposed to long-term strategies, such as providing micro credit and education.

She asked PACHA to demand evidence demonstrating the linkage of elimination of prostitution and sex trafficking. She said her Center is unaware of such evidence at this time. PACHA should also demand evidence showing the efficacy of rescue and restore programs. She said her Center is unaware of such evidence at this time.

In summary, the proposed resolution should not be approved in its current form.

Ms. Smith called Ms. Myla Moss.

Ms. Moss said that the American Dental Education Association (ADEA) and the American Association for Dental Research (AADR) join Secretary Leavitt in calling for the reauthorization of RWCA as crucial to the health and well-being of the estimated 1,185,000[1] people living in the United States with HIV/AIDS, as well as the some 40,000 individuals estimated to become newly infected with the disease this year.

The ADEA represents academic dental institutions, educators, researchers, residents, and students training in these institutions. The AADR represents the oral health research community by advancing research and increasing knowledge for the improvement of oral health. Together these organizations constitute the entirety of members and institutions that are dedicated to the advancement of research, education, and the delivery of oral health care for the improvement of the health of the public.

RWCA funds dental and oral health services through Titles I, II, III, and IV, and Part F. Part F consists of two programs, the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CDPP). The DRP helps repay uncompensated dental care, and the CDPP links providers to communities with high unmet oral health needs. Part F is designed specifically to develop the skills of dental students and dental residents in recognizing the oral pathology associated with HIV/AIDS, how to properly care and treat HIV/AIDS patients, how to identify persons at risk for infection, and how to recognize changes in the oral cavity associated with

[1] A Glance at HIV/AIDS Epidemic, Centers for Disease Control and Prevention, http://www.cdc.gov/hiv/PUBS/Facts/At-A-Glance.htm

infection. Skills are also developed in HIV counseling and testing, as well as appropriate and timely referral to initial and ongoing medical care.

RWCA reauthorization should be a high priority for the U.S. Congress, as it expired on September 30, 2005. Through reauthorization, improvements can be made to respond appropriately to the needs of those suffering from HIV/AIDS, to ensure that dental and medical treatment are compassionate and comprehensive, to promote prevention efforts, and to foster greater coordination of services.

Commenting on President Bush's principles for RWCA reauthorization, Ms. Moss emphasized the following:

- The need to service the neediest first, by establishing objective indicators to determine the severity of need for funding core medical services
- The need to focus on life-saving and life-extending services by establishing a set of core medical services.

Addressing the first point, Ms. Moss said that although HHS plans to revise its Severity of Need for Core Services Index (SNCSI) using objective criteria, including HIV incidence, poverty, and the availability of other resources, the organizations she represents have reservations about SNCSI's impact on those who desperately need access to oral health care.

Specifically, a thorough explanation is needed of how HHS will account for the "availability of other resources, including local, State, and Federal programs and support, and private resources" and how the "requirement of maintenance of effort on the part of State and local governments" is intended to work.

Addressing the second point, Ms. Moss said it is essential that HHS include oral health as a core medical service. Oral manifestations of HIV infection are a fundamental component of disease progression and occur in approximately 30-80 percent of the affected patient population. The unmistakable link between oral health and systemic health is demonstrated by conditions commonly found in HIV/AIDS patients. Ms. Moss went on to list those conditions, including hairy leukoplakia and candidiasis.

Ms. Smith concluded the public comment period and thanked all participants.

International Subcommittee Presentation

International Subcommittee Chair Mr. Mason summarized how the United States has become the leader in the global fight against HIV/AIDS in a mere 4 years, primarily through PEPFAR, which has demonstrated that treatment is possible even in the poorest parts of the world. He said PEPFAR's achievements should not go unnoticed in the face of a pandemic that represents the greatest challenge to human life we have ever known. As Americans, we have good reason to be proud of the challenge we took on and what we've accomplished. Now it is vitally important for us to maintain that leadership.

In writing its section of the draft report, the Subcommittee kept in mind two overarching goals:

- Achieving an HIV-free generation, which is important both domestically and internationally
- Continuing U. S. leadership through reauthorization of and changes in PEPFAR.

Recommendations: Mr. Mason read the Subcommittee's recommendations.

Recommendation 1: "The United States should continue to fund HIV efforts through both multilateral collaboration and bilateral agreements."

Recommendation 2: "As we maintain our commitment to those we helped place in care, the next phase of the emergency plan should broaden the focus from personal health to public health."

Recommendation 3: "All of America's foreign aid should complement public health by spurring development of basic infrastructure and supporting economic and political stability."

Recommendation 4: "The United States should broaden partnerships with indigenous faith-based organizations, nongovernmental organizations (NGOs), and the private sector to strengthen the nongovernmental social safety net of host countries."

Recommendation 5: "Host nations must repeal taxes and tariffs on HIV-related medical supplies and pharmaceuticals."

Recommendation 6: "Host nations must vigorously combat corruption and bureaucratic red tape in their public health delivery systems."

Recommendation 7: "The U. S. Government should consider making basic education campaigns a prerequisite of HIV assistance."

Recommendation 8: "As a demonstration of commitment to fighting HIV, we must encourage prominent political and social leaders of host nations to speak publicly about the causes of HIV and the basic biological facts of the disease."

Recommendation 9: "The U. S. Government must support basic research and maintain incentives for companies to invest in preventatives, vaccines, and treatments to meet the needs of the developing world."

Recommendation 10: "The U. S. Government should support, in conjunction with other donor nations, the harmonization of data collection and reporting requirements."

Recommendation 11: “Ensure that health professionals are trained in a broad range of interventions and increase economic incentives for trained health professionals to remain in their countries of origin.”

Recommendation 12:” The United States should promote successful prevention strategies.”

Recommendation 13: “Prevention of MTCT should be a major component of the post-emergency plan.” (Mr. Mason noted that this recommendation could be the fulcrum for a shift from personal to public health.)

Recommendation 14: “Human trafficking must be eliminated.”

Recommendation 15: “Careful consideration should be given to programs that encourage circumcision.” (Mr. Mason noted that the latest data indicate circumcision could have a positive effect on the scale of a partially effective vaccine.)

Mr. Mason concluded by saying that the United States can help the world achieve the goal of an HIV-free generation through continued leadership and by making connections between domestic and international policies.

Discussion: Rev. Sanders asked if the International Subcommittee section refers to vaccine development. Mr. Mason said Recommendation 9 refers to incentives for pharmaceutical companies, and there is a role for Governments and academic institutions in basic research as well. Both basic and applied research should be encouraged.

Dr. Green noted that supporting text for Recommendation 12 states that “Assumptions cannot be the basis for measuring effectiveness.” He asked that the word “consensus” be added or that perhaps both the words “assumptions” and “consensus” be used. Ms. Ivantic-Doucette suggested “consensus based on assumptions.” The Council seemed to agree to this suggestion.

Regarding Recommendation 15, which he supports, Dr. Green asked for recognition that striking declines in transmission from circumcision are usually found in heterosexually driven epidemics. He also suggested that the International Subcommittee section contain cross-references to the Treatment and Care Subcommittee section. He added that if we can’t treat our way out of the pandemic globally, this should be clearly stated in the International Subcommittee section.

Mr. Mason noted that the Subcommittee attempted to address some of Dr. Green’s comments in Recommendation 2. The recommendation does not suggest we should not treat those in need; rather, it suggests that while we continue to maintain a commitment to treatment, we should also shift focus from personal to public health. Mr. Grogan noted that the International Subcommittee section states early on that we can’t treat our way out of the pandemic.

Dr. Jane Hu commented on the issue of drug resistance and the projected greater need in the future for second-line drugs. One way to prevent resistance is comprehensive care, but it is not certain that sufficient funding will be available. PACHA should address this problem, if not now, in the future.

Dr. Sweeney suggested that Recommendation 8 refer not only to first ladies but to first husbands.

Dr. Primm asked that the circumcision studies underlying Recommendation 15 be mentioned. Mr. Grogan summarized the Subcommittee's earlier discussions on this, which noted that the early data for circumcision is striking, but the effect needs further study. Dr. Primm wondered how developing countries would react to the recommendation. Dr. Green said tribal societies in Africa are receptive.

Addressing Recommendation 11, Dr. McIlhaney asked whether the Subcommittee discussed the appropriateness of faith-based organizations following their own beliefs in what they teach. Mr. Mason said the topic was not discussed. It was noted that this subject has been dealt with in an amendment to the PEPFAR legislation.

Dr. Yogev suggested in text outlining "HIV Prevention Successes" on page 6 that the words "are effective messages" not be used in conjunction with delay of sexual debut for youth, partner fidelity, and correct and consistent condom use in Uganda. Dr. Yogev also suggested that text providing background for Recommendation 13 mention the connection between breastfeeding and MTCT as an unresolved issue.

Mr. Mason proposed changes to respond to Dr. Yogev's suggestions, substituting "most appropriate measures" for "are effective messages" in the page 6 text and mentioning the need to educate mothers about safe breastfeeding in Recommendation 13.

Ms. Jacobs-Rock asked that Recommendation 11 be changed to mention training to become peer educators. Mr. Mason accepted the change.

Dr. Bowers-Stephens asked that Recommendation 11 also mention community health workers.

Rev. Sanders suggested that the Preface or perhaps the Introduction mention that the unresolved issue of breastfeeding and MTCT needs to be addressed in the larger context of economics and development in the developing countries.

Mr. Mason asked Rev. Sanders to review Recommendation 3 as well as general text preceding it. Rev. Sanders then asked if debt relief had been reviewed as an incentive to developing countries. Mr. Mason said Recommendation 3 might also address this. Mr. Grogan said the concepts that would lead to debt relief are in that text. Rev. Sanders said the text might need clarification.

Rev. Sanders then addressed the issue of circumcision as requiring trust. He suggested that its "potential usefulness" be stressed in Recommendation 15, and Dr. Hu agreed. She suggested that the text speak to enlisting the help of Tribal leaders.

Mr. Mason said Subcommittee members think not enough is known to take Recommendation 15 to the implementation stage.

Further discussion ensued. Ms. Ivantic-Doucette and Ms. Jacobs-Rock suggested that additional language be added that shows careful review of new data is needed. Dr. Sweeney objected and said the recommendation already has many caveats in it. She then moved that it be adopted as presented. Further discussion ensued on the need to provide explanatory cites in the International section of the draft report. Ms. Clements said mentioning circumcision and early data supporting it for prevention is the kind of bold, unusual step that might need to be taken if the goal of an HIV-free generation is going to be achieved. There was further discussion of altering the recommendation language to remove words such as "programs" and "encourage."

Dr. Primm and Rev. Sanders suggested that if circumcision is going to be mentioned as an international recommendation, it should also be mentioned as a domestic recommendation.

It was proposed that Recommendation 15 be tabled. A motion was made and seconded. Dr. Reznik said the scientific evidence is too strong to table the recommendation.

Ms. Smith called for a vote on the motion to table. By a show of hands, the motion failed 18-4, with no abstentions.

Dr. Green proposed new language for the recommendation, as follows: "Careful consideration should be given to review of the evidence that male circumcision reduces the likelihood of HIV transmission." Discussion ensued on whether the proposed language changes were acceptable.

Dr. Bowers-Stephens suggested that the report note, perhaps in a "Breaking Science" section, that the scientific evidence regarding circumcision is worthy of further study and possibly programmatic action both internationally and domestically. Mr. Grogan said something like that could be placed in the Introduction.

Dr. Sweeney suggested that new circumcision text adopted for the International Subcommittee section could be repeated in the Prevention Subcommittee section of the report. Further discussion ensued. Dr. Primm asked about the rate of HIV in Israel, where males are routinely circumcised. Dr. Yogev noted that the rate is close to zero, and Dr. Primm said that then needs to be stated.

Mr. Mason and Ms. Smith asked for a vote by show of hands in favor of the new language proposed by Dr. Green. By a show of hands, the vote was 16 for; 2 against; and 1 abstention.

Rev. Sanders then made a motion that the Prevention Subcommittee section reflect the language just adopted for the International Subcommittee section. He proposed that another section of the report address Dr. Bowers-Stephens' proposal regarding "Breaking Science." Dr. Bowers-Stephens summarized what was under discussion as "scientific evidence that is worth further study to translate into practice, domestically and internationally." In addition, she proposed that the report state: "We recognize that there are social and cultural implications to this that might prove to be barriers to implementation." She added that it takes about 10 years to take science to practice.

Dr. Bowers-Stephens clarified that she is proposing that such language be added to both the International and Prevention Subcommittee sections.

Mr. Mason stated that there seemed to be consensus around Dr. Bowers-Stephens' proposal and asked for her exact wording.

Mr. Mason and Ms. Smith asked for and received a motion and a second to vote on the entire International Subcommittee section, as amended. By a show of hands, the vote was unanimous to adopt.

Draft Motion on HIV/AIDS and Prostitution and Trafficking of Women: Discussion and Adoption

Mr. Mason asked members to review the International Subcommittee's draft motion on HIV/AIDS and prostitution and trafficking of women.

Dr. Yogev made a number of suggestions for minor changes, which were then integrated into the draft motion.

Mr. Mason and Ms. Smith asked for and received a motion and a second to adopt the draft motion. The draft motion as follows was adopted unanimously by a show of hands.

Presidential Advisory Council on HIV/AIDS
International Subcommittee
Motion on HIV/AIDS and Prostitution and Trafficking of Women

WHEREAS, women, children, and men in prostitution and trafficking have consistently higher HIV prevalence than other people in the same region and, therefore, may contribute to higher levels of HIV infection in the general population;

WHEREAS, HIV infection rates may increase when a high proportion of males frequent people in prostitution;

WHEREAS, HIV incidence and prevalence in general populations can be reduced if HIV infection rates in high-prevalence groups are reduced;

WHEREAS, approximately 10 million children worldwide have been recruited and trafficked into prostitution by individuals who exploit them ruthlessly, placing them in

brutal conditions that may result in physical, sexual, and psychological devastation and trauma (ref: *The Lancet*, Vol. 359, April 20, 2002);

WHEREAS, the trafficking of women across international borders (global estimate is 600,000 to 800,000 per year) is a violation of human rights;

WHEREAS, many women in prostitution are physically and psychologically abused;

WHEREAS, President George W. Bush has taken a strong stand against human trafficking—condemning it as "a special kind of evil in the abuse and exploitation of the most innocent and vulnerable" and that "we must combat this trafficking and protect and assist its victims both domestically and globally";

WHEREAS, the United States and other developed countries commit billions to HIV/AIDS treatment, while efforts to curb one of the epidemic's significant drivers, human trafficking and prostitution, lag;

BE IT THEREFORE RESOLVED that PACHA commends the President for his initiatives to stop the spread of HIV/AIDS and to reduce and eliminate trafficking and forced prostitution of children, women, and men.

PACHA further recommends:

1. Development of programs to eliminate the sex trade, extending the President's advocacy of worldwide freedom for all;
2. Support of further development and funding of programs and practices to rescue and rehabilitate those trapped in the sex trade and protect them from violence. These programs should support effective short- and long-term strategies;
3. Development of programs to train healthcare workers in state-of-the art risk reduction programs (such as condom use and STD diagnosis and treatment) and in referral techniques to enable rescue and rehabilitation services;
4. Continued vigorous investigation and prosecution of individuals supporting human trafficking; and
5. Advocacy and funding of further research on the link between the sex trade and the HIV epidemic.

Preface and Introduction of the Draft Report: Discussion and Adoption
Ms. Smith asked members to consider any issues they might have with these sections of the report. She then announced a break.

Break

Reconvening
After the break, Ms. Smith asked for and received a motion and a second for discussion of the Preface. She then asked for a motion and a second for a vote on the section. The section was adopted unanimously by a show of hands.

Ms. Smith asked for and received a motion and a second for discussion of the Introduction.

Dr. Green proposed that the important role of nutrition in treatment be mentioned in the Introduction. This seemed to meet with consensus.

Dr. Yogev asked if the potential for a vaccine should be mentioned in the Introduction. After discussion, it was agreed that the Introduction would mention the need for continued research on a vaccine.

Dr. Hu proposed that drug resistance be mentioned. Dr. Yogev proposed that when research is mentioned in the Introduction, discussion of a vaccine, drug resistance, and effective treatments be grouped together. There seemed to be agreement on this proposal.

There was discussion of various sentences in the Introduction, and there seemed to be agreement on changing bullet 7 on page 2 to mention the need for leadership throughout the public and private sector, both domestically and internationally; on changing bullet 4 on page 2 to add oral health as an essential component of HIV prevention, treatment, and care; and on changing bullet 10 on page 2 to substitute "addressed" for "alleviated."

There also seemed to be agreement to change the last sentence of paragraph 1 on page 1 to read "…has now become a pandemic stretching…"; to strike the term "planet earth" from paragraph 2 on page 1 and substitute the word "worldwide"; and to specify African Americans as well as other minority communities in paragraph 4 on page 1.

Ms. Smith asked for and received a motion and a second to adopt the Introduction as revised. By a show of hands, the vote was unanimous in favor to adopt.

Ms. Smith announced that the Council's business on the report was now concluded.

Availability of the Report

Mr. Grogan announced the plan for publication of the report. He hopes it would be printed by December 1, 2005, and appear on the HHS Web site within a day or two after that. He will provide at least one copy of the printed report to each member.

Presentation by Ms. Carol Thompson, Director, White House Office of National AIDS Policy

Ms. Smith introduced Ms. Thompson to make a statement on behalf of President Bush.

Ms. Thompson voiced the President's regret at not being able to attend the PACHA meeting. He is on his way to Asia with Mrs. Bush to attend high-level meetings.

Ms. Thompson noted that because she hasn't been part of the HIV/AIDS world for the past 20 years, she has very much relied on the Council to keep her up to date. She particularly appreciates the Council's advice and counsel regarding reauthorization of

RWCA. She asked members who are rotating off of the Council to continue to be in touch with her.

Ms. Thompson congratulated departing members for all their hard work. She said they had served the Administration, the Nation, and the world well and promised that their time and efforts will result in the best possible Administration policies on HIV/AIDS. She particularly noted how the Council has advanced debates inside and outside the Administration.

Ms. Thompson noted with enthusiasm the title and goals of the report adopted by the Council. Achieving an HIV-free generation is a very bold statement, but it needs to be said. This challenge is one the United States should be leading. It is a challenge that needs to be looked at seriously. She endorsed the report for recognizing all of us as AIDS activists. She agreed that reaching the goal will take effort and leadership across the world and at all levels, not just at the Government level, but among all citizens. She noted the report's recommendation for routine care and testing as comporting with statements made by the President last year. She noted that a great deal of work needs to be done on Capitol Hill to get reauthorization of RWCA moving faster. She added that the International section of the report will serve as a resource for the Administration and the White House as policy teams look for ways to continue PEPFAR's advances.

Ms. Thompson said she personally guarantees that all the report's recommendations will be seriously considered by the President and the Administration's policy teams as they review new HIV/AIDS initiatives to be taken over the course of his remaining years in office.

Ms. Thompson called the Council an amazing group of compassionate, committed, incredibly experienced Americans who bring to the table just the kinds of advice needed from advisory boards. She expressed sadness at the departure of members rotating off of the Council. She noted that they had given of their expertise and insight without compensation and had taken time away from their families and jobs in the service of the Government and those in need of their help. "There are a lot of people in need who will benefit from what you've done here," she added.

Ms. Thompson then presented plaques and small gifts from the White House to the departing members. A round of applause followed.

Final Comments

Ms. Smith thanked the members on behalf of herself and Co-Chair Dr. Sullivan. She hopes to continue to hear from departing members on future issues before the Council.

Adjournment

Ms. Smith adjourned the meeting at 4 p.m. She concluded that the Council can be proud of its work on the report.