Presidential Advisory Council on HIV/AIDS (PACHA)
Thirty-first Council Meeting
Howard University
Armour J. Blackburn University Center
2397 6th Street, N.W.
Washington, DC 20059

October 16-17, 2006

Council Members—Present
Alan Holmer, J.D., Co-Chair, PACHA
*Marilyn Maxwell, M.D., Co-Chair, PACHA
Robert Redfield, M.D., Chair, International Subcommittee
David Reznik, D.D.S., Chair, Domestic Subcommittee
Troy Benavidez
Rosa M. Biaggi, M.P.H., M.P.A.
Robert Bollinger, Jr., M.D., M.P.H.
Cheryll Bowers-Stephens, M.D., M.B.A.
*Freda Bush, M.D., FACOG
Jacqueline S. Clements, B.S.
*Shenequa Flucas
Edward C. Green, Ph.D.
Franklyn Judson, M.D., M.P.H.
*Robert Kabel, J.D.
Herbert H. Lusk II, M.Div.
*David Malebranche, M.D., M.P.H.
*John Martin, Ph.D.
Jose Montero, M.D., FACP
Beny Primm, M.D.
*Barbara Wise
Ram Yogev, M.D.

**New Members*

Council Staff—Present
Joseph Grogan, Esq., Executive Director, PACHA
Dana Ceasar, PACHA Program Assistant

Other Participants
John Agwunobi, M.D., M.P.H., M.B.A., Assistant Secretary for Health, U.S. Department of Health and Human Services (HHS)
Victor F. Scott, M.D., FACP, Senior Vice President for Health Sciences, Howard University
Celia J. Maxwell, M.D., FACP, Assistant Vice President for Health Sciences, Howard University Hospital, D.C. Mayor's Task Force

Marsha Martin, D.S.W., Senior Deputy Director, D.C. Department of Health, HIV/AIDS Administration
Alan Greenberg, M.D., M.P.H., George Washington University Department of Public Health
Amanda Castel, M.D., M.P.H., George Washington University Department of Public Health /D.C. Department of Health, AHPP
Catalena Sol, M.D., La Clinica del Pueblo
John Hogan, M.D., Director, Unity Healthcare
Veronica Jenkins, M.D., Medical Director, Family Medical and Counseling Services
Ron Mealy, M.D., Carl Vogel Center for Complementary Services
Flora Hamilton, D.S.W., Family Medical and Counseling Services
Cornell Jones, Miracle Hands, Inc.
Susan Galbraith, M.S.W., Our Place
Devon Brown, Director, D.C. Department of Corrections
Frances Ashe Goins, R.N., M.P.H., Deputy Director for Women's Health, U.S. Department of Health and Human Services
Patricia Nalls, The Women's Collective
Kenneth Robinson, M.D., Commissioner, Tennessee Department of Health
Rev. Canon John Harmon, Trinity Episcopal Church, Trinity Development Corporation
Rev. Susan Newman, Ph.D., The Balm in Gilead, D.C. Office
David Catania, Chair, Committee on Health, D.C. City Council
Greg Pane, M.D., Director, D.C. Department of Health
Adaora Adimora, M.D., M.P.H., Assistant Professor, Department of Medicine, University of North Carolina at Chapel Hill
Peter Leone, M.D., Medical Director, HIV/STD Prevention and Care Branch, Associate Professor of Infectious Disease, University of North Carolina at Chapel Hill
Lynette Mundey, M.D., Director, Student Health Services, Howard University
Timothy Mastro, M.D., FACP, Deputy Director for Science, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention
Thomas A. Kenyon, M.D., Principal Deputy Coordinator and Chief Medical Officer, Office of the U.S. Global AIDS Coordinator

DAY ONE

Welcome Remarks

PACHA Co-Chair Alan Holmer opened the meeting and welcomed **Dr. John Agwunobi**. Dr. Agwunobi expressed special thanks to the D.C. Mayor's Task Force as host of this meeting for bringing the issue of HIV/AIDS into the real world. He asked the seven new PACHA appointees to come forward to be sworn in as official Council members.

Dr. Agwunobi noted that there was much progress in treating AIDS to celebrate but continuing disparity in access to care and infection outcome. The African American community needs to stand up and protect itself. The importance of testing and knowing one's HIV status are messages that should be carried to every community; the epidemic crosses all boundaries. The stigma of being tested must be eliminated. Dr. Agwunobi

urged Howard University to lead the fight to get everyone to volunteer to be aware of their status. Howard has established a tradition of leadership in the global arena and can play a significant role here where leadership is essential. He said PACHA is one of the most important committees in the Federal Government; its pronouncements save lives. Dr. Agwunobi emphasized the Administration's personal commitment to combating HIV/AIDS—exemplified in the President's Emergency Plan for AIDS Relief (PEPFAR) initiative and support for Ryan White reauthorization.

As Senior Vice President for Health Sciences at Howard University, **Dr. Victor Scott** said he considered the University to be at the forefront of concern. The Howard University Hospital offers testing and treatment to all. Dr. Scott recalled the "terrible" days when drugs to treat infected patients were lacking, and said Howard is committed for the long haul. He expressed the University's pleasure in hosting PACHA and welcomed participants on behalf of Howard's president and provost.

Dr. Celia Maxwell greeted participants, noting the disproportionate effect of the epidemic in the District of Columbia, but said Howard is pleased to lead the Nation in testing all patients who come through the hospital. We hope, she said, it will lessen the burden of this disease.

Mr. Holmer welcomed members and guests and introduced Dr.David Reznik as a tireless worker for PACHA and advocate for passage of the Ryan White CARE Act.

David Reznik, D.D.S., *Achieving an HIV-Free Generation: Recommendations for a New American Strategy*

Dr. Reznik stressed we must commit to victory and recommended that everyone read the new PACHA publication, *Achieving an HIV-Free Generation: Recommendations for a New American Strategy*. Among its underlying themes are*:*

- Every American should know his/her HIV status.
- Access to treatment must be ensured.
- Leadership and continuing research are essential.
- The growing epidemic among African Americans and Hispanic Americans must be addressed.
- Programs and approaches must be continually updated.
- Social, economic, psychological, substance abuse, and legal factors fueling the epidemic must be addressed.
- The goal of efforts must be zero infection.

A total of 26 recommendations are contained in the book's "Prevention" section, including the Centers for Disease Control and Prevention (CDC) recommendation that HIV testing should be a routine component of primary care. PACHA's recommendation that every pregnant adolescent and woman be tested is incorporated. Fifteen recommendations under "Treatment and Care" cover resource allocation, links with prevention and testing, core medical service, mental health and substance abuse, co-morbidities, case management, oral health, incarcerated populations, quality assurance, and research. Dr. Reznik said that money must follow the disease and noted that ADAP

(AIDS Drug Assistance Program) funds under Ryan White must be distributed more effectively. In addition, recommendations note that there is a particular need for creative solutions to increasing the number of skilled providers.

Dr. Reznik updated members on the progress of Ryan White legislation, which had passed in the House of Representatives but was blocked in the Senate. To illustrate the consequences of non-reauthorization, he presented impacts on Georgia and Atlanta, where thousands of people living with the disease would lack critical care. Pending passage of the bill, Health Resources and Services Administration (HRSA) HIV/AIDS working groups have already been suspended. Appropriation concerns remain with the new legislation, but Ryan White must be reauthorized. Dr. Reznik praised the work of Marty McGeein and others who have worked "passionately" on behalf of the Act's reauthorization.

PANEL: ***Overview of the D.C. HIV Epidemic, African American HIV Demographics Nationally, and the D.C. HIV Screening Campaign***

Dr. Marsha Martin introduced the panel members.

Dr. Alan Greenberg presented slides covering HIV surveillance under CDC, the history of key data collection, and rationale for transition to more comprehensive HIV/AIDS surveillance—pathways. The background for a comprehensive national surveillance system to monitor pathways includes: (1) a National HIV Behavioral Surveillance System (NHBS); (2) an HIV Incidence Surveillance System (conducted in 34 sites); and (3) HIV case surveillance implementation status by State. A morbidity monitoring project is also underway. Each project is being designed for the long term. Data show AIDS peaking in the 1980s, but an increasing number of people currently living with AIDS despite fewer cases. Race/ethnicity data confirm the incidence among African Americans at a disproportionate rate. There has been a dramatic reduction in perinatal transmission.

Dr. Amanda Castel discussed surveillance in the District of Columbia—work funded by CDC. In 2006, African Americans account for 49 percent of newly diagnosed cases, a much higher rate than that in other cities of the same size or larger. The 25-44 age group shows the highest number of AIDS cases and deaths. Women make up a large proportion of those infected, but pediatric AIDS has gone down. In trying to determine maternal risk factors, it was found the majority were unspecified, 21 percent were drug-related, and 21 percent were the result of heterosexual contact. Overall, African Americans accounted for 82 percent of D.C. cases versus 14 percent for whites. Surveillance is clearly important, since one in four persons infected is unaware of his/her status, and prevention and care efforts must be targeted. D.C. uses a name-based system, which is currently not accepted by CDC. An estimated 17,806 to 25,405 D.C. citizens are living with AIDS. In an effort to improve surveillance, CDC recommends code-based reporting linked to Federal funding. Changes in the law would require extensive outreach to providers. Partnership with George Washington University's Department of Epidemiology will promote behavioral and incidence surveillance, as described by Dr. Greenberg.

***Comments*:**

- CDC's "pediatric AIDS" definition skews reporting. There are other definitional problems such as "high-risk heterosexual." Dr. Greenberg said they were moving toward different definitions.
- Why is it difficult to make the transition from a name- to a code-based reporting system? Dr. Castel said D.C. currently uses two reporting systems and wants to preserve data collected previously. Providers also must be alerted throughout the health system.
- More information would be helpful for other communities on new AIDS cases captured—cases not known to be patients.

Dr. Marsha Martin drew members' attention to material in the folder she had distributed: *HIV/AIDS in the Nation's Capital,* describing the "Campaign to Screen All City Residents for HIV." The Campaign has taken off, she said. A year ago, the Campaign had 17 partners; now there are 51, a total that includes private doctors and individuals. Student services at six colleges and universities have initiated testing based on Howard University's example. Since June 27, 2006, 16,000 people have been screened—testimony to the value of outreach and networking. D.C. Jail officials now require automatic testing, and 5 percent of inmates have tested positive since June. "We have expanded, are involved, and committed….We are prepared to reinvent and modernize," said Dr. Martin. Latinos are an equal target of attention; all program materials are bilingual. Dr. Martin promised to provide more demographic information at the next meeting.

Comments:

- Accomplishments in D.C. since Dr. Martin's arrival have been remarkable.
- When people are discovered with AIDS, they are referred to a provider, treatment, and lab tests, depending on the case. D.C.'s ADAP program provides medication to capture people quickly and provide care. While screening can be accomplished, followup and monitoring for care in the next phase is more challenging but critical.
- D.C.'s annual budget for HIV/AIDS is $80 million. The Mayor's Task Force is chaired by the Mayor and supported by the City Council—two helpful factors.
- People should not be stratified according to gay or heterosexual labels. Stratification should be based on behavior (condom use, unprotected anal sex, etc.). Surveillance projects are looking at behaviors.
- A perennial question concerns what kind of data are being collected from doctors of white patients, since most data are collected at public health clinics used more by minorities. Dr. Martin said all hospitals are required to report, although field investigators have found a lack of reporting. Dr. Reznik said private practitioners are unlikely to report.

COMMUNITY PANEL: *HIV Care and Treatment in D.C. and Prevention Issues*

Dr. Martin introduced the panel members.

Dr. Catalena Sol described La Clinica del Pueblo, a 20-year-old clinic that was founded in response to the growth of the Latin American population from Central America in D.C. She noted that yesterday was National Latino Testing Day, and their clinics are following up today. Dr. Sol said new cases of HIV/AIDS are increasing in the United States and Latin America, and listed a number of problems that place Latinos with HIV/AIDS at special risk:

- Diagnosis tends to be late; the patient often has AIDS already and is in medical and social crisis.
- Latinos suffer unequal access to care, often have several jobs, and are ineligible for many programs because of immigration barriers. There are major conflicts between having to work and seeking care. Immigrants are more likely to have socioeconomic barriers preventing adequate health care.
- Immigrants fear hostility from established health providers.
- People are forced to move frequently because of lack of affordable housing.
- Immigration barriers discourage seeking medical help.
- Most patients lack family support structures and are known only to La Clinica.
- Linguistically and culturally appropriate services, especially in the area of mental health, are lacking.
- The Latino community is far less likely to receive prevention services.
- Cultural taboos discourage discussing negative things—"It's better not to know."

La Clinica's model of care—prevention and early detection—includes use of *promotores de salud* (health promoters from the local community) and companions to accompany patients; using the target population to develop and staff programs, providing wraparound services for families; and providing interdisciplinary/bilingual/flexible/warm/onsite supplementary services. To better serve Latinos, Dr. Sol recommended:

- Ensuring cultural competency, supporting triage/referrals, addressing the stigma of AIDS, and exercising vigilance and advocacy concerning the human rights of Latin immigrants living with HIV;
- Capacity-building for Latino community-based organizations;
- Adopting a family approach; and
- Supporting funding streams for programs that understand the Latino community.

Dr. John Hogan described his experience as a physician coming to Unity Healthcare and the rapid growth of the program, which now serves 6,000-7,000 patients. His presentation summarized Unity's treatment, monitoring, screening, and prevention work at multiple D.C. clinics, the jail, and the RAP program, spanning all eight wards. Facilities served by Unity, the largest local provider of HIV services, include community health centers and homeless service sites. Dr. Hogan termed the AIDS epidemic in D.C. as "crazy, out of control" and speculated that the same conditions exist elsewhere in the United States and many other countries. His patients include regular Unity patients from the community, referrals from the STD clinic, discharges from D.C. hospitals, and court-referred patients, among others.

Unity takes its medical services to patients at multiple sites, uses a team approach, and offers comprehensive services. Through Project ORION, its homeless outreach, a van with a doctor on board travels at night to bridges where homeless people have taken shelter. Counseling and testing take place on the van. Unity is beginning a discharge program for ex-offenders from the D.C. Jail, using a network of clinics; the program provides for a seamless transition between treatment while incarcerated and after release. Dr. Hogan concluded saying, "It takes a village to raise a child," and recalled speakers at the Toronto AIDS conference referring to a global village. AIDS, he said, will be found "anywhere where people are living lives of quiet desperation."

Dr. Veronica Jenkins practices social outreach as well as medicine at Family Medical and Counseling Services (FMCS) in Ward 8. In the past 5 years, the agency encountered HIV-positive patients for the first time. Patients come to FMCS because they feel they cannot discuss their condition with anyone else; often social stigma prevents use of services altogether. Dr. Jenkins emphasized the need for public discussion of HIV/AIDS, and attention to its related social impacts in the areas of housing, employment, education, substance abuse, etc. She cited 10 deaths in the past 6 weeks from hepatitis C, reflecting the comorbidity of this encompassing disease.

Education on exposure to HIV and drug treatment must begin long before adolescence, with different approaches for different populations. For example, IV drug users are familiar with drug regimens whereas crack cocaine users are not. Dr. Jenkins uses incentives to encourage client appointments—at the same time they have blood work done, clients receive free vitamins. Offer people something to get them into the clinic if they won't come otherwise, she advised.

Dr. Ron Mealy heads the Carl Vogel Center, which combines outpatient medical care with a range of rehabilitation services/complementary therapy, including massage therapy and acupuncture, nutrition counseling, and mental health services. As a one-stop provider, the Center's partnering of traditional and alternative medicine offers benefits that may decrease pain and fatigue, improve mental health, and decrease medication-related symptoms, thereby increasing adherence to antiretroviral drug regimens. Dr. Mealy's slides on demographics indicated that most of the Center's patients are male African Americans. The Center faces challenges of insufficient resources, continual growth of the epidemic in a disadvantaged population, keeping clients with complex needs in care, and improving linkages between prevention and care services. Solutions include diversifying funding/using creative sources for resource development; transition to a medical case management model; improving collaborations with other providers; enhancing multidisciplinary approaches; and continuing participation in community planning to develop seamless service delivery.

***Comments**:*

- How can testing address the fact that a person may contract HIV later? Dr. Marsha Martin referred Council members to the pamphlet in the D.C. folder that responds to this question; information must be provided to clients in understandable ways. Dr. Sol suggested that PACHA review current assumptions

about how people enter or stay in care. Dr. Mealy asks those tested to return and provides an incentive to return. Dr. Hogan recommended educating patients about risks after they have been tested.

- It should not be the clinic's task to provide broad education.
- Routine screening will produce false positives and false negatives. Dr. Martin acknowledged this problem and said they were working on monitoring issues. The first goal, she said, is to screen.
- More funding is critical for counseling, broader services, and education. The education component is still in its infancy.
- Dr. Sol explained that use of *promotores de salud* is common in Latin America, where community people are recruited and trained to be midwifes or to provide health information on water sanitation, disease risks, etc. They can work as a sentinel system in bringing emerging problems to light. *Promotores* offer a family-based response to health questions.
- Rev. Lusk invited Dr. Marsha Martin to visit his program in Philadelphia.

Members of PACHA introduced themselves.

CORRECTIONS PANEL: *HIV and D.C. Corrections Services Response*

Dr. Marsha Martin introduced panel members.

Dr. Flora Hamilton said Family Medical and Counseling Services (FMCS) started as a social work agency and evolved into a community-based organization dealing with substance abuse. While the media focused on gay white males in the 1980s, FMCS realized that many substance abusers were infected throughout the community and began developing continuum-of-care services. Services included discharge planning, counseling and testing for those in the correctional system with the objective of ensuring continued care, and expanded counseling and testing. As of June 1, 2006, services include routine testing of all people entering the correctional system at entry on a 24-7 basis. Findings from June 1 to September 30, 2006, indicate 4,800 persons tested, with 5 percent testing positive for HIV/AIDS. Only half of those cases were known. The goal, Dr. Hamilton said, is to routinize testing throughout the system.

Cornell Jones, an ex-offender, founded Miracle Hands, Inc., to use peer education inside jails to teach prisoners about HIV risks. Focusing on youth, he counsels them on the dangers of needle use within prisons, where the same needle may not only be used for both tattooing and IV drugs, but may be shared with as many as 2,000 people. Even though jails may test for HIV/AIDS on entry and exit, prison populations do not receive adequate education on risk behavior. Federal prisons do not even test their populations. Mr. Jones estimated that 80 percent of prison staffs are ex-offenders.

Susan Galbraith described Our Place, a center for D.C. women coming back into the community after release from jail. Because the numbers of women in prisons and jails have grown dramatically, there is a need to focus on women. The center's clients are generally African American, mothers, unemployed, substance abusers, and have

experienced sexual and physical abuse. They frequently suffer from mental health problems, especially depression. The primary sources of their HIV-positive status are drug use and heterosexual sex. Little to nothing is done for released offenders, who often lack a home, food, or job. Prisons themselves are overcrowded, understaffed, and filled with the mentally ill, according to wardens.

Our Place resources are based on needs defined by the target population. The center found that even when women know they are HIV-positive, discrimination and fear of consequences prevent disclosure. It is critical to understand this fear. Our Place conducted general education to encourage disclosure. When women are provided safety, they will disclose; when treated with respect, they will take advantage of services. Without responding to their needs, women are unable to rebuild their lives. A gender-specific comprehensive response is needed, including pre- and post-test counseling, emergency housing and funds, clothing, education, and medical and mental health services.

Devon Brown said he was proud of the national leadership role of the D.C. Department of Corrections in developing automatic entry and exit testing for HIV/AIDS at D.C.'s municipal jail. The United States leads the world in numbers of people incarcerated, with two million individuals behind bars. Prisoners bring a variety of health problems to the correctional system, including HIV. Only eight States test for HIV/AIDS, usually on release, which relieves the corrections system from addressing the problem. All jails/prisons test for other diseases at intake. Mr. Brown met with Dr. Martin's staff to develop the automatic HIV-testing initiative. There is no sanction for noncompliance, but 96 percent of inmates have agreed to be tested to date. Those who decline are counseled. When a prisoner tests positive, treatment and counseling are provided through Unity Healthcare. Contracting with Unity means that the same provider who tests in jail will see that patient after release. D.C.'s municipal jail handles mostly pretrial detainees who will return quickly to the community.

Comments:

- Unlike other correctional systems, the D.C. Department of Corrections gives inmates information on their status and provides them with followup services. Peer educators in jail engage in a 6-week training course on HIV, and often continue as peer educators after release.
- Peer education is the public health response to needle use. A member asked whether there are data on HIV contracted during incarceration.
- D.C.'s approach calling for the same health provider inside and outside of prison is based on a Massachusetts model that showed increase in continuity of care. HIV can open the door to a person accessing care for the first time. The Robert Wood Johnson Foundation chose D.C. to test a pilot program in an urban setting.
- Condoms will be available at various locations within the jail.
- Questioned about the success of maintaining a person on medication, Dr. Martin said that the jail discharge packet contains provider information, an ADAP application, and a 2-week supply of medications. Patients referred to FMCS are

followed up. The response to HIV in corrections is well established; we are proud of it, she said.

DOMESTIC VIOLENCE PANEL: ***HIV and Domestic Violence***

Dr. Marsha Martin introduced the speakers.

Frances Goins emphasized the need to understand the shame women feel and the secrecy surrounding them as domestic violence victims. Domestic violence is an issue of power reflected in, generally, the male partner's isolation and control of the victim. This control directly affects a woman's ability to seek counseling or treatment. Male partners often do not allow women to be tested because their HIV-positive status would implicate their partners. Ms. Goins related a case in which a woman who was a virgin at marriage and had no other sexual partners than her husband found herself HIV-positive when tested for pregnancy. When her HIV status was revealed, her husband refused any further support for her or their prospective child. A new U.S. Department of Health and Human Services program addresses the link between domestic violence and HIV.

Patricia Nalls related her personal history: she has been HIV-positive for 20 years. She said many women infected by their partners stay in the relationship because they lack other choices, are exhausted, and in some cases, literally starving. Ms. Nalls started a support group in her home, which became an agency, The Women's Collective, serving hundreds of women. Domestic violence occurs most often during pregnancy, accounting for 80 percent of female fatalities. Women who test positive are often beaten severely. A large number of women become infected by partners who do not reveal they have multiple other partners, including men. Female college students are at risk of rape and beating, since it is often difficult for them to walk away safely from threatening situations. In addition, their sexual partners are unlikely to use condoms. A significant proportion of women are infected as a result of sexual violence. When women find themselves infected, many do not take their medications or reveal their status. Women need other means of protecting themselves than relying on their partners to wear a condom. Training on HIV/AIDS is needed for domestic violence shelters. Domestic violence and female HIV are strongly linked.

Comments:

- Ryan White and private foundations provide some funding for domestic violence-linked HIV/AIDS.
- Dr. Beny Primm invited Ms. Nalls and Ms. Goins to visit shelters that he is associated with in New York City.

FAITH-BASED PANEL: ***Faith-Based HIV Initiatives***

Dr. Martin introduced panel members.

Dr. Kenneth Robinson is both the Commissioner of Tennessee's Department of Health and an AME church pastor. Answering his own question, "Why the black church?," he

said, "We are theologians in residence, the historical social service agency in the African American community….We've always had a general holistic approach. We are the most practical of community-based organizations—we have automatic credibility. We are everywhere….We have ownership in the community…the community owns us. We have resources." The African American church has not wholeheartedly embraced HIV/AIDS for various reasons:

- The church is theologically conservative though socially liberal. AIDS presents unique challenges. Is it sin or disease?
- Helplessness; like leprosy, there is no cure.
- Homophobia.
- Hypocrisy and fear, denial of sexual activity.

Dr. Robinson cited a need for spiritual authority and proposed five approaches that churches could take, while acknowledging great differences among churches: (1) primary prevention education. It is unfair to ask a church to become a messenger of messages that it cannot theologically carry. Those churches can stick to what churches do best; (2) logistical assistance—e.g., financial and housing—for parishioners living with AIDS; (3) family support and group programs; (4) outreach to high-risk populations and testing; and (5) intersectoral partnerships. Culturally sensitive education outreach should be extended to individual churches. Dr. Robinson is pleased with the increase in his ecumenical partners, and asked PACHA to facilitate gatherings of the African American church community to address issues, train clergy, and encourage involvement in some of the proposed approaches.

Rev. Canon John Harmon spoke of standing in line to be tested and publicly asking for his HIV status—an example of clergy leadership and involvement in HIV/AIDS issues. Education is a primary way that clergy can be involved, especially since clergy hear confessionals. Organizing meetings between large and small churches in D.C. is needed to help with resources—small churches must rely on others to undertake the research. The church needs to view AIDS from a theological standpoint; it can carry the message of health and healing, hope and education for risk reduction. The church "should get off its moral pedestal…instead we can offer hope and exemplify that we all come as children of God."

Rev. Dr. Susan Newman presented slides describing The Balm in Gilead as a "model for mobilizing the African American faith community to address HIV/AIDS." As a nonprofit organization, it seeks to enhance the capacity of faith communities, provide compassionate leaders, disseminate HIV information, and deliver supportive services to those infected and affected. It also seeks to build capacity of community-based agencies while raising awareness of the unique strengths of black faith institutions to address HIV/AIDS. Black communities consider churches and mosques to be the most important institutions in their communities. Since August, The (D.C.) Balm in Gilead has amassed 30 church partners and trained 60 HIV/AIDS ministry coordinators, whose ministry will include HIV counseling and testing. Advocacy is a natural activity for churches, as are campaigns to create awareness, develop capacity, and mobilize communities. Rev. Dr. Newman distributed a brochure on upcoming meetings, and stressed the importance of

approaching churches sensitively. Leadership is key. "We have dedicated ourselves to being available for technical assistance….We work from faith."

Comments:

- Having the church on board is cause for celebration. The church is the resource to which African Americans can turn.
- Questioned as to what extent African American men with AIDS are "reachable," Rev. Dr. Newman said no one is beyond help. Dr. Robinson noted there were some too marginalized to reach.
- Many churches are developing HIV/AIDS ministries, but the greater problem in America relates to discussing overall sexuality. Panelists said talking about HIV necessitates talking about other sexual issues, but it should not be forced. Rev. Dr. Newman recommended a national black summit on sexuality resulting in curricula that all churches could adopt. Rev. Harmon said many churches would not get involved until the terminology changes.
- How much information is provided in primary prevention efforts? Rev. Dr. Newman pairs presentations with a medical professional and also promotes dialogue with young people. The approach allows children and parents to be simultaneously trained.
- Dr. Martin said D.C.'s faith-based initiative hopes to have church resources for assistance located in each ward. There is a huge amount of ignorance about HIV/AIDS. This is an invitation to bring the medical and social worlds together.

PUBLIC COMMENT

Joseph Grogan reminded potential speakers of a 3-minute limit on comments. The following individuals provided comment:

Carl Schmid, NMAETC, Howard University: The Ryan White CARE Act is critically important and should be passed. There are serious fiscal consequences of delay. He hopes PACHA will urge Congress to increase funding levels.

Trina Scott, Advocates for Youth, Mayor's Task Force: As a person living with HIV and several other diseases, she cares for her granddaughter, is a grandmother of 13, was infected by a person who was incarcerated and had done drugs, endured the murder of her son, was evicted from her apartment, and has worked all her life.

Adrian Davis, **PWA, Northern Virginia:** Northern Virginia clients are already receiving no services because of Ryan White delays. The State is paying to put people in abandoned housing. Other jurisdictions, including D.C., are setting up good programs but people can't access them.

Larry Bryant, Housing Works: He has been HIV-positive for 21 years, and feels discouraged because of the disconnect between service providers and community people who are directly affected. Mr. Bryant is worried about resource availability when more and more people are diagnosed and need funding for treatment. He does not want to be personally stigmatized.

Jamila Taylor, The AIDS Institute: Women are particularly at risk and have added responsibility for children and maintaining households. Research on microbicides has great potential and should be supported. Very little funding is allocated to research.

DAY TWO

Welcome Remarks

PACHA Co-Chair Dr. Marilyn Maxwell reiterated PACHA's appreciation to Howard University and Dr. Marsha Martin. Dr. Maxwell expressed hope that this meeting marked the beginning of PACHA's links with D.C., and said Dr. Martin's team was setting the standard and providing leadership for the country. Dr. Martin noted the holistic nature of D.C.'s efforts regarding HIV/AIDS, and pointed out coverage of this morning's PACHA meeting by the local Channel 16. Dr. Martin said D.C.'s demographics include immigrants from throughout the world. "We are concerned about people who come here and people who return home." She introduced Dr.Greg Pane, an emergency doctor who met with the CDC when D.C.'s initiative began.

Dr. Greg Pane said it felt like a new day with PACHA at Howard University, Dr. Martin as part of the D.C. team, and Magic Johnson speaking to D.C. students in the past week. The D.C. City Council has provided prevention funds, and is responding to the Appleseed Report highlighting HIV in D.C. He is a committed and active member of the D.C. advisory group. Dr. Pane introduced "a passionate advocate" for HIV/AIDS and health issues, City Council Member David Catania.

David Catania said he would like PACHA to return to the District of Columbia every year for updates on the city's progress. As chair of the D.C. City Council's Health Committee, he has been able to use budget line items to target agents of transmission, including transgender individuals, the commercial sex industry, and communities of color. The correctional system had been ignored, but appropriations have made it possible as of October 1, 2006, to link health care with entrance and exit HIV testing of prisoners and to provide condoms in jail. Oral hygiene efforts have not been ignored in the overall battle to prevent HIV transmission. Mr. Catania credited Dr. Martin with coordinating these accomplishments.

Dr. Martin advised PACHA to consider working with city councils, whose committee chairs have budgetary powers. Without that leadership in D.C., the city would not have made as much progress. The national response has to engage local leadership.

SOCIAL AND SEXUAL NETWORKS PANEL: ***Social and Sexual Networks on College Campuses and HIV Transmission***

Dr. Peter Leone began his slide presentation by acknowledging the contributions of Andy Kaplan, who died recently. Noting the disproportionate impact of HIV/AIDS on African Americans throughout the country, Dr. Leone presented data on North Carolina. AIDS is everybody's problem, he said, illustrated by the fact that 32 percent of the known HIV-positive women were infected through heterosexual transmission and were not themselves engaged in high-risk behavior. Since Dr. Leone’s last presentation to PACHA, the number of cases has increased. A growing number of student cases are evident across North Carolina, but especially prevalent at traditionally black institutions; 85 percent of HIV-positive college students are African American. Given the fact that

many men are having sex with both men and women, ways must be found to discuss sexual identity and stress women's need for protection. Fifty percent of men having sex with men (MSM) do not report this when interviewed, and 20 percent do not at the time they are told they have HIV. Dr. Leone's study showed that MSM who also had sex with women were particularly active.

Researchers are trying to develop messages based on the findings. Interviews illustrate that terminology is interpreted differently by white and black respondents. The MSM don't define themselves as either gay or bisexual, for example. The challenge is to use responses in devising messages that do not stigmatize people whom it is important to reach. Among Dr. Leone's conclusions are that current messages about condoms are ineffective. Homophobia, racism, and poverty are feeding the epidemic, he said.

Dr. Adaora Adimora presented her study on "Social Forces and Racial Disparity in HIV Rates in the United States," stressing the importance of addressing social factors and racial disparities if there is to be impact on the epidemic. The population-based case-control study sought to answer why rates of heterosexually transmitted HIV were so high among blacks in the South and to identify sexual network characteristics. The study showed that most HIV-positive persons had high-risk factors, but 27 percent did not. Low-risk study participants had lower education, food insecurities, incarceration and sexually transmitted disease (STD) experiences, and nonmonogamous partners. Black and white married women had about the same total number of sexual partners.

Focus groups of African American men and women, aged 18-59, cited extensive economic deprivation, racism, gender inequality, and a high ratio of women to men in communities—men were dead, incarcerated, or "strung out on drugs." Because the number of men is so limited, women tolerate negative male behavior. The overall effects of poverty and proximity of drugs encourage men to have concurrent sexual partners, which spreads infection. In the face of these factors, Dr. Adimora argued that it is critical to develop structural interventions to alter the context of life to improve health behaviors and health outcomes. Interventions include programs, policies, and laws that increase economic opportunities and decrease incarceration rates and their adverse impacts. She concluded that HIV is a U.S. human rights issue: as long as we accept disparity, we are accepting HIV.

Dr. David Malebranche's presentation on "Bisexual Behavior, Gay Identity, and Black MSM" resulted from 29 interviews of black MSMs (BMSMs) located through the Internet and at a local park frequented by BMSMs. The study aimed to describe the subjective life experiences of BMSMs and explore their social context. Findings showed a strong correlation with childhood molestation, very young parents, paternal disconnect/close maternal relations, geographic instability, few positive role models, and strong religious influence. Sixty-six percent ranked spirituality as their greatest priority. Childhood abuse was associated with lack of verbal communication with the often-older abuser, homosexual blame by the abuser, and the subject's association of same-sex desire with child sexual abuse.

The study looked for strengths and asked about terms such as masculinity, gay, cheating, and self-labels. Most respondents were unwilling to label themselves as bisexual, gay, homosexual, transgender, etc., and they defined cheating on a partner as sex with someone of the same gender as the partner. Sex with someone of the opposite gender was not considered cheating. (Similarly, a woman in another study denied having "sex" because she only practices oral and anal sex.) The BMSMs' high-risk sexual behavior was characterized by multiple partners, and associated with troubled family dynamics, fluid sexual identity, fluid mental health, and masculine socialization. Future research directions include exploring factors influencing sex behavior; considering family-based prevention programs; male mentorship; and looking at long-term responses beyond testing and treatment. Among research works in progress are the Brothers United and Gatekeepers studies. Dr. Malebranche cited the fundamental power of sex and observed that asking people to put on condoms represents an attempt to stop natural behavior. Other members of PACHA commented that they found widespread reluctance to use condoms because they decreased the pleasure of the sexual experience.

Dr. Lynette Mundey described the CDC grant awarded to Howard, Auburn, Jackson State, and three universities in Arkansas to explore different venues for testing college/university students for HIV. While Howard had previously done testing, it was not sufficient to reduce HIV rates. Under the new grant, the strategy is to conduct testing periodically in dorms and to offer testing daily in the University Health Center. To Dr. Mundey's surprise, the dorm testing attracted large numbers of students. Staff learned, however, that they did not know how to discuss sexual issues with students. Health care providers have to be trained. Dr. Mundey reported a successful approach has been to acknowledge that "we all have sex." When that is openly stated, students are more likely to talk rather than assume they are being lectured by parental figures.

In interviews students cited the large gap (two to one) between the number of men and women on campus, which provoked competition for men; the alleged promiscuity of freshman women and their likelihood for engaging in high-risk behavior; upperclassmen who prey on younger women; the lack of discussion of HIV status among peers; and much greater concerns about possible pregnancy. The majority said they would change room assignments if their roommate was HIV-positive. Medical students were especially resistant to being tested. Fear was the greatest barrier to testing—fear of telling parents or ruining one's reputation if results were positive. Dr. Mundey said other campuses have successfully offered testing at big events. She concluded that while students are aware of HIV, they do not consider themselves at risk. She recommended periodic health assessments that include questions on risk behaviors. Howard's initiative appears successful, because all slots for testing at the health center are filled for the future.

Comments:

- Would family-based programs be useful? We focus on young people, but older people need help in discussing HIV risks. Focusing on the family as a unit could prove successful, since behavior doesn’t occur in a vacuum. A *New York Times* article on substance abuse found that dealing with families resulted in less incarceration.

- Asked to name priorities, presenters recommended changing sentencing laws on crack cocaine; training providers to discuss sexual issues; increasing programs on male empowerment that include mentoring, health education, and job training; and convening a group of criminal justice, legislative, and health experts to develop feasible structural interventions.
- To transition to the step beyond testing, testing must be coupled with strong prevention approaches.
- Trauma and behavior are clearly linked. It is important to ensure accessible support for people who test positive, particularly when it is unexpected.
- Dr. Franklyn Judson took issue with claims that HIV is related to poverty, racism, or homophobia, saying the disease resulted from multiple sex partners. This social norm could be changed, as the successful campaign to curb smoking showed. Dr. Adimora disagreed, stating that racism and poverty play major roles. She agreed that behavior needs to change, and said study respondents believed concurrent partners were problematic. However, the social environment, as reflected in the high rate of mortality among African American men, has a significant effect. Racism and poverty structure behavior. Dr. Adimora said unilateral reliance on condom use rather than addressing structural inequities explains the limited success in fighting HIV/AIDS. While Dr. Judson objected to the term “inequity” since it implies blame, Dr. Adimora said she believed some things like disproportionate incarceration are wrong.

Timothy D. Mastro, M.D., FACP*, New CDC Testing Guidelines and Implications for Prevention of HIV Among African Americans*

Dr. Mastro's slide presentation, "Revised Recommendations for HIV Testing in Health Care Settings in the United States," described the rationale and process for revising CDC's testing recommendations. Based on public, PACHA, and agency comment, the original guidelines changed to the final recommendation of routine HIV volunteer screening for all persons aged 13-64 in health care settings. The comment period prompted revisions for adolescents, adults, and pregnant women. The written informed consent requirement elicited the most polarized comments, along with the change in the requirement for prevention counseling. It was decided that prevention counseling was pointless for those testing HIV-negative and to focus on HIV-positive counseling.

The status quo and study findings point to numerous missed opportunities for early diagnosis, treatment, and prevention. The fact that late diagnosis is common among socioeconomically disadvantaged persons makes a strong case for routine screening. Dr. Mastro reported strong support for the guidelines on publication. CDC met with medical partners on rollout and is strengthening partnerships with national medical groups. Concern to date has focused on perinatal testing. There is an urgent need to increase the number of people who know their HIV status. Screening is cost-effective and must be expanded.

Comments:

- Asked why CDC limits perinatal testing, when the mother's status is unknown, to a recommendation rather than making it mandatory, as PACHA recommended, Dr. Mastro said local jurisdictions have the option to require perinatal testing.
- Health providers have the option of testing those over 64 years of age.
- While negative tests present teachable moments, CDC did not want to require counseling for those who test negative because of time factors.
- It is unclear what effect South Carolina's code requirement had on testing practices.

Dr. Robert Redfield stated that the President made an historical commitment to extend the battle on HIV/AIDS beyond the United States with the PEPFAR program, which represents an important contribution to long-term global health. Like the Ryan White CARE Act, PEPFAR should be viewed as a long-term commitment.

Thomas A. Kenyon, M.D. ***Overview of PEPFAR***

PEPFAR was announced in President George Bush's 2003 State of the Union address, a $15 billion 5-year strategy covering 15 of the countries suffering the greatest impact from the AIDS epidemic. It is an unprecedented program, both in funding and in Federal partnership agencies. All of the agencies work together under the single leadership of the U.S. Ambassador in each country. PEPFAR's approach calls for supporting one national plan with one evaluation plan; building managerial and technical capacity of indigenous partners; using a network model; strengthening infrastructure; implementing the program according to nationally accepted national guidelines; monitoring with the use of international indicators; and funding efforts based on results.

Dr. Kenyon called on Dr. Michael Johnson to present information on PEPFAR's Caribbean outreach. Dr. Johnson stressed the collaborative nature of achievements with other organizations. A video about PEPFAR's scope, mission, and programs was then presented to the meeting.

Comments:

- This is the fourth year of a 5-year program. Is there a planned transition out of PEPFAR funding? Dr. Kenyon said officials were discussing the issue in terms of individual country impacts, but there was no formal plan.
- Under PEPFAR's New Partners Initiative, several organizations have been asked to submit followups to proposals.
- In the Caribbean, Guyana and Haiti are focus countries. Other funding streams include the Global Fund and the World Health Organization.
- Regarding congressional intent, a report due in November should delineate treatment allocations for medicine versus funding for distribution. While the cost of medications is lower, major distribution problems remain. The current amount allocated to treatment appears to be reasonable. Dr. Redfield noted that PACHA would like to be more helpful regarding distribution costs, since it has focused in the past on treatment.

- The Food and Drug Administration (FDA) has now approved 30 generic medications, which has lowered costs; 80 percent are now generic in contrast to 10 percent 2 years ago.
- PEPFAR is exploring supply chain issues, including how to reduce tariff costs.

PUBLIC COMMENT

Jesse Milan, Co-Chair of HRSA/CDC: As advisors to the Secretary of the Department of Health and Human Services, we would like to work more in concert with PACHA. While PEPFAR embraces one national plan, and the United States agreed on a national plan 5 years ago, we have no national plan yet. This is a request for both of PACHA's Subcommittees to reiterate the need for a national plan and work toward its establishment.

Ronald Johnson, Deputy Director, AIDS Action Council: The *Connecting to Care* publication, which Dr. Marsha Martin cited, should be considered seriously. It is especially important to shore up care at the same time testing is being emphasized. Reauthorizing the Ryan White CARE Act is a priority, along with increasing appropriations under the Act.

Dr. Marsha Martin: We share concern for development of a national plan and would like to prepare as a city and a Nation to be part of the Global Plan. It would be useful for key bodies to explore commonalities among States that could be addressed and shared. D.C. could be considered the 16th PEPFAR country. It would be helpful if PACHA helped codify its experience as a concept for global dialogue.

Rebecca Shields, Americorps: As a peer educator on prevention issues in the schools, I hope you will affirm the value of continuing to have young people work in public schools on prevention.

MOTIONS AND VOTING

Dr. David Reznik presented the revised versions of three motions proposed by the Domestic Subcommittee.

Motion on Medical Workforce

The Subcommittee added a culturally competent provision and edited the final section under "Be it resolved…."

Discussion: After adoption, all resolutions are forwarded to Secretary Agwunobi and then to the President. The resolution has been discussed. PACHA members expressed concern for the resolution's speedy adoption, so Dr. Reznik added language on "interim steps" directed at Secretary Agwunobi. A motion was made, seconded, and passed to approve the following language:

WHEREAS HIV infection continues to evolve toward a complex, chronic, ambulatory illness for many people, with continued emphasis on reduced mortality, decreased hospital utilization, and long-term viral suppression; and

WHEREAS appropriate expertise and experience in the management of HIV infection lead to better outcomes for people living with HIV disease [1,2]; and

WHEREAS there are over 1,000,000 people living with HIV disease in all parts of the United States that are in need of lifelong care; and

WHEREAS there is concern that there exists a workplace shortage and that present medical providers are having difficulty managing their current patient caseload;

WHEREAS this shortage of medical providers is having a significant impact on providing culturally competent service for HIV patients; then

BE IT RESOLVED THAT the Presidential Advisory Council on HIV/AIDS calls on the Secretary of Health and Human Services to sponsor an Institute of Medicine study of the HIV medical workforce. This study will assess the capacity of the HIV medical workforce, including issues surrounding reimbursement, to respond to the needs of persons living with HIV/AIDS on a regional and national basis.

BE IT FURTHER RESOLVED THAT the Secretary of Health and Human Services develop interim steps to address areas of known medical workforce shortages.

1. *Shapiro M, Morton SC, McCaffrey DF, et al. Variations in the care of HIV-infected adults in the United States: results from the HIV Cost and Services Utilization Study. JAMA. 1999; 281:2305-2315.*
2. *Kitahata MM, Van Rompaey SE, Shields AW. Physician experience in the care of HIV-infected persons is associated with earlier adoption of new antiretroviral therapy. J Acquir Immune Defic Syndr. 2000;24:106-114.*

Motion on New CDC Recommendations on Universal Testing

The Subcommittee added jurisdictions and territories under "best practices."

Discussion: Mr. Holmer and Dr. Maxwell will follow up both of the resolutions with the Secretary's Office to promote their adoption. It was suggested that Mr. Grogan should also follow up on their status. Dr. Redfield said widespread adoption is unlikely until a code-based change is implemented, since that affects reimbursement. Dr. Reznik added the word "expeditiously" for emphasis. Concerns about State restrictions on testing were addressed in an additional "Be it resolved…." A motion was made, seconded, and passed to approve the following language:

WHEREAS an estimated one-fourth (252,000 – 312,000) of the more than 1 million persons in this country who are living with HIV do not know they are infected and could be spreading HIV to their partners unknowingly; and

WHEREAS routine HIV testing will reduce the stigma associated with an HIV test and make it a normal part of taking care of oneself; and

WHEREAS most people, after finding out they have HIV, adopt behaviors that reduce HIV transmission, and routine HIV testing may help protect the partners of persons who are living with HIV but do not know it; and

WHEREAS new sexually transmitted HIV infections could be reduced more than 30 percent per year if all HIV-infected persons knew of their infection and adopted changes in behavior similar to those of persons already aware of their infection; and

WHEREAS mother-to-child transmission of HIV infection could be further reduced through the implementation of these new guidelines; and

WHEREAS people living with HIV can receive effective treatment, resulting in improved health and extended life, if their HIV infection is diagnosed earlier; then

BE IT RESOLVED that the Presidential Advisory Council on HIV/AIDS (PACHA) commends the President, the Secretary of Health and Human Services, and the U. S. Centers for Disease Control and Prevention (CDC) for the development of the new initiative, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings; *and*

BE IT FURTHER RESOLVED that the Secretary of Health and Human Services work closely with the American Medical Association and the Centers for Medicare & Medicaid Services to develop expeditiously coding that would allow HIV screening to become a covered service for both private and public insurance; and

BE IT FURTHER RESOLVED that the Secretary of Health and Human Services and designees work closely with States, jurisdictions, and territories to overcome barriers and develop best practices that will facilitate HIV screening in all medical settings; and

BE IT FURTHER RESOLVED that the Secretary of Health and Human Services will establish annual targets for new HIV diagnoses.

Motion on Ryan White CARE Act

Dr. John Martin exited the room for discussion of this motion.

Discussion: Dr. Reznik noted that the Subcommittee had added “before the end of this year," removed a “that,” and changed "enact" to implement. A motion was made, seconded, and passed to approve the following language:

WHEREAS the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provides primary care, treatment, and essential support services to approximately 533,000 uninsured and underinsured people living with HIV/AIDS in the United States; and

WHEREAS reauthorization of the Ryan White CARE Act has been and remains a priority for the Presidential Advisory Council on HIV/AIDS and the Administration; and

WHEREAS the Ryan White CARE Act reauthorization expired September 2005, and reauthorization is now more than 1 year overdue; and

WHEREAS the dedicated efforts of the bicameral, bipartisan process led to the reauthorization legislation called the Ryan White HIV/AIDS Treatment and Modernization Act of 2006, which follows many of the principles put forth by PACHA, and was overwhelmingly passed by the House of Representatives but was not considered by the Senate; then

BE IT RESOLVED THAT the Presidential Advisory Council on HIV/AIDS calls on the President, the Secretary of Health and Human Services, and the Congress to achieve enactment of the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 before the end of this year; and

BE IT FURTHER RESOLVED THAT sufficient funds be appropriated to the Ryan White Treatment and Modernization Act of 2006 to ensure that every American, no matter which part of the country they reside in, has access to life-saving treatment, care, and support services that improve medical outcomes; and

BE IT FURTHER RESOLVED THAT once reauthorization occurs the Secretary of Health and Human Services work as expeditiously as possible to implement this improved legislation for fiscal year 2007 in order to best serve people living with HIV disease in the United States.

Next Steps

- PACHA Co-Chairs Dr. Maxwell and Mr. Holmer will confer with Joe Grogan about ways to facilitate implementation of the above resolutions.
- Possible future meeting times may be in January, May, and September of 2007.

Closing Remarks

Mr. Holmer thanked the PACHA staff and Cindy Marquina, Social & Scientific Systems, Inc. Dr. Redfield expressed appreciation for the opportunity to hear about accomplishments in the District of Columbia. Dr. Maxwell thanked Howard University, Dr. Marsha Martin, and the D.C. Mayor's Task Force and then adjourned the meeting.