Minutes of the 19th Meeting

Presidential Advisory Council on HIV/AIDS

March 14–15, 2002

The White House Conference Center
Washington, D.C.

Members Present:

Thomas A. Coburn, M.D., Co-Chair
Louis W. Sullivan, M.D., Co-Chair
Stuart C. Burden
Philip P. Burgess, R.Ph., M.B.A.
Joseph A. Cristina
The Honorable Ronald V. Dellums
James P. Driscoll, Ph.D.
Ingrid M. Duran
Mary Fisher
Charles Francis
Vera Franklin
Mildred Freeman
John F. Galbraith
Cheryl-Anne Hall
Karen Ivantic-Doucette, M.S.N., F.N.P., A.C.R.N.
Rashida Jolley
Caya B. Lewis, M.P.H.
Abner Mason
Sandra S. McDonald
Joe S. McIlhaney, M.D.
Hank McKinnell, Ph.D.
Brent Tucker Minor
Nathan M. Nickerson, R.N., M.S.N.
Debbie Rock
Reverend Edwin Sanders II
Prem Sharma, D.D.S.
Lisa Mai Shoemaker
Anita Smith
M. Monica Sweeney, M.D., M.P.H.

Members Not Present:

Katryna Gholston
Cynthia A. Gomez, Ph.D.
Joseph Jennings
Dandrick Moton
John A. Perez

Present from ONAP:

Patricia Ware, PACHA Executive Director
Tracy Carson
Scott Evertz
Greg Smiley
Ken Thomas

Thursday, March 14, 2002 – General Council Session

Welcome and Introduction of New Members

Ms. Ware, PACHA Executive Director, welcomed the Council members and guests. She explained that PACHA was established in 1995 to make recommendations to the President and to provide advice, information, and recommendations to the Secretary of Health and Human Services (HHS) regarding programs and policies intended to promote prevention, advance research, and provide high-quality services to people living with HIV/AIDS.

The Council members introduced themselves, and Ms. Ware called roll.

Introduction of Co-Chairs and Co-Chair Remarks

The new PACHA co-chairs, Thomas A. Coburn, M.D., and Louis Sullivan, M.D., were introduced. Dr. Sullivan would preside on the first day and Dr. Coburn on the second day of the Council meeting.

Dr. Sullivan stated that the HIV/AIDS situation has improved greatly during the past 20 years. With the investment in research, the disease is better understood, and people are living productively for many years with the virus suppressed. However, no cure exists for HIV/AIDS.

Dr. Sullivan explained that the Council is charged with recommending policies and strategies for Government and the private sector to find more effective therapies and a cure. The current meeting was intended to brief the Council members on the status of the HIV/AIDS situation, not to debate issues or give policy speeches. Dr. Coburn added that he envisions a day when there are no new HIV infections, when no babies are born with HIV, when addicted drug users have treatment options, and when HIV/AIDS treatment is widely available. He said he hopes to see the Council build a consensus to make recommendations in the near future.

Remarks from the Secretary of HHS and Swearing-In of PACHA Members

Ms. Ware introduced Tommy G. Thompson, Secretary of HHS. She noted that the Secretary is very committed to fighting the HIV/AIDS epidemic, to providing care and treatment to those who are infected or affected by the disease, and to raising awareness of the epidemic. Secretary Thompson will visit Africa in the near future to increase his understanding of the epidemic there.

Secretary Thompson thanked the members for their participation in the Council and, on behalf of President Bush, thanked the members for their dedication. He also thanked Dr. Coburn and Dr. Sullivan for their leadership in raising public awareness and tackling the issue of HIV/AIDS and recognized Ms. Ware and Mr. Evertz of the Office of National AIDS Policy (ONAP).

The Secretary stated that in the United States more than 450,000 people have died from AIDS and one million people are living with HIV/AIDS. Worldwide, 40 million people have HIV and more than 22 million people have died from AIDS. PACHA, he said, seeks to develop effective, tangible steps to make HIV/AIDS a distant memory. The PACHA members have a mission to help arrest the spread of HIV/AIDS, advance effective treatment, and find a cure for the disease.

The Secretary explained that a management review is now underway within HHS to look at ways to make the Department's activities more accountable, better coordinated, and more efficient. He then spoke about the U.S. investment in tackling HIV/AIDS through the National Institutes of Health (NIH), Medicare and Medicaid, and the Centers for Disease Control and Prevention (CDC). Some of the Federal funding is specifically targeted to addressing the epidemic within racial and ethnic minority populations. The Secretary also stated that the global HIV/AIDS epidemic is a concern to the United States and that he serves with Secretary of State Colin Powell on a global task force that will travel to Africa and the Caribbean. The United States has also contributed $500 million to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the

Global Fund). Secretary Thompson asked the Council members to provide constructive criticism and recommend solutions to the Department.

The PACHA members then were sworn into service.

Secretary Thompson then opened the floor to questions. Questions concerned the "flat funding" allocated to address the epidemic in minority communities and for Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, the U.S. contribution to the Global Fund, and the need to build the public health infrastructure. The Secretary noted that significant funding will be committed to strengthening the state and local public health departments' infrastructure, which will help address the HIV/AIDS epidemic and homeland security concerns. He also said the United States has made a major contribution to the Global Fund.

Briefing from the U.S. Department of Health and Services

Joe O'Neill, M.D., Acting Director, Office of HIV/AIDS Policy, thanked Secretary Thompson, Dr. Coburn, Dr. Sullivan, and Ms. Ware for their leadership. He reflected on the progress made in tackling the HIV/AIDS epidemic, but noted that much more must be done. He said the management review within HHS is looking at a range of programs, including HIV/AIDS programs, to find ways the Department can better manage and coordinate programs and to become as accountable as possible. He also expressed a need to identify successful HIV/AIDS program models.

Bill Steiger, Special Assistant to the Secretary for International Affairs, discussed the U.S. Government's multi-agency involvement in fighting HIV/AIDS, tuberculosis, and malaria worldwide. He noted that President Bush, Secretary Thompson, and Secretary Powell have provided leadership. He also recognized Paul DeLay of USAID and others who helped to establish the Global Fund, which is a public-private partnership. With the $200 million U.S. contribution in FY 2003, the total U.S. contribution to the Global Fund will be $500 million, or one-fourth of the funding from all of the donor governments. The Global Fund is a non-profit, staffed organization that is located in Geneva and incorporated under Swiss law. Most of the staff will be hired and contracted throughout the World Health Organization, assuring the Global Fund's independence. The funds are held in trust at the World Bank.

The Global Fund's board of director comprises 18 members who represent donor nations, recipient Governments, private-sector organizations, and nongovernmental organizations (NGOs), or are *ex officio* members. A technical review panel with expertise in HIV/AIDS, tuberculosis, and malaria is reviewing the first round of grant applications, and grantees will be announced in April 2002. A total of $700 million will be granted in 2002. Mr. Steiger said the PACHA members can advise HHS on how best to monitor the success of the Global Fund as a true public-private partnership.

The floor was opened to questions and comments. Mr. Dellums noted that the Global Fund is expected to leverage private-sector funding and asked to what extent the private sector has been educated about the Fund. Mr. Steiger said that outreach to the global private sector must be strengthened and that Secretary Powell is organizing a forum to discuss private-sector

involvement, which is essential to the fund's success. Dr. Sullivan noted that the expectation for private-sector involvement may be different in the United States than in other countries. A suggestion was made to involved the Global Business Council on HIV/AIDS and other large organizations in raising dollars for the Global Fund.

A Council member asked whether the funds will be divided among HIV/AIDS, tuberculosis, and malaria. Mr. Steiger explained that the United States has taken the position that the funds should not be earmarked for specific diseases or interventions, and that proposals can address the interrelated nature of the diseases and cross-sectoral approaches. The funds, however, are limited to programs concerned with HIV/AIDS, tuberculosis, and malaria.

Ms. Rock mentioned that there is a need for the Health Resources and Services Administration (HRSA) to streamline paperwork so community-based organizations (CBOs) can spend more time in service delivery and less time doing paperwork. Mr. Steiger agreed, saying that CBOs can play an important role in improving processes and advising about how to reduce mandated paperwork.

Full Council Presentation: The State of the Domestic Epidemic

Robert Janssen, M.D., Director, Division of HIV/AIDS Prevention, Surveillance, and Epidemiology, CDC, explained that surveillance begins with submission of information by health care providers and laboratories. The information is sent to local health departments, which may collect additional information, and then send it on to the CDC. As of mid-2001, more than 822,000 AIDS cases and more than 470,000 deaths of persons with AIDS had been reported to the CDC. Since 1995, annual AIDS cases and deaths have dropped sharply, but the decreases have reached a plateau, racial and ethnic disparities persist, and only half of infected people are in care. In general, people with HIV are living longer and better. Furthermore, mother-to-child transmission declined 80 percent between 1992 and 2001 because of treatment.

Dr. Janssen reflected that the epidemic in this country began among whites, but the proportion of African Americans and Hispanics affected has increased. The highest rate of AIDS reported to the CDC is 74 per 100,000 in the African-American population. The lowest rate is in the Asian and Pacific Islander population. The epidemic began among men who have sex with men (MSM) and injection drug users (IDU), but there has been a steady increase in cases of heterosexual contact, especially among African Americans.

Dr. Janssen noted that surveillance data are useful in targeting prevention programs. Prevention programs must be tailored to the population, interventions must be science-based, and peers are important in the development and delivery of HIV prevention. He also noted that no single intervention is universally effective, and knowledge alone is not enough to prevent the spread of the disease.

The CDC funds prevention services through health departments and CBOs, and provides training and assistance to service providers. The largest portion of funds goes toward prevention through HIV Prevention Community Planning, a collaborative process that is locally planned and based on priorities of the local epidemic. One-third of the CDC's prevention funds are used for

counseling, testing, and referral to care, and to partner notification. Forty percent of the funds are used for health education programs, and funds are also used for school-based and other youth interventions. Publicly funded counseling, testing, and referral services were initiated in 1985, and over 11,000 sites are now funded. Health education and risk reduction efforts are directed at reducing or preventing behaviors that result in transmission. AIDS community demonstration projects provide community-level intervention in five cities and are targeted at high-risk groups.

Dr. Janssen explained that the overall national HIV prevention goal is to reduce by half the number of new infections in United States—from 40,000 to 20,000 per year—by 2005. Objectives include to: decrease the number of persons at high risk for acquiring or transmitting HIV; increase the proportion of persons who learn they are infected; increase the proportion of infected persons who are linked to prevention, care, and treatment services; and improve systems to monitor and evaluate prevention programs.

A recent survey found that HIV prevalence among men 23 to 29 years old who have sex with men was 13 percent, and the prevalence among African American men in that group is 32 percent. There have been several outbreaks of HIV among MSMs in several cities. New data suggest that much of the increase in unsafe behavior may be because people view AIDS as a chronic, treatable disease.

Dr. Janssen stressed, however, that it is more useful to look at the incidence of new HIV infection rather than at the prevalence of infection. Now testing technology that can distinguish recent and remote infections, and infection incidence data can be used to target prevention programs and evaluate their impact. About 75 percent of infected people are aware of their infection and about half of that group have received care. An important message, therefore, is to get tested, get treated, be safe.

Important challenges include determining whether prevention dollars are tracking the epidemic, and finding ways to build the capacity of new CBOs, improve service coordination among grantees, and improve community planning.

Dr. Coburn asked if the CDC still conducts blinded surveys. Dr. Janssen said there is a movement away from such surveys and more emphasis on measuring incidence through testing history. Other questions concerned measurement of heterosexual risk, surveillance in the incarcerated population, and the population of people exiting prison. A member suggested that reports and recommendations from a congressional commission studying the incarcerated population be reviewed. Dr. Janssen also noted that the CDC is evaluating laws that restrict syringe availability, educating state legislators about that issue, and examining interventions to prevent sexual transmission by IDUs. He said the CDC welcomes the PACHA members' recommendations for reaching its five-year goal of halving the number of new infections by 2005.

Briefing from the State Department/USAID

Paul DeLay, Acting Director, Office of HIV/AIDS, Bureau for Global Health, U.S. Agency for International Development (USAID), spoke about the global HIV/AIDS epidemic. An estimated

65 million people have been infected, and 40 million adults and children were living with HIV/AIDS at the end of 2001. New data to be released in July 2002 will show significant increases in HIV prevalence in sub-Saharan Africa. In Zimbabwe, for example, the prevalence was 25-35 percent in 2001. In nine sub-Saharan countries, between one-fifth and one-third of children have lost a parent to HIV/AIDS, and in some countries the average life expectancy is 29. HIV prevalence is also increasing in countries such as Indonesia.

Mr. DeLay said that USAID's HIV/AIDS program includes prevention, care, and mitigation, and a primary goal is to reduce risk behaviors and efficiency of transmission. However, infrastructure challenges and other issues are significant in developing countries, and each program must be tailored to the dynamics within the country. Despite the epidemic, prevention programs have shown success among sex workers in Cambodia and Thailand and among adolescent girls in Uganda.

Many countries have insufficient budgets to keep pace with the pandemic, Mr. DeLay said. Care and treatment are critical, but challenges faced include lack of standardized treatment regimens, lack of infrastructure (minimal lab capacity, trained health care workers), equity of access to treatment, nutritional requirements of HIV-infected persons, and the cost of treatment. The cost of treatment in developing countries has been reduced to $1,200 per year, but *per capita* health care expenditures are much less (e.g., $16 in Haiti, $91 in the Dominican Republic, and $319 in Brazil).

Mr. DeLay offered to provide resources to assist the Council members as they make recommendations. He closed by saying that investment in infrastructure and training is critical. Intellectual property rights, the balance of prevention and care, and funding for education and other services are also important issues.

David Kramer, Senior Advisor for Global Affairs, U.S. Department of State, said that President Bush has demonstrated interest in the global HIV/AIDS pandemic and Secretary Powell has reinforced the U.S. commitment to tackling the global challenge. In addition, the Deputy Assistant Secretary of State is working to reach out to the NGO community and legislators on Capitol Hill.

HIV/AIDS is prominent on the foreign policy agenda because of the economic and security impact, and because it threatens countries' stability and undermines development activities. For example, countries in sub-Saharan Africa will face demographic upheaval. Botswana is expected to experience negative population growth by 2010. Therefore, he said, time is of the essence, and sustained global cooperation is essential.

Mr. DeLay and Mr. Kramer responded to questions from the PACHA members. It was noted that the State Department tries not to permit the political situation in any country result in the country's population suffering. Mr. DeLay added that USAID has "notwithstanding language" that allows work in any country regardless of the political situation. For example, USAID likely will establish small programs in Burma. Mr. Kramer also noted that it is important for the Secretary of State to speak out on the issue of HIV/AIDS and to work with countries in need of assistance.

Office of National AIDS Policy Update

Scott Evertz of ONAP thanked Dr. Coburn, Dr. Sullivan, and Mr. Dellums for their Council leadership and he welcomed the new PACHA members. Mr. Evertz said he had just come from a meeting at the Inter-American Development Bank at which President Bush stressed that HIV/AIDS must be confronted along with poverty and other issues in developing countries. Mr. Evertz reported that a new initiative will significantly increase funding for global assistance for HIV/AIDS and other issues over the next 3 years through the Millenium Challenge Account. He also said that the United States has contributed $500 million to the Global Fund and will increase contribution as the fund proves successful. There is recognition in the Administration that the United States cannot separate itself from the global community.

Mr. Evertz then presented an overview of ONAP, which focuses on the domestic struggle with HIV, especially in communities of color; efforts to alleviate the global HIV/AIDS pandemic and to develop global policy, especially as it relates to U.S. efforts to combat the disease abroad; and coordination of PACHA. ONAP will participate in national campaigns such as National Testing Day and promotes the need to encourage individuals to seek treatment early in the disease rather than waiting until they have AIDS-related complications. The office also is studying the impact of regulations that eliminate Federal benefits if people with AIDS return to work. In addition, ONAP is concerned with the need to provide resources to people living with HIV/AIDS and with empowering people to choose organizations that have funding to serve them.

Mr. Evertz challenged the PACHA members to develop recommendations that will force ONAP to respond, and he recognized the ONAP staff for their contributions. He provided his fax number (202-456-7315) to use for this purpose.

Dr. Sullivan said he is encouraged by Mr. Evertz's report of President Bush's comments and suggested that the Council send a resolution to the President to commend those comments. Mr. Evertz then responded to comments and questions from the floor. He agreed with a Council member that the Council should review the Surgeon General's report on sexual health and could identify information in the report to which the Administration should respond. Dr. Sullivan said that copies of the report will be distributed to the membership. Mr. Evertz said that ONAP will develop a response to the report for review by the Council.

Other topics raised by Council members included Medicaid and Medicare involvement in treatment, the movement to upgrade public health infrastructure at the State and local levels, the need to focus on the epidemic in racial and ethnic minority populations, the need for effective care and health care professional training, the role of dental professionals in prevention, the need for better women's services, and creation of an HIV/AIDS medical specialty.

Dr. Sullivan said that the topics suggested would be considered as agenda items at future Council meetings.

Full Council Presentation: Substance Abuse Issues and HIV/AIDS

James H. Autry, M.D., Deputy Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA), spoke about SAMHSA's involvement in confronting HIV/AIDS and the close relationship of HIV/AIDS with substance abuse and mental health. SAMHSA's mission is to strengthen the capacity of the Nation's health care delivery system to provide substance abuse prevention, addiction treatment, and mental health services in order to reduce the human and economic cost to society of mental and addictive disorders. Mental health and substance abuse service systems need to be built according to community needs and to be representative of the community to be served, he said.

SAMHSA's HIV/AIDS program goals are to increase access to care, to develop strong infrastructure through targeted technical assistance, and to institutionalize critical linkages to maximize program effectiveness. Initiatives within all three SAMHSA centers—theCenter for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services—are designed to achieve these goals. HIV/AIDS is a high priority for SAMHSA, and the agency's investment in HIV/AIDS in FY 2003 will be $174 million, Dr. Autry said. He explained that many AIDS cases are related to injection drug use, but that alcohol and other drug use also have a profound influence HIV transmission (e.g., because of unsafe sex practices). In addition, the mental health impact of HIV on people affected by HIV is a critical concern of SAMHSA.

Dr. Autry said that SAMHSA plays an important role in developing the Minority AIDS Initiative and funds technical assistance centers that serve CBOs and indigenous service providers. The agency has received significant increases in its HIV/AIDS funding since 1999. In FY 1999, it was provided $22 million from the Minority AIDS Initiative for comprehensive substance abuse treatment and prevention programs for minority populations affected by HIV/AIDS. CSAP and CSAT were designated to administer the Congressional Black Caucus (CBC)-funded initiatives. In FY 2000, SAMHSA received almost $50 million from the CBC initiative, and in FY 2002, it received $102.5 million to expand and continue programs.

Dr. Autry said that CSAP has augmented the ability of 47 grantees to implement HIV/AIDS prevention programs in communities of color that were targeted by the CBC. These programs seek to reach high-risk, sero-negative people to provide prevention counseling, to increase the number of people who learn their HIV status, and to increase efforts to provide counseling to prevent transmission and reinfection of individuals who are already infected. Grants will also support technical assistance and organizational development essential to sustaining the work of CBOs.

In CSAT, the Targeted Capacity HIV program provided services to 4,300 clients in communities that are disproportionately affected by HIV/AIDS. An HIV/AIDS outreach program has also been operating for a number of years. The program recently funded 25 sites, which have exceeded the projected number of individual and group contacts and HIV tests to be provided.

Dr. Autry also stressed that mental health issues associated with HIV/AIDS must be addressed. Better outcomes result when mental health, substance abuse, and primary care services are

integrated. Under the CBC initiative, the Center for Mental Health Services will expand traditional and nontraditional mental health treatment for racial and ethnic minorities who are living with HIV/AIDS.

SAMHSA continues to collaborate with Federal Government partners, particularly HRSA and CDC, by jointly sponsoring programs, activities, and conferences. Dr. Autry concluded by saying that in FY 2002, SAMHSA will continue existing grant programs and will provide increased technical assistance to serve minority communities that have not been successful grantees.

Dr. Autry responded to questions and comments from the floor. Topics raised included funding of drug abuse treatment and HIV, and SAMHSA funding for HIV services.

Full Council Discussion: Report from the Previous Council

Mr. Dellums, former PACHA Chair, congratulated the Council co-chairs on their appointment and recognized the contributions of former PACHA Executive Director Daniel Montoya. Mr. Dellums also acknowledged and commended the efforts of the President, the Vice President, and the Administration, and applauded ONAP's leadership.

Mr. Dellums urged the Council members to read the previous Council's final report, entitled *AIDS – No Time to Spare: Final Report to the President of the United States.* Citing the report, he said that HIV/AIDS is the greatest threat faced by the human family and that the disease's devastation around the globe during the past 20 years is severe. Globally, the communities with the greatest HIV/AIDS challenges are those that are poorest and those of people of color. In today's increasingly interconnected world, no community or nation can afford to respond in isolation, so a global action plan should be developed. Investments in biomedical research have paid off, but these efforts should be expanded.

In *AIDS – No Time to Spare*, PACHA made 64 recommendations, offering an initial challenge to the Administration and signaling a shift to a global perspective that should be maintained. The following recommendations were presented by Council members:

- Support full funding of the Minority HIV/AIDS Initiative at $540 million in FY 2002, ensure that the funds are used to support minority CBOs and HIV service providers, and declare an AIDS-related emergency in communities of color and respond accordingly;
- Increase appropriations for U.S. and global HIV/AIDS programs, including efforts to increase the U.S. contribution to the Global Fund to Fight AIDS, Tuberculosis, and Malaria;
- Support passage of the Early Treatment for HIV Act to improve access to care for low-income, uninsured people living with HIV;
- Prioritize vaccine and microbicide research, support policy reforms to speed vaccine and microbicide development, and ensure access to such prevention tools worldwide;
- Improve coordination and continue U.S. leadership in the global fight against HIV/AIDS; and

- Commit to providing comprehensive sexuality education programs consistent with sound public health research presented in the Surgeon General's *Call to Action to Promote Sexual Health and Responsible Sexual Behavior* and avoid the politicization of HIV prevention through emphasis on abstinence-only education.

Mr. Dellums emphasized that more treatment should be available to the global community. He said the previous Council grappled with the concept of globalism, and he hopes that the new PACHA will continue to do so.

Dr. Sullivan said that the previous Council's recommendations will be reviewed. Confronting the epidemic globally requires cooperation from other Governments, which involves greater challenges, he added. Council members noted that the Council might frame its response to the issue of developing a global initiative in the context of national security.

Public Comment

Members of the public addressed the Council. Comments and questions concerned: HIV/AIDS in the incarcerated population; the HHS management review; the need to improve information about and access to services; the need to develop leadership at the community level; the need to fund programs to address the HIV/AIDS epidemic in minority communities and among minority populations; and the importance of building on the Council's past recommendations, specifically in the area of HIV/AIDS and substance abuse.

Members of the public also recommended that Secretary Thompson take the same leadership role in confronting HIV/AIDS as he took in confronting the anthrax crisis; asked the Council to look at how the issues of homeland security and HIV/AIDS relate, especially in building the public health infrastructure; and requested that the Council consider issues related to therapies, vaginal and anal microbicide research, and vaccine development research.

A representative of HRSA's AIDS Advisory Committee said the Committee is working with CDC's Advisory Committee on the need for ongoing care for HIV and welcomes PACHA's support of these efforts. Dr. Sullivan requested that Ms. Ware obtain copies of the HRSA Advisory Committee's report.

Full Council Discussion

Ms. Duran recommended that the PACHA members discuss involving Mrs. Bush, Mrs. Cheney, or other public figures in addressing HIV/AIDS.

Ms. Smith stated that there is a need to address rural issues in addition to urban issues.

Ms. Shoemaker recommended that HIV/AIDS education for K-12 school children and their parents be improved. Ms. Freeman added that there is a need to increase messages targeted to young people.

Rev. Sanders reiterated the need to frame HIV/AIDS in the broader contexts of public health and homeland security. Ms. Ware said that the HHS management review includes review of homeland security and bioterrorism programs, and that there is a need to look at how the review can address the issue of HIV/AIDS in the context of these issues.

Dr. Driscoll pointed out that increasing global funding is important, but that it is also important to find ways to persuade countries to change their policies and to recognize the basic human rights of their people. He also stated that more priority should be placed on HIV/AIDS in the Caribbean and Mexico because immigration of people from these countries directly impacts the U.S. HIV/AIDS problem.

A Council member suggested that the Council's previous recommendations and President Reagan's report on HIV be provided to the Council members.

Dr. Sullivan said that the PACHA co-chairs will work with Ms. Ware to develop agendas for future Council meetings. Dr. Coburn noted that the Council should consider choosing two or three major issues that will have the greatest impact.

Adjournment

The March 14, 2002, session adjourned at 5 p.m.

Friday, March 15, 2002

Welcome

Ms. Ware took roll call. Dr. Coburn introduced the first panel of presenters.

Full Council Presentation: Financing of AIDS Medications

Deborah Parham, Acting Director, HIV/AIDS Bureau, HRSA, described the programs operated under the Ryan White CARE Act, which was reauthorized in 2000 and provides $1.9 billion in funding. The Ryan White CARE Act program is the largest Federal Government program to pay for care for poor and uninsured people living with HIV/AIDS and provides services for half of the people living with HIV/AIDS in this country.

Ryan White CARE Act programs include: Title I, which provides funds to 51 eligible metropolitan areas that have high populations of people living with HIV/AIDS; Title II, which provides funds to states for AIDS Drug Assistance Programs (ADAPs) and other services; Title III, which provides funds directly to CBOs for early intervention services, care, and treatment; Title IV, which provides funding to serve women, children and youth; the AIDS Education and Training Centers, which provide training of health care providers; the Dental Reimbursement Program, which provides funding to dental training programs; and Special Projects of National Significance.

Ms. Parham then focused on the ADAP component, which is managed by individual states. The program, which includes 56 ADAPs, provides funds to pay for medications for people who have no or limited health insurance. The drug formularies and eligibility criteria vary across the ADAPs. The formularies include between 17 and 453 drugs.

In 2000, ADAPs served 125,000 clients and in 2002, an estimated 138,000 will be served, Ms. Parham said. In any given month, approximately 79,000 people receive services through the programs. Demand for ADAP services outstrips the supply, so some states have implemented cost saving strategies, such as using ADAP funds to purchase health insurance, encouraging clients to enroll in programs that have negotiated discounts with drug companies, and maintaining close coordination with Medicaid programs. Some states also have limited the number of drugs in their formularies, capped the amount spent per patient on drugs, capped program enrollment, implemented waiting lists for clients, and added program eligibility requirements. Most ADAPs have established consumer advisory boards to help them make choices about how to use funding.

The reauthorized CARE Act sets aside 3 percent of funds for states that have severe needs. In 2001, $17 million in funding was set aside for this purpose, and $19.2 million was set aside in 2002.

Randy T. Graydon, Deputy Director, Division of Advocacy and Special Issues, Centers for Medicaid and Medicare Services (CMS), then described the CMS HIV/AIDS program. He began by stating that CMS administers four programs: Medicaid, Medicare, the State Child Health

Insurance Program, and the Health Insurance Portability and Accountability Act (HIPAA) Program. HIPAA is an important piece of legislation for persons living with HIV/AIDS because it protects those who change jobs. Medicaid and Medicare are the two largest payers for care of AIDS. In 2002, Medicaid will spend $7.2 billion and Medicare will spend $2.1 billion for this care. In 2002, Medicaid will serve 218,000 people with AIDS and Medicare will serve 46,000 persons with AIDS, but may pay for services for many more people who are not reflected in these figures.

Medicaid includes mandatory eligibility groups, most of whom are covered by SSI. Optional eligibility groups include persons who are medically needy, Ticket to Work and Work Incentive Act groups (i.e., the working disabled), individuals in medical institutions, and individuals who receive home- and community-based services. Medicaid pays for mandatory services (e.g., inpatient hospital, laboratory, and X-ray services) and optional services (e.g., prescription drugs, nursing care, and dental services). All states do not have to cover prescription drugs, and states have their own drug formularies.

States can use Medicaid waivers to circumvent rules. These waivers include: 1915(b) waivers (allow states to mandate enrollment of people into managed care); 1925(c) waivers (home- and community-based services waivers); 1915(b)/(c) combined waivers; and 1115 waivers. The 1115 waivers, which are approved for 5 years, must be budget neutral to the Medicaid program. CMS has oversight in developing 1115 waivers, which are flexible enough to allow testing of new ideas of merit. Evaluation is required under 1115 waivers.

Medicaid pays services for 55 percent of people living with AIDS and for 90 percent of children living with AIDS. Special income levels have been set for pregnant women to improve access to care. Income levels and family size for eligibility in each state are listed on the CMS Web site at www.hcfa.gov/hiv/subpg1.htm.

Tom Liberti, Chief, Bureau of HIV/AIDS, Florida Department of Health, described the Florida AIDS Drug Assistance Program, a $75 million program that has 55 drugs in its formulary. The Florida ADAP is administered through 67 county health departments. Drugs are purchased from drug wholesalers with a discount through a state central pharmacy and shipped to the county health departments. More than 15,000 clients currently are enrolled in the Florida ADAP. Of these clients, 71 percent are men and 29 percent are women, mirroring the epidemic in Florida. Seventy percent of the clients are racial and ethnic minorities. Ninety-two percent of the clients receive at least triple combination antiretroviral drugs by prescription.

Mr. Liberti highlighted reasons for increasing ADAP costs. Most importantly, he said, public health and community partners have been successful in encouraging patients to know their HIV status. In 1999, public health departments performed 231,000 HIV tests, and in 2001 the number grew to 271,000. Between 1985 and 2002, a total of 2.9 million tests were done in the state. Reportable cases of HIV was 5,772 in 2001, with growth reflecting increased testing. As a result, enrollment in ADAP has increased.

Mr. Liberti said that other reasons that ADAP costs continue to rise include new infections, the success of minority AIDS initiatives in bringing more people into care, the rise in drug costs, the

reduction in insurance plans' pharmacy benefits, and drug resistance that requires additional antiretroviral therapies. Neighboring states' ADAP waiting lists, client expenditure caps, and drug access restrictions also impact Florida's ADAP funding needs.

Bill Arnold, Chairman, ADAP Working Group, described his group's activities. The Working Group is a coalition of almost 40 AIDS organizations, care providers, and pharmaceutical companies that lobbies at the Federal level for adequate ADAP funding and works at the state level to address other funding issues. The ADAP Working Group began meeting in late 1995 and has received support from legislators and the Administration.

ADAPs are the heart of the states' systems to support people with HIV/AIDS, Mr. Arnold said. The ADAP funding crisis did not receive any public attention until combination treatments were introduced, and today, many people are not being served.

The FY 2001 ADAP budget was at least $60 million lower than the ADAP Working Group's projected need, and the FY 2002 budget is $162 million less than what is needed. Mr. Arnold said that an $82 million emergency supplemental appropriation is needed now or the program will not be able to assist all the people who need drug assistance. He asked the PACHA members to support an emergency supplement and an adequate FY 2003 budget. A Medicaid drug benefit, Medicaid expansion, and Medicare drug benefit would be help to relieve the lack of funding.

John Palen, Ph.D., George Washington University, discussed methods of expanding access to HIV-related therapeutics for low-income persons with HIV disease through the Medicaid and Ryan White CARE Act programs. Administrative procedures used by grantees, management and organizational activities, integration and coordination of program activities, and legal and regulatory proposals may be useful.

Better integration and planning of services within states could result in significant administrative savings and improved access to drugs, Dr. Palen said. Rebate programs are available to Medicaid programs that could reduce costs further. For example, the Medicaid program could be evaluated regarding reimbursement and rebates and may be a program where cost savings can be derived. He also said there may be ways to leverage Medicaid buying opportunities, and assessment of appropriate utilization/drug prescribing is important.

Management and organizational activities to expand access to therapies for low-income people living with HIV may include private health insurance or continuation of coverage for drugs for ADAP clients. In addition, Medicaid programs can influence drug utilization and prescribing patterns, create drug formularies, and encourage the use of generic drugs. Medicaid waivers available to states provide opportunities to address drug needs.

Dr. Palen also suggested that program activities could be better integrated and coordinated to help improve access to medications. For example, there has been discussion within the Federal Government regarding simplifying funding streams or allowing states to use funding in more flexible ways. This could result in administrative savings. For example, integrating ADAP into the Medicaid program could provide greater continuity of care.

Legal and regulatory proposals include using the provisions in Section 603 of the Veterans Health Care Act, modifying formulas, and expanding Medicaid eligibility criteria to include low-income persons who are HIV/AIDS asymptomatic.

Hank McKinnell, Ph.D., Chairman of the Pharmaceutical Research and Manufacturers Association (PhRMA), and Chairman and Chief Executive Officer of Pfizer Inc., noted that highly active antiretroviral therapy (HAART), introduced in 1990s, has transformed AIDS into a manageable, although difficult chronic disease. HIV was first characterized in 1981. Today, physicians can prescribe more than 64 medications to treat HIV/AIDS and more than 100 clinical studies are underway. Success in finding new medicines presents the challenge of how to pay for them, however. Much of the progress seen (e.g., fast track approval by Food and Drug Administration) reflects the work of the HIV/AIDS activist community.

Dr. McKinnell said that a critical issue is when to start therapy. He presented data from controlled studies suggesting that beginning therapy late results in high relative risks of progression to AIDS and death. When therapy is begun early, the risk is halved and costs are lower. There is also a good argument for starting treatment earlier because doing so improves quality of life and allows those with HIV/AIDS to remain in the workforce and pay taxes.

Dr. McKinnell said that Medicaid covers more than half of all HIV-infected people who are in therapy, but states are reducing funding. Sixteen states reduced Medicaid funding in 2001 and more are expected to do so this year. The current system pays for care late in the disease cycle, when the disease is most expensive to treat. Dr. McKinnell suggested changing the system to treat people earlier in the disease cycle. Several states and the District of Columbia are experimenting with this approach, and other states are considering it.

Pfizer Inc. is committed to working with advocacy groups to ensure there is adequate ADAP funding and wants to ensure that as many patients as possible have access to needed medications. With $32.3 billion in annual sales, Pfizer is the world's largest pharmaceutical company. The company invests $100 million a week to find new medicines.

Dr. McKinnell announced to the PACHA members that Pfizer will not increase the price of Viracept, a leading protease inhibitor, for the next two years. He also described the Pfizer for Living Share Card program, which is designed for low-income, uninsured Medicare recipients. The program offers a 30-day supply of Pfizer drugs for $15 per prescription and is designed as a bridge to help modernize Medicare.

One concern is that most people fail in the initial course of therapy. Therefore, the pharmaceutical industry must continue to look for new therapy options, and there are new pressures on product discovery firms and on sources of medical care funding. Dr. McKinnell recommended that the PACHA members examine the trade-off between better access today and new options for the future. When patents expire, there will be a financial dividend in making generics available. The pharmaceutical industry also can work to create new drug options, including simpler regimens that are better tolerated by patients.

The pharmaceutical industry is working in the developing world to deal with the global crisis, and partnerships are important in dealing with global crisis, Dr. McKinnell said. Pfizer has formed alliances in sub-Saharan Africa to create a training and treatment facility in Uganda and has created a partnership program in South Africa that dispenses Diflucan, processes prescriptions, and trains professionals.

Dr. McKinnell concluded by saying that the financing situation is barely in a state of equilibrium, and pressures on the system will continue to increase. Half of all HIV-positive people are not insured, but that group has little influence on Government. When HIV/AIDS emerged, activist groups were more vocal, but today's population is less vocal. He recommended that the Council maintain a focus on the human aspects of the disease, make education a national priority, look at earlier treatment, encourage and reward research, and forge true partnerships to manage the disease and care for its victims. He said that Pfizer is committed to early treatment and supports expanded Medicare and Medicaid coverage, continuing incentives for research and innovation, increased recognition for an HIV medical specialty, and ongoing collaborations with NGOs and patient support groups.

The speakers then responded to questions and comments from the Council. Ms. Ivantic-Doucette noted that the ADAP consumes one-fourth of all Ryan White CARE Act funds, but many drugs are prescribed inaccurately or inappropriately. She also expressed concern that HIV/AIDS care has become institutionalized in the United States and that this institutionalization is being exported to programs to other countries (e.g., in providing training for physicians who may not provide the bulk of the care). Ms. Parham responded that HRSA is very concerned about providers' accountability in spending CARE Act dollars and noted that 5 percent of CARE Act dollars can be spent on quality improvement. HRSA also conducts site visits to determine if care is being provided according to standards.

Full Council Presentation: HIV and Co-Infection with Other Infectious Diseases

Jules Levin, Founder and Executive Director, National AIDS Treatment Advocacy Project, said that one of the most problematic issues for people with HIV is co-infection with hepatitis C virus (HCV). In the United States, four million people have HCV, 2.7 million with HIV have chronic HCV, and 300,000 are co-infected with HCV and HIV. HCV often is spread is through injection drug use, and the disease transmits more easily than HIV.

Co-infection with HCV and HIV can cause problems that are unrecognized and not well understood by many health care workers and case managers. For example, HIV accelerates HCV progression because HIV impairs the immune system, and HCV progresses differently with HIV co-infection.

Mr. Levin said that people who are co-infected are among the most vulnerable groups, including current or former IDUs, sexual partners of IDUs, African Americans, Hispanics, women, people who are poor and uneducated, and people with poor access to medical care. It is often very challenging to educate people who are co-infected about their disease. Many people who are co-infected learn that they have HCV long after they are infected, and many people with HIV are not tested for HCV. Therefore, everyone who is tested for HIV should also be tested for HCV.

Mr. Levin also noted that large gaps exist in reimbursement treatment of hepatitis C. Public reimbursement for diagnostics and treatment is inconsistent, and it is difficult to get treatment and all diagnostics covered. Many ADAPs do not pay for HCV treatment and diagnostics.

Mr. Levin concluded by listing the following needs: education about co-infection, including among health professionals; funding to improve care for co-infection; more and better research on co-infection (e.g., the effect of HAART on HCV progression); funding for treatment and diagnostics (e.g., by adjusting ADAP formularies and earmarking ADAP funds for HCV treatment); outreach to Congress and the Administration to prioritize this issue; and increased awareness about testing and education about co-infection and HCV prevention.

Dickens Theodore, M.D., University of North Carolina Chapel Hill, presented an overview of HCV, with a focus on special populations. There are a number of genotypes, or subtypes, of HCV. Genotype 1 is more resistant to therapy, and genotypes 2 and 3 are easier to treat. Approximately 30 percent of people clear infection, leaving at least 70 percent with chronic infection. The effects of HCV usually are mild, but may progress to cirrhosis of the liver. Models show that prevalence of cirrhosis of the liver will increase five-fold by 2008, and liver-related deaths, decompensation, and the need for liver transplantation will increase.

Injection drug use is the most common means of HCV infection, although the prevalence is also high among hemophiliacs and people on hemodialysis. Blood transfusion has decreased as a risk factor during past 15 years. The estimated incidence of HCV in the United States decreased between 1982 and 1996 because of HIV preventive measures.

Dr. Theodore said that risk for HCV varies across groups in the United States. African Americans and Mexican Americans have higher rates than whites, probably because of lower socioeconomic status. The disease also is different in African Americans and Caucasians. Genotype 1 is more common in African Americans.

Dr. Theodore explained that perinatal transmission of HCV is higher in people with HIV. There is also evidence that people with HCV progress to HIV-related illness much faster than people without HCV, particularly with HCV genotype 1.

The goals of therapy are to eliminate the HCV infection, delay fibrosis progression, and prevent negative clinical outcomes. Pegylated interferon is the current focus of treatment. More than half of people respond to pegylated interferon, but those with genotype 1 are less likely to respond to this therapy. There are few data on the safety and efficacy of HCV treatments in the HIV-co-infected population, although some studies are in progress.

Dr. Theodore recommended that directions for the future include more research on the interaction between HCV and HIV, hepatoxicity, and pathogenesis; development of improved therapy; increased education of patients and providers; and increased funding for research, education, and treatment.

Joe McIlhaney, M.D., Founder and President, Medical Institute for Sexual Health, discussed the relationship between HIV and other sexually transmitted diseases. Most studies show that genital ulcer disease (GUD) increases susceptibility to HIV in both men and women. Genital herpes doubles the risk of subsequent HIV infection, and syphilis and chancroid also increase the risk of HIV infection. Data showing an association between non-ulcerative disease (NUD) and HIV also continue to accumulate. NUD may increase HIV susceptibility for women by increasing the pH of the vagina.

Dr. McIlhaney said that risk behavior is an important issue. For example, when syphilis rates in a population rise, HIV rates often follow, suggesting an association with increased risk behavior in the population. In addition, GUDs and NUDs seem to increase the infectiousness of people with HIV, and HIV-infected individuals may be more susceptible to sexually transmitted infections (STI) and their effects. Therefore, he suggested, STI monitoring and control programs should be a part of all HIV prevention efforts, and STI and HIV programs must be integrated. Programs should include counseling, screening, treatment, and prevention.

Dr. Coburn opened the floor to comments and questions. Mr. Levin stated that because people are living longer with HIV/AIDS, they are having complications that did not arise in the past.

Mr. Levin suggested that IDUs be educated about HCV and HIV prevention and treatment. Likewise, HCV awareness and testing programs offer opportunities to encourage IDUs to enter drug treatment. Case managers and health care professionals must also be educated about the relationship between HCV and HIV. Today's reimbursement systems result in physicians spending less time with patients, so HCV and co-infection with HIV do not receive adequate attention, Mr. Levin said. The problem of co-infection will become more of an issue as the HIV-infected population ages.

Ms. Ware noted that health care providers are talking about the relationship of HCV and HIV, but that policy makers are not. She also pointed out that tattooing has increased incidence of HCV in teens. Tattoo parlors are not regulated and teens sometimes tattoo one another. Education of young people about HCV and HIV may be an appropriate topic for a future PACHA meeting, she said.

Full Council Presentation: The State of HIV/AIDS Research

Anthony Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases (NIAID), presented an update on the HIV/AIDS pandemic and the NIH and NIAID research agendas. Dr. Fauci said that NIH HIV/AIDS research funding has increased dramatically during past 21 years, with continuing growth. HIV/AIDS resources now comprise 10 percent of NIH resources and 50 percent of NIAID resources. Therapeutic and drug development research increases each year, but there is even greater emphasis on vaccine development.

Dr. Fauci noted that HIV/AIDS epidemic trends drive the NIH strategic plan. Globally, 40 million people are living with HIV and most new infections are in the developing world. Sub-Saharan Africa has been hard hit, but there is potential for an explosion in the epidemic in Asia and India. NIH international AIDS projects are now conducted at 345 sites in 105 countries.

International research involves studying vaccine development, topical microbicides, prevention of disease transmission and progression, women and AIDS, prevention and treatment of HIV infection in children, prevention and treatment of opportunistic infections, capacity building and training of foreign scientists, and research collaboration.

The Comprehensive International Program of Research on AIDS (CIPRA) was launched last year. Major goals are to provide long-term support to developing countries to plan and implement comprehensive HIV/AIDS prevention and treatment agendas relevant to their populations and to enhance the infrastructure needed to conduct such research.

HIV Vaccine and Prevention Trials Networks (HVPTNs) are located worldwide. These networks are developing programs for non-vaccine prevention of HIV infection and building infrastructure for Phase II and Phase III trials.

Dr. Fauci then discussed the domestic HIV/AIDS situation. As of June 30, 2001, 793,000 AIDS cases and 457,000 AIDS deaths had been reported to the CDC. Between 850,000 and 950,000 U.S. residents are living with HIV infection; half of them are untested, untreated, or both. In addition, 40,000 new infections, half in people younger than 25, occur annually. The rate of AIDS cases per 100,000 people is 10 times higher among African Americans than in the non-Hispanic white population.

The Multicenter AIDS Cohort Study is being extended to focus more on minority groups, Dr. Fauci said. In the past, the proportion of minorities in clinical trials was smaller than in the population, limiting access to new drug trials and limiting the ability to study differences in the disease across populations.

Dr. Fauci also discussed NIH-supported HIV/AIDS pathogenesis research and briefly described the HIV replication cycle and the typical course of HIV infection. An understanding of the life cycle and clinical course has allowed researchers to develop targeted drugs and to know when to begin and when to modify therapy. Studies are looking at fusion/entry inhibitors and integrase inhibitors, in addition to reverse transcriptase and protease inhibitors. There has been a 70 percent decrease in deaths in the past few years, but the recent plateau reflects individuals' inability to tolerate some drugs. Current anti-HIV drugs are limited because of the persistence of viral reservoirs. Therefore, there will be an evolution of drug resistance, providing good reason to sustain drug development research. The questions of when to begin treatment and the effectiveness of structured intermittent therapy also require further study.

Prevention research is an important part of the NIH HIV/AIDS research agenda, and expenditures for vaccine and non-vaccine prevention research at NIH are increasing, Dr. Fauci said. This research examines prevention of maternal-fetal transmission, topical microbicides, behavior modification, reducing transmission from injection drug use, and STD control.

NIH HIV vaccine research funding will increase in FY 2003. A major focus of this research is on the use of attenuated adenovirus with HIV genes inserted. The NIAID Vaccine Research Center on the NIH campus opened less than 2 years ago and now has trials underway.

Dr. Fauci then responded to questions from the Council. Questions and comments focused on the importance of leadership and infrastructure in tackling the HIV/AIDS crisis in developing countries, the importance of behavior modification in prevention, progress in developing an HIV vaccine, parallels between the HIV/AIDS situation in developing countries and among underserved groups in United States, and drug toxicity.

Dr. Fauci suggested that the Council discuss the importance of developing a uniform leadership front within the African-American and Hispanic communities, and the importance of U.S. leadership in confronting the global pandemic.

Full Council Discussion

Dr. Coburn began the full Council discussion by stating that all input about Council's work and operations is welcome, noting that individuals affected by HIV/AIDS, not politics, should be the Council's focus. He also suggested that the Council committees consider both policy changes and legislative recommendations.

Ms. Ware said that the Council meeting was designed to provide background information and that future meetings will include more time for interactive discussions and development of policy recommendations. Presenters will be made available to the Council committees as they meet, and it is hoped that committee reports will be presented at the next Council meeting.

The PACHA members then recommended topics they felt should be addressed by the Council. The topics suggested included:

- Medicaid waivers and issues related to cost neutrality and quality of care;
- Increase of HIV/AIDS services funding, including for ADAPs;
- HIV/AIDS prevention and involvement of communities in prevention planning and implementation;
- The need for more HIV/AIDS education among children and adolescents, and the involvement of youth in education;
- HIV/AIDS services within the prison system;
- Program and funding efficiency and accountability;
- Preservation and support of established minority group leadership;
- The role of dental professionals and professional organizations in HIV prevention;
- The need for national and international moral leadership and activism to ensure that funding for drugs and research is available;
- The need to ensure that early treatment is available;
- U.S. leadership in confronting the global epidemic and the need for balance in addressing the global and domestic HIV/AIDS epidemics;

- Best practices in containing the epidemic;
- Concerns about industrialization of HIV/AIDS prevention and treatment and the hazards of exporting the "industry" to other countries;
- The need to look at the President's priorities and areas where the Administration's and PACHA's concerns dovetail (e.g., in upgrading the public health system);
- Barriers posed by regulations and increased administrative costs on the work of CBOs; and
- Whether the nation's level of commitment is commensurate with the gravity of the problem.

A member suggested that the Council revisit past Council recommendations to determine which are still relevant and have not been addressed. Choosing only two or three powerful themes could have the greatest impact. Another member suggested that the Council move quickly to deliver a first set of recommendations to the President; that *ad hoc*, topic-focused working groups be established; and that the Council members make concrete, specific recommendations. A recommendation was also made to seek input from the public and organizations (e.g., the National Minority AIDS Council) and to raise PACHA's visibility.

Dr. McKinnell offered to make specialized resources (e.g., meetings with researchers) available to the Council.

Other Business

Ms. Ware expressed her pleasure with the Council meeting proceedings. She noted that the President was very clear that HIV/AIDS is not partisan and that the Council membership composite reflects this.

She also encouraged members to find opportunities to speak about HIV/AIDS and the Council's work in the community or at meetings. However, Council members must receive approval from the Council co-chairs for speaking engagements on behalf of the Council. Furthermore, Council members are not permitted to express personal opinions when speaking on behalf of the Council.

Ms. Ware added that the Council can meet three more times in the next year, and committees will be established.

Dr. Coburn suggested that the Council develop a consensus on immediate recommendations to the Administration. The points he suggested were: markedly increase the U.S. contribution to the Global Fund; increase ADAP funding; and change the Medicaid 1115 waiver. Council members also suggested that the Council support funding for prevention and early treatment of HIV/AIDS; that the President raise awareness of HIV/AIDS through a "know your status" campaign; that the President, Mrs. Bush, or another high-level public figure become directly involved in raising awareness (e.g., by getting tested on National Testing Day); and that assurances be made that that the Global Fund is being used effectively and as intended.

Dr. Coburn recommended that options for immediate Council recommendations be disseminated by e-mail to the Council members for review and comment the week of March 25, 2002. Immediate input on the suggested recommendations will be requested.

Public Comment

The Council members heard comments from the public. Members of the public recommended that the Council: take action because small steps are better than no steps; open its meetings to the public; discuss the behavioral and attitudinal aspects of HIV/AIDS; address the mental health aspects of the disease; address the impact of HCV/HIV co-infection, particularly in the prison population; and encourage the public to "know your status."

Other Business

Mr. Smiley said he has enjoyed working with past and present Councils and is highly encouraged by the Council's discussion during the 2-day meeting. He offered to serve as a resource in the future.

Dr. Coburn said the PACHA members will be polled regarding future Council meeting dates.

Adjournment

The 19th meeting of the Council adjourned at 4 p.m.