Presidential Advisory Council on

HIV/AIDS

Achieving an HIV-Free Generation:

Recommendations for a New American HIV Strategy

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Acknowledgements

The Presidential Advisory Council on HIV/AIDS ("PACHA" or the "Council") is indebted to many people who help make our work possible. It is impossible to recognize every organization and person who has contributed to our efforts, but we cannot overstate the importance of the help we are given.

Though the work of the Council will continue, we wish to take the opportunity of the issuance of this document to publicly thank all those who have helped us over the last few years. Many generous people take the time to travel to Washington, D.C. to offer their advice and share their experiences. Those of you who shared your wisdom with us should know how greatly indebted we are.

We also thank the many federal employees, those administering vital programs to fight HIV, and to America's brilliant doctors and scientists working throughout the Department of Health and Human Services in agencies like the National Institutes of Health, the Health Resources Services Administration and the Centers for Disease Control and Prevention, for sharing their work with us. These giants provide invaluable service to our nation and the world, and we are greatly indebted to them.

Most of all, we wish to thank the many unsung heroes toiling throughout the United States and throughout the World, devoting their lives to soothe the suffering of those afflicted with HIV, care for orphans and families disrupted by this awful disease, and to prevent others from becoming infected. Please know that your work and your lives both inspire and humble us.

This Council is grateful for the opportunity to serve our nation. For this, we thank President George W. Bush and Secretary Michael O. Leavitt for their support and for the extraordinary leadership they continue to demonstrate in the fight against HIV. We also thank former Secretary Tommy G. Thompson for the friendship he extended to us as we began our terms on PACHA. Finally, we thank the many members of PACHA who have come before us, and for those who will come after us to continue this fight until it is won.

Member Biographies

Rosa M. Biaggi, M.P.H., M.P.A., is responsible for the management of over $45M, and the Chief of the AIDS and Chronic Diseases Section at the Connecticut Department of Public Health. She oversees the following: HIV prevention program; the Ryan White Title II office; Heart Disease and Stroke Prevention Program; HIV Surveillance; Arthritis; and viral Hepatitis. She is also responsible for the implementation of public health policies and protocols concerning the programs under her management.

Cheryll Bowers-Stephens, M.D., M.B.A., *Assistant Secretary for the Office of Mental Health, Department of Health and Hospitals; Baton Rouge, LA.* In addition to this position, she also serves on the National Advisory Board to the Center for Mental Health Services for Mental Health and Substance Abuse Administration, and recently was appointed to the national board of directors for the American Academy of Community Psychiatrists. Her professional affiliations include serving as Chair of the Board for the Alliance to Combat AIDS. This is a non-profit organization; as part of its mission, the Alliance provides assistance to countries in Sub-Saharan African in the eradication of the AIDS virus.

Jacqueline Clements is an HIV test counselor and provides medication adherence support for Durham County Health Department and Lincoln Community Health Center in Durham, North Carolina. She has been involved in the field of HIV/AIDS for many years, first as a volunteer and then later in a professional and in a consultant capacity with various local and national agencies. Jacqueline, herself was diagnosed HIV positive in 1986 and lost her daughter and husband to AIDS in the early 90's.

Mildred Freeman is currently the President/CEO of Health Education Network a 501(c)(3) non-profit-organization which provides health education to HBCU's about HIV/AIDS , and other sexually transmitted diseases, substance abuse, tobacco and obesity. She was the former Director of Health Education for the National Association for Equal Opportunity and Higher Education. A membership organization representing 118 historically black colleges and universities.

John F. Galbraith is President and Chief Executive Officer of the Catholic Medical Mission Board (CMMB). Established in 1928, CMMB is a leading U.S. faith-based charity focusing exclusively on international healthcare, particularly the wellbeing of women and children. CMMB works in more than a dozen countries to meet the challenges of HIV/AIDS. It has also established programs in Latin America and the Caribbean to lower mortality rates of children under five. In 2004, CMMB provided more than $135 million in medicines and medical supplies, volunteer services and healthcare programs to more than 48 developing countries worldwide. CMMB works collaboratively to provide quality healthcare without discrimination to people in need.

Edward C. Green, Ph.D. is considered an expert on global AIDS issues, especially those concerning sexual behavior change and AIDS in Africa. He is a medical anthropologist, and Senior Research Scientist in the School of Public Health, Harvard University. He has testified in both Houses of Congress on AIDS issues. His work in developing countries has spanned Africa, Latin America, the Caribbean, Asia, the Middle East and Eastern Europe. He served as an adviser to the Ministries of Health in Mozambique (1994-95) and Swaziland (1981-83). Dr. Green is the author of several books, including "Rethinking AIDS Prevention";

"AIDS and STDs in Africa", and "Indigenous Theories of Contagious Disease", as well as more than 350 journal articles, book chapters, presented papers, and commissioned reports.

Joseph Grogan is Executive Director of the Presidential Advisory Council on HIV/AIDS (PACHA). He was appointed in May 2004. Prior to becoming Executive Director, he was Special Assistant in the Office of Community Services (OCS) of the Administration for Children and Families. At OCS, he was integral to the management of the $6 billion dollar division's procurement, personnel and grant making decisions. He also served as Program Manager for the first two years of the Compassion Capital Fund, helping to launch the principal funding mechanism of the President's Faith-based and Community Initiative. As program manager of the Compassion Capital Fund, he oversaw the awarding of over $60 million in grants and cooperative agreements. Joseph received his B.A. from the State University of New York at Albany in 1994. He received his J.D. from the College of William and Mary in 2000. Prior to joining the federal government, Joseph was an attorney in private practice.

Cheryl-Anne Hall is Vice President of Governmental and Corporate Affairs for Lutheran Family Health Centers(LFHC). LFHC is the largest federally qualified health center in the country. As the Director of one of the LFHCs, the Caribbean Family Health Center, which is located in the largest Caribbean community in America, she created programs to respond to the AIDS crises, specifically targeting Caribbean Immigrants. She was the director of one of the first AIDS adult treatment programs in New York City. She also lends support to a nursery in the Caribbean that cares for HIV-positive children whose parents have died from AIDS. She has spent over twenty five years in hospital administration. Ms Hall is also the Co-PI for the U.S. Caribbean Twinning Initiative which is funded by HRSA/HAB. The principal objective of this grant is to strengthen human capacity to improve the service delivery to people living with HIV/AIDS both in the U.S. and the Caribbean.

Jane Hu, Ph.D. is the founder and Chairperson for the China Foundation, Inc., a charitable and Think Tank Organization founded in 1997. Dr. Hu works with the Word Bank, UNICEF, the CDC and WHO to promote prevention and treatment in China to prevent the spread of HIV/AIDS, Hepatitis B, and TB.

Karen Ivantic-Doucette is a Clinical Assistant Professor at Marquette University College of Nursing with a teaching focus on HIV Disease and Primary Health Care. She is a HIV/AIDS Certified Family Nurse Practitioner who maintains a clinical practice caring for a majority of HIV infected women and their families at Aurora Health Care in Milwaukee, Wisconsin. She is the former Principal Investigator of two USAID projects focused on training of nurses and community health workers in HIV and AIDS care in resource poor settings and using nutrition and clean drinking water interventions to improve the efficacy of antiretroviral medications in Kenya. She has worked as a consultant to HRSA and several other agencies in training and delivery of care in resource poor settings. She has facilitated international service learning opportunities for students to work in HIV care that have served as transformational experiences with many now working in the Peace Corps or other international work settings.

Rashida Jolley, *Motivational speaker; Washington, DC.* Ms. Jolley has spoken extensively throughout the country to youth and young adults to educate them on the benefits of abstinence and HIV/AIDS prevention.

Franklyn N. Judson, M.D., is Professor in the Departments of Medicine (Infectious Diseases) and Preventive Medicine, University of Colorado Health Sciences Center, and for 22 and 18 years respectively, was Chief of the Infectious Diseases/AIDS Service and Director of the Denver Public Health Department at Denver Health and Hospitals. Dr. Judson helped establish the first and largest HIV/AIDS clinic in Colorado and in 1986, worked to pass the nation's first state-wide confidential name based HIV reporting system. He currently is President of the WHO associated International Union Against Sexually Transmitted Infection (IUSTI). Dr. Judson has authored or co-authored more than 250 scientific publications, many on HIV/AIDS, and has extensive international public health experience including 2 years with Geneva based WHO Global Program on AIDS.

Abner Mason is Executive Director of AIDS Responsibility Project and previously served as Chief Policy Advisor for the Governor of Massachusetts.

Sandra McDonald, *President and Founder, Outreach, Inc. Atlanta, GA.* OUTREACH, INC., established in 1986, is recognized nationally as one of the country's preeminent HIV/AIDS service providers. The agency was the first minority non-profit, HIV/AIDS community based organization created in the State of Georgia to provide AIDS awareness and prevention programs in Metropolitan Atlanta's African American communities. In the agency's nineteen (19) years of service to the community, holistic services have been provided to 5,500+ clients who are HIV-positive or have AIDS; and, more than 75% of these clients have had chemical dependencies and histories of substance abuse.

Joe McIlhaney, Jr., M.D., *Founder/Chairman, The Medical Institute for Sexual Health; Austin, TX.,* is a board certified obstetrician/gynecologist who operated a private practice for 28 years. As a physician, he focused his attention on reproductive technologies which included co-founding one of the first successful non-university affiliated IVF programs in the USA. He also focused on health and fitness promotion which led to his authorship of several books. The goal of which were to educate individuals about health issues. Research for those books led to his realization that an STD epidemic existed in the United States; an epidemic many people were unaware of. This led to his establishing the Medical Institute for Sexual Health in 1992 and leaving his private practice to join the organization full-time in 1995. The Medical Institute is a non-profit organization that informs, educates, and provides solutions to medical professionals, educators, government officials, parents and the media about problems associated with STDs, HIV and non-marital pregnancy. Dr. McIlhaney has published extensively in the area of STDs and speaks in numerous settings about HIV/AIDS prevention.

Henry McKinnell, Jr., Ph.D., *Chairman and CEO, Pfizer, Inc.; New York City, New York.* Hank McKinnell is chairman of the board and chief executive officer of Pfizer Inc. In 2001, Dr. McKinnell was appointed to PACHA by President Bush; he is the first pharmaceutical executive named to the Council. Dr. McKinnell has presided over Pfizer's widespread efforts to improve the lives of those suffering from HIV/AIDS, including Pfizer's Diflucan(r) Partnership Program; support for U.S. AIDS Drug Assistance Programs; and, Pfizer's role as a founding partner of the Infectious Disease Institute at Makerere University in Kampala, Uganda. A leader for corporate involvement in increasing access to HIV-related medicines and fighting the pandemic, Dr. McKinnell's personal commitment has taken him around the world to observe the effects of the pandemic and to help develop clear responses. His vision for an AIDS free generation was outlined in his recent book, *A Call to Action*.

Jose A. Montero, M.D., FACP, *Associate Professor, Department of Internal Medicine, Division of Infectious and Tropical Disease, University of South Florida College of Medicine, Tampa, FL.* Dr. Montero also serves as the Chief of Medical Staff at the Hillsborough County Health Department in Tampa, FL, and is a member of the faculty at the Florida/Caribbean AIDS Education Training Center in Tampa, FL. He has worked as a faculty coordinator for the CDC STD Faculty Expansion Program conducted at the University of South Florida College of Medicine in Tampa, FL. Dr. Montero is a member of several professional associations, including the American Medical Association, the Infectious Disease Society of America, and the American College of Physicians.

Dandrick Moton, *former Director of Community/Youth Relations, Prim 'N Proper, Inc./Excel; Conway, AR.* Prim 'N Proper, Inc./Excel is a non-profit, Section 501(c) organization. The organization works within the Arkansas public school system to promote healthy lifestyles for youth. The program works along with teachers, counselors, and other schools officials to make a positive difference in the lives of youth by promoting abstinence and healthy choices. Mr. Moton speaks annually to thousands of youth across the country about HIV and teen pregnancy prevention issues, as well as other healthy life choices. Mr. Moton is currently a Public Speaking/Business Professional Speaking Instructor and second year graduate student in communication at Arizona State University.

Beny Primm, M.D., is the President of the Urban Resource Institute, a non-profit organization that provides social and medical services to underserved populations in New York. He is the Executive Director to the Addiction Research and Treatment Corporation. He has been involved in numerous research projects and is the Founder and Board Chairman of the Brooklyn AIDS Task Force, a Founder and Board Chairman of the National Minority AIDS Council. Dr. Primm led the national fight to establish the Congressional Black Caucus' Minority HIV/AIDS Initiative, and was a member of President's Reagan's Human Immunodeficiency Virus Epidemic Commission.

David Reznik, D.D.S., is Chief of Dental Services and Director of the Infectious Disease Program's Oral Health Center (OHC) at Grady Health System in Atlanta. Dr. Reznik has broad policy expertise on matters concerning HIV/AIDS. He is an active member of the Ryan White Planning Council and is President of HIVdent, a not-for-profit coalition committed to assuring access to oral health care services for people living with HIV disease. Under his direction, the OHC is part of the most comprehensive interdisciplinary HIV/AIDS care program in America. Dr. Reznik has published numerous peer-reviewed articles on HIV care and oral health, and is a peer-reviewer for the Journal of the National Medical Association.

Debbie Rock, MSW, *Executive Director of the Baltimore Pediatric HIV Program, Inc., Baltimore, Maryland.* Ms. Rock founded a specialized day care program that has served over 600 children, many of whom are HIV-positive. This program is recognized as a national model for its services and innovation. Ms. Rock was instrumental in developing a kinship care program and helping to pass state legislation that created stand-by guardianship to protect parental rights. Her work with children and families has led to expansion of her day care program to include counseling services for parents and guardians and prevention education and risk reduction programs for teens and adults. She has forged collaborations with Johns Hopkins University Hospital, University of Maryland Medical Systems, and Glass Substance Abuse Treatment Programs as well as numerous community-based and AIDS service organizations. Ms. Rock serves as chair of the Baltimore planning council, is a member of the Baltimore City Mayor's Commission on HIV/AIDS and the Mercy Medical Center Board of Directors. The business community has also recognized Ms. Rock's various contributions to the Baltimore metropolitan area by naming her one of the Top 100 Women in Maryland.

Rev. Edwin Sanders, II, is the Senior Servant and Founder of the Metropolitan Interdenominational Church, a congregation that has attracted a broad cross-section of people. Metropolitan has outreach ministries in the areas of substance abuse, advocacy for children, sexual violence, and harm reduction, in addition to providing services to persons infected with, and affected by, HIV/AIDS through the First Response Center, which Rev. Sanders founded in 1992.

Prem Sharma, D.D.S., M.S., is Associate Dean Emeritus and Professor of the Marquette University School of Dentistry. With extensive experience in research and writing for scientific literature, Dr. Sharma has authored two novels and is a motivational speaker on race and religious relations.

Lisa Shoemaker is one of six patients to be HIV infected by a Florida dentist, who performed two root canal surgeries for her in 1988. Since her diagnosis, Lisa has spoken to hundreds of audiences about compassionate care for those who are HIV infected, and for implementation of effective public health strategies, avoidance of drug abuse and promotion of abstinence education in order to control the risk and spread of the virus. She has been interviewed on major TV and radio stations including Oprah, 20/20 and the Maury Povich Show.

Anita M. Smith, *Co-Chair, President, Children's AIDS Fund, Washington, D.C.* The Children's AIDS Fund (CAF) limits the suffering of children and families caused by HIV/AIDS by providing services, care, treatment, referrals and education. CAF develops resources and materials to help educate the general public about HIV disease. Mrs. Smith is a recognized expert on HIV, has written a wide range of articles on HIV/AIDS, youth development and parenting, and has served as a primary investigator for HIV research on services and funding.

Louis Sullivan, M.D., *Co-Chair, Founding Dean and President, Morehouse School of Medicine; Atlanta, GA.* Dr. Sullivan was appointed Secretary of Health and Human Services in 1989. He served in this capacity until 1993. In addition to his tenure in this Cabinet-level position, Dr. Sullivan served as the President, Morehouse School of Medicine (MSM) for two decades. Under his leadership, MSM developed and facilitated a number of nationally recognized programs that support HIV research, care and other services in communities throughout the South with principal focus on rural communities. Dr. Sullivan left the presidency in July 2002; however, he continues to assist on the MSM Board of Trustees, to teach and assist in promotional activities to benefit MSM. Dr. Sullivan has served as Co-Chair during his tenure on the Council. It is recommended that Dr. Sullivan continue to serve in this capacity during the proposed term of reappointment.

M. Monica Sweeney, M.D., MPH, FACP, *Vice President, Medical Affairs, Bedford Stuyvesant Family Health Center, Inc; Brooklyn, NY.* The Bedford Stuyvesant Family Health Center is a community health center that has provided primary medical health services to the Bedford Stuyvesant community for over twenty-five years. The Bedford-Stuyvesant community has one of the highest HIV infection rates in the nation. Dr. Sweeney also is a Clinical Assistant Professor in the Department of Preventive Medicine and Community Health at the State University of New York Health Science Center. She is the first African American woman to be elected president of the 177 year old Kings County (NY) Medical Society. Dr. Sweeney has received numerous awards for her work. She is the author of many lay as well as peer reviewed publications and is the author of Condom Sense: A Guide to Sexual Survival in the New Millennium.

Ram Yogev, M.D., Professor of Pediatrics, Northwestern University Medical School and Associate Head, Division of Infectious Diseases, Children's Memorial Hospital; Chicago, IL. Dr. Yogev also serves as Director of the Section of Pediatrics, Adolescent, and Maternal HIV Infection at Children's Memorial Hospital, and services as Director of the Center for HIV/AIDS Research at Children's Memorial Research Center. Dr. Yogev has worked extensively with HIV/AIDS patients since 1987. His compassionate leadership in HIV/AIDS helped establish the hospital's HIV-Affected Families Advocacy Center, a policy making program which also provides family counseling, and community-based outreach/education programs. In addition, he conceived and founded the Children's Place Association, a respite home HIV infected children and families. Dr. Yogev is a naturalized U.S. citizen from Israel. He is the author of numerous articles and books and belongs to several professional organizations, including the American Academy of Pediatrics and Children Affected by AIDS Foundation, Health and Social Service. In 2002, the Chicago Medical Society awarded Dr. Yogev the Henrietta Herbolsheimer, MD, Public Service Award for his dedication to treating children with HIV/AIDS.

Preface

We Are All AIDS Activists.

The Presidential Advisory Council on HIV/AIDS (PACHA) is charged with providing advice, information, and recommendations to the President and the Secretary of the Department of Health and Human Services regarding programs and policies intended to promote effective prevention of HIV, and to advance research on HIV and AIDS.

This document contains assessments of the current HIV epidemic and recommendations to guide our domestic and international HIV efforts with a clear strategy to achieve an HIV-free generation. None of these recommendations will make much difference without effective leadership. The United States requires a coherent, unified, honest approach to lead the world to victory over HIV. We recognize all too well the politics and frustrations that confront those who labor in this field. Many of us have found ourselves struggling in our own communities to implement policies essential to help those infected with HIV and to prevent more people from becoming infected. We understand that this work is not easy, and we are in a race against time.

Through all of our discussions about what it would take to win against HIV, we always return to the absolute necessity of leadership. By leadership, we do not mean just political leadership. Rather, we mean leadership across our society. Elected leaders at the state, local and community level, the entertainment and news media, doctors and nurses, members of the civil service, state, federal and health employees, educators and faith leaders– all of us, together. Every American must engage in this fight.

Success is impossible without courageous leadership, and leaders in the fight against HIV must be recognized, thanked and supported. We commend President Bush for his extraordinary commitment to fighting HIV in the developing world and his leadership in announcing the President's Plan for Emergency AIDS Relief. We also commend the President and Secretary Leavitt for calling for the reauthorization of the Ryan White CARE Act, and for their development of principles to guide that reauthorization. We thank the many leaders we have met in the United States and across the globe who have dedicated their lives to fighting this disease. Perhaps most importantly, we thank the countless others who have stepped forward quietly to take personal responsibility to fight HIV in their communities.

PACHA is a diverse group: we are women and men, gay and straight, black, white and Latino, HIV-positive and HIV-negative, doctors, nurses, academics, community leaders, leaders of industry, wealthy and not so wealthy, native born and immigrants, but we have found one thing that unites us all. Through public meetings and personal discussions, conference calls, and disagreements, we have found a common devotion to fighting this dreaded disease, and we have found that We Are All AIDS Activists.

Introduction

Twenty-five years ago a new illness appeared, affecting homosexual men in a few metropolitan areas in the United States and Western Europe. Ultimately, Acquired Immune Deficiency Syndrome (AIDS) was discovered to be caused by the Human Immuno-Deficiency Virus (HIV). Unknown to experts at the time, the same virus had been infecting multiple populations around the world at an alarming rate. HIV/AIDS is now a pandemic stretching to every corner of the globe and almost every demographic group imaginable.

In 2004, somewhere between 4.3 million and 6.4 million citizens worldwide became infected with HIV, more than any year before. Today, it is estimated that nearly 40 million people worldwide are living with HIV. The death toll continues to mount: HIV killed 3.1 million people in 2004, and over 20 million since the first cases of AIDS were identified in 1981.[1]

Recognizing the staggering damage HIV was causing overseas, in 2003 President Bush unveiled a 5-year, $15 billion initiative to combat HIV and AIDS internationally. The President's Plan for Emergency AIDS Relief (the Emergency Plan) demonstrates an extraordinary commitment of resources both in terms of actual U.S. dollars but also in terms of U.S. human capital. The Emergency Plan has achieved some amazing successes, providing hope where there was none.

In the United States, somewhere between 1,039,000 and 1,185,000 Americans now live with HIV.[2] While the stunning developments of new pharmaceutical products, advances in the medical management of HIV and progress in HIV research have seen HIV diagnosis no longer an immediate death sentence in the United States, we have not stopped HIV's spread. The continuing need for HIV treatment and care for the most vulnerable Americans spurred President Bush, in his January 2005 State of the Union Address, to call for reauthorization of the Ryan White CARE Act. The following summer, the President, recognizing the changing demographics of HIV and its disproportionate impact in the African American and other minority communities, released a set of principles asking Congress to ensure that the re-authorized Ryan White CARE Act confronts the present state of the epidemic. The President urged that dollars need to be flexible enough to go where the disease is today and where it is going tomorrow. The Ryan White CARE Act demonstrates this nation's compassion for those with HIV, but we look forward to the day when the CARE Act is no longer necessary.

The Presidential Advisory Council on HIV/AIDS (PACHA) has come to realize that we are guaranteed failure if we do not make winning the ultimate goal of our HIV/AIDS efforts. To PACHA, "winning" means an HIV-free generation. It will not be achieved overnight, but devotion to this goal will force us to focus our attention and our resources. Every time someone gets HIV, it is a failure, a defeat, and it must be recognized as such.

We cannot achieve an HIV-free generation without developing an HIV/AIDS strategy based upon sound science and sound public health policy. Our enemy is too strong to allow us the luxury of squandered resources and lack of focus.

We note that when the United States partners with a country to help them fight HIV and AIDS in their own countries through the Emergency Plan, we require that country to produce a comprehensive national strategy document, laying out an integrated treatment and prevention plan. Yet the U.S. government does not require states and jurisdictions receiving federal money to develop a similar integrated treatment and prevention plan. It is time to re-examine and clarify our goals, to unify our efforts and turn the tide.

PACHA has undertaken to issue a series of recommendations to help develop a new American HIV strategy. We do not presume that the recommendations contained here are all that need to be done. Indeed, there is more this nation must do, but we hope this marks a beginning of honest debate and focused attention, and a commitment to reject HIV as inevitable. This nation must discuss what we need to do to beat HIV and to ask every American to summon the will to achieve it.

This document is separated into three parts. The first two sections focus domestically, on the Prevention of the continued transmission of this disease and the Treatment and Care of those already infected. The third section is devoted to The Emergency Plan and the epidemic in the developing world.

We stand at a pivotal moment in the fight against HIV. The Emergency Plan is at its mid-way point, the Ryan White CARE Act is up for re-authorization, and as the face of this epidemic changes, great attention is focusing on our domestic HIV prevention efforts.

Several underlying themes run throughout these three sections:

- We will not treat our way out of this epidemic.
- HIV is a totally preventable disease.
- The goal of the America's HIV efforts should be to have zero infections and achieve an HIV-free generation.
- Substance Abuse Treatment, Oral Health and Mental Illness Treatment are essential components to comprehensive HIV prevention, treatment and care.
- Federal authorities need to promote sound public health policies and encourage states, jurisdictions and countries receiving U.S. federal aid to adopt them.
- Every American must know their status and pledge that "HIV Stops With Me."
- Leadership throughout the public and private sectors in the fight against HIV is essential both domestically and globally.
- Every American who needs HIV treatment and care should have access to it.
- The growing epidemic in the African American and Hispanic American communities must be specifically addressed.
- Research is essential, including vaccine research, research studying drug resistance, and research to study behaviors that affect the spread of HIV.

- HIV does not exist in isolation, and the social, economic, psychological, substance abuse and legal factors that fuel the epidemic must be addressed.

- Programs and approaches must be continually evaluated and updated as new knowledge is shared and the epidemic continues to evolve.

- The Emergency Plan is a success, providing hope where there was once despair, and proving that treatment is possible in resource poor settings.

- In the developing world, America's HIV efforts need to begin to focus on creating the infrastructure that will make the long-term fight against HIV sustainable.

CONCLUSION

The fight against HIV and AIDS both at home and abroad will continue for many years to come. The United States leads the world in that fight and must continue to do so. We cannot accept HIV as inevitable. We must fight it wherever it exists, and wherever it threatens to infect others. This fight does not simply require financial resources, but open minds, compassionate hearts, and unshakable will. Sound public health policies must be deployed and those approaches that do not work, that do not maximize effectiveness, must be rejected. HIV is a totally preventable disease, and we must commit to victory. If we commit to the eradication of HIV, we will be forced to focus our attention and deploy our resources most effectively. This will require us to challenge assumptions, confront stigma, and engage in an honest discussion of what we, as a nation, are willing to do to defeat this modern plague. The war against HIV will be won or lost, as all wars are, in the trenches, on the ground, in the communities where every individual life is fought for and protected. Let these recommendations be one step toward our shared victory: the dawn of an HIV-free generation.

References

1. UNAIDS/WHO Annual AIDS Epidemic Update (December 2005)
2. U.S. Centers for Disease Control and Prevention

Prevention

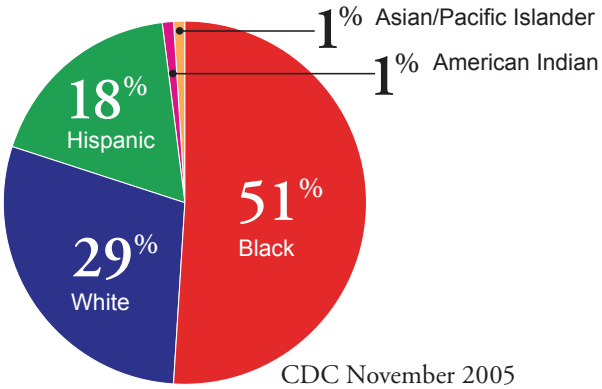
Prevention

We cannot treat our way out of this epidemic.

If we are to defeat HIV we must invigorate our current prevention approach and make prevention a central component of our HIV efforts. On the federal level, we spend almost $12 billion dollars on HIV treatment efforts. This does not include state expenditures, which approach $6 billion.[1] Combination AIDS therapy alone costs between $10,000 and $20,000 per patient per year. When additional medical expenses for doctor's visits, laboratory tests, and drugs to prevent or treat HIV-related opportunistic infections are taken into account, average annual costs rise, with even higher expenses for those with more advanced HIV-related illness.[2]

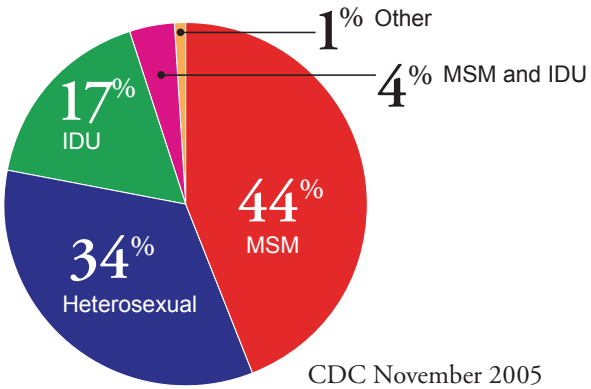
Domestically, the federal government spends over $660 million on HIV prevention programs through the Centers for Disease Control and Prevention (CDC). This represents roughly 5% of the federal government's HIV-related expenditures. CDC's articulated HIV prevention goal is to cut the number of annual HIV infections from 40,000 to 20,000 per year by 2005.[3] This goal has not been met.

New HIV Diagnoses — Race/Ethnicity



CDC November 2005

New HIV Diagnoses — Transmission Category



CDC November 2005

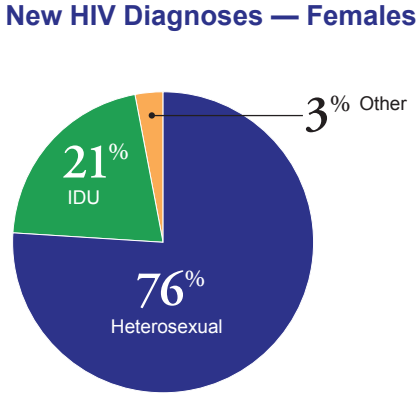
The data make clear that the United States needs a coordinated strategy to prevent uninfected Americans from contracting the virus.

RECOMMENDATION 1:

The goal of U.S. domestic HIV prevention policy should be to have zero new infections, and all our Prevention policies should be targeted to achieve that goal.

PMTCT and Reason for Hope

The one clear success in America's fight against HIV is in the Prevention of Mother to Child Transmission (PMTCT). We are on the threshold of eliminating this tragedy. We are succeeding on PMTCT because we have been blessed with amazing advances in pharmaceutical treatments and we have been aggressive in testing pregnant mothers for HIV. By getting women tested as they come into medical settings for prenatal care and delivery, we take advantage of a unique opportunity. Many women, especially in underserved or minority communities, do not get regular medical care, which is why this opportunity cannot be missed.



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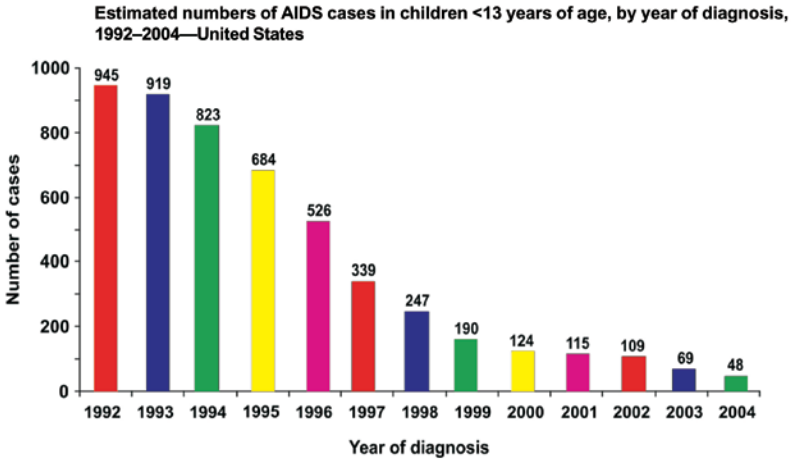


Note. These numbers do not represent reported case counts. Rather, these numbers are point estimates, which result from adjustments of reported case counts. The reported case counts are adjusted for reporting delays. The estimates do not include adjustment for incomplete reporting.

CDC November 2005

RECOMMENDATION 2:

Every pregnant woman in the United States should be tested for HIV, and more than once if medically warranted. Every State should consider a patient's general consent to receive medical treatment and testing as consent to be tested for HIV. HIV should not be treated any differently than all the other blood tests performed on pregnant women. If an expectant mother refuses to allow HIV testing, or her status is unknown, the baby should be tested at birth and the results should be available before the mother and baby are discharged from the hospital. If a mother is found to be HIV-positive, medical professionals must follow-up with mothers to make sure that treatment, care and support are continued. HIV-positive women must also be educated to avoid breast-feeding to guard against transmission. Research supporting new pharmaceuticals and treatment protocols should be funded to further reduce Mother to Child Transmission in the United States.

Testing

RECOMMENDATION 3:

HIV testing should be a routine part of primary care in the U.S. The Centers for Disease Control and Prevention estimates that roughly 25% of Americans infected with HIV do not know they are infected.[4] Everyone in the United States should know their HIV status, taking responsibility for their own health and those they may expose to risk. It is unacceptable to knowingly or unknowingly infect another person. If someone is found to be infected, they should immediately be referred to care and efforts must be taken to educate them on how to avoid infecting anyone else. Once a person is found to be HIV-negative, every effort should be made to encourage behaviors to remain HIV-negative.

RECOMMENDATION 4:

We must seek out opportunities to get people tested. Just as in the area of mother to child transmission, every opportunity to get people tested must be seized. Routine HIV testing should be a universal standard of care and should be reimbursed by insurance companies and applicable government health programs. The federal, state and local governments must get people in their care tested. Every person in federal or state prison must be tested upon entering the prison and upon their release. Substance abuse clinics, jails, sexually transmitted infection (STI) clinics, institutes for mental health disease, community mental health clinics, hospitals, emergency rooms and health clinics should all have rapid HIV tests and an aggressive testing policy. Colleges and Universities should be encouraged to promote HIV testing among their student populations.

RECOMMENDATION 5:

Contact Tracing and Partner Notification should be standard. When an individual is found to be HIV-positive, a responsible public health official should confidentially notify every person known to have been exposed to HIV, without revealing the identity of the index case. States should require contact tracing and partner notification for those discovered to be infected with HIV. Those notified that they may have been exposed to HIV should be strongly encouraged to get tested. We have enough history in the practice of contact tracing and partner notification regarding HIV to know this can be accomplished without breaches in confidentiality.

RECOMMENDATION 6:

Anonymous Testing should be eliminated. We must be able to inform people who are HIV-positive that they carry HIV. Anonymous testing makes appropriate follow-up needlessly difficult, and frequently impossible.

Prisons

RECOMMENDATION 7:

The federal government needs a major HIV prevention initiative in America's prisons, jails and correctional facilities. This would include getting states to follow suit, and providing financial incentives if necessary. In addition to testing prisoners upon entry into prison, the Justice Department and relevant health departments need to use the opportunity presented by incarceration to counsel inmates regarding HIV transmission and risky behavior. Prisoners found to be HIV-positive must be given access to treatment and care, including all DHHS approved medications used in the medical management of HIV disease. Contact tracing should be in place for anyone found HIV-positive, and notification should take place both in prison and in the community where those contacts reside. Just as importantly, prisoners anticipating release must be re-tested, and there must be a comprehensive education effort to keep these prisoners from engaging in risk-taking behaviors when they return to their communities. HIV-positive prisoners released on parole should have treatment adherence, doctors' appointments, and case management as conditions of their release. President Bush has shown tremendous compassion toward prisoners and the families of prisoners with his Prisoner Re-Entry Initiative and Mentoring Children of Prisoners Initiative among others. These need to be expanded to protect prisoners, their families and their communities from HIV transmission.

Prevention and Ryan White

RECOMMENDATION 8:

States accepting federal dollars should demonstrate to the Department of Health and Human Services that they have developed a Prevention Action Plan to combat new infections. We commend the President for stressing the importance of Prevention in his principles to guide re-authorization of the Ryan White CARE Act. States must use sound public health policies to prevent new infections. In the international context, the United States requires nations receiving Emergency Plan aid to present a strategic plan for both treatment and prevention. The same principle should apply within the United States.

This would include references to the latest HIV epidemiologic data available in the state and how that data informs the Prevention Action Plan.

RECOMMENDATION 9:

HRSA and CDC need to fully integrate their Treatment and Prevention efforts. Effective, comprehensive Treatment is a form of Prevention. Every patient diagnosed with HIV should pledge that "HIV stops with me." Every health care provider treating a patient should pledge to do everything in their power to make sure that "HIV stops with my patient." We commend HRSA and CDC for the strides they have taken in recent years to work more closely together. Nonetheless, bureaucracy makes coordination among agencies difficult, and unless communication and cooperation remain priorities, disjointed initiatives will result. We urge CDC and HRSA to continue their progress in this vital area, and to consider employing training incentives to educate health providers about prevention counseling.

Mental Illness and Substance Abuse Treatment as Prevention

RECOMMENDATION 10:

Those in HIV treatment and care must have access to mental health and substance abuse treatment. Risk behaviors are frequently driven by drug and alcohol abuse and by impaired judgment due to mental illness. The federal government must continue the progress it has made to integrate Substance Abuse and Mental Health programs with HIV prevention. In addition to providing HIV testing at Substance Abuse and Mental Health clinics, clinicians must provide the services necessary to assist people who engage in anti-social and self destructive behaviors that can spread HIV.

Once a diagnosis of HIV is made, patients often initially face a range of psychological effects from denial and depression to anger and hostility. Access to mental health services is essential to help those newly diagnosed accept the diagnosis and the demands of treatment. These people must be referred to counselors and mental health professionals to help them through this difficult period.

RECOMMENDATION 11:

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

Time for a Comprehensive HIV Prevention Campaign

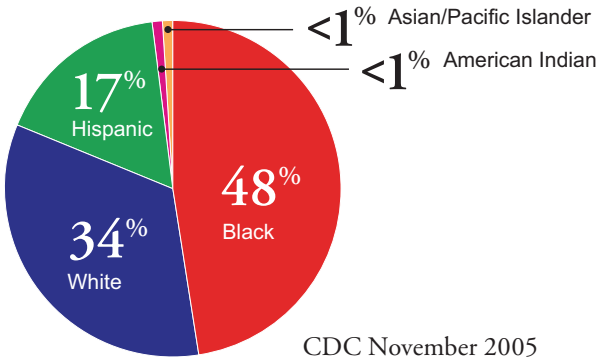
RECOMMENDATION 12:

The federal government needs a comprehensive, multi-media HIV Prevention campaign. In the United States, we are in denial about the risk of HIV. The media focuses on HIV and AIDS in Africa and many Americans do not know that 40,000 Americans are infected and 18,000 Americans die every year from HIV.[5]

A Prevention campaign would convey honest messages about the state of the epidemic, risk behaviors driving the epidemic, how people can protect themselves, testing information and promotion, and information about treatments. We need to encourage behaviors that protect Americans from HIV infections and discourage risky behaviors. With the billions we spend on HIV treatment in the United States, it is time. HIV is a totally preventable disease and the government has an interest in promoting messages that discourage behaviors that expose people to HIV. The public is presently inundated with ads to fight drunk driving displaying young people cut down in the prime of life. Ads directed against smoking reveal polluted and rotting lungs. Where once smoking was seen as sexy, sociable and positive, and drunk driving was seen as "cool", humorous or innocuous, now perceptions and legal consequences have changed. Some promising advertisements recently have been unveiled, supported with some federal funds, that discourage methamphetamine use and cite the link between this drug and HIV transmission. Behavioral change is possible and positive behaviors can be reinforced. AIDS prevention efforts need to convey a personal perception of vulnerability to HIV infection, rather than something remote that concerns only residents of Africa or men who have sex with men. This means there may be a role for the kind of "fear appeals" that have worked in smoking cessation; indeed meta analyses of published studies have shown fear appeals can work in changing behavior, when they are linked with "self efficacy" (knowing how to avoid unwanted outcomes).

Media elites, movie and television stars should be enlisted to help relay important HIV prevention messages. Creative incentives should be considered to encourage media participation. Community leaders and leaders of the faith community must be enlisted to help, confronting stigma head-on and encouraging people to get tested and avoid risk taking behaviors.

People Living with HIV/AIDS in the U.S. — Race/Ethnicity



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RECOMMENDATION 13:

A particular emphasis in any prevention effort is needed for the African American, Hispanic and minority communities. This will entail getting faith-based leaders, entertainers, movie and television stars and business leaders engaged in raising awareness, promoting testing, and reinforcing risk avoidance behaviors. The numbers of people who are HIV-positive in the African American community reveal a disturbing racial gap in infection rates. The numbers in the Hispanic community, while better than for African Americans, are still disturbingly disproportionate. It should be noted that during President Bush's administration, the Minority AIDS Initiative has received a three-fold increase in funding. Money devoted to HIV prevention may need to be supplemented, but it must certainly be shifted to focus on where the epidemic is moving, and it is moving, tragically, to devastate African Americans, Hispanics and other minority communities.

RECOMMENDATION 14:

In all messages to the public, we need to be honest, focusing on the realities of HIV. Approximately 18,000 Americans will die this year as a direct result of HIV infection. Many ads funded by philanthropic organizations and the federal government display young, attractive, healthy-looking people. The American people deserve to see the realities of HIV infection: a disease that has no cure; and a disease whose treatments often have devastating side effects, affecting physical, neurological and mental functioning. HIV is a horrific virus. While we should never be scared of those living with HIV, we, as a people, should fear a virus that debilitates and ultimately, kills. Politicians, community leaders and public health officials must discuss and fight stigmas that restrict honest discussion. We cannot leave anyone behind. We are all in this war together.

RECOMMENDATION 15:

An HIV Prevention campaign must be appropriate to age, culture and risk behavior.

No segment of the American population can be written off as not worth fighting for. Behaviors that put people at risk are found in every demographic group, regardless of age, race, ethnicity or socioeconomic status. We must strive to make prevention messages culturally relevant. We must discourage casual, multi-partner sexual behaviors while stressing the importance of correct and consistent condom use for those unable or unwilling to restrict their sexual contact to one partner of known HIV status. A constant dialogue must be established between members of the African-American community, the Gay community, Hispanics, Native Americans, immigrants, inner cities, rural communities, faith leaders, seniors and youth, etc., and government leaders to ensure that information flows back and forth. Many people in the United States are at risk and they do not know it, because they perceive HIV as a problem that only affects "other" people. HIV is now moving to affect people who did not think they were at risk. The data showing an increase of infections among women, particularly African American women, and an increase in HIV infections among young MSM makes it all too clear that stopping the spread of HIV is everyone's responsibility.

RECOMMENDATION 16:

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

RECOMMENDATION 17:

Care should be taken to ensure the dignity and humanity of those infected with HIV. This campaign must confront difficult issues, but it must re-affirm our commitment to Americans infected with HIV. Done well, this campaign would galvanize Americans to fight HIV together while we care for those who need help.

RECOMMENDATION 18:

Careful consideration should be given to the evidence that male circumcision reduces the likelihood of HIV transmission. The latest data, although incomplete, on reduced transmission rates from circumcision are so striking that they warrant careful review. While more research must be done, and concerns about possible behavioral disinhibition, sterile procedures and effective education to accompany the procedure are justified, the recent data from 40 epidemiological studies as well as a randomized clinical trial (RCT) in South Africa are compelling.[6] If these findings are supported by ongoing work in Kenya and Uganda, it is possible that transmission rates can be reduced dramatically, on the scale of a partially effective vaccine. Much thought and discussion will be required to consider the cultural and sociological implications of encouraging circumcision to reduce HIV transmission.

Private Sector Partners

RECOMMENDATION 19:

Government officials should work with pharmaceutical companies to ensure continued caution and responsibility in the marketing of HIV pharmaceuticals. We commend the pharmaceutical industry for the stunning advances in medicines that have transformed this disease over the past 20 years. We compliment the pharmaceutical industry for the informative advertisements they use to market their products, but we must remain cautious in how we market HIV treatments. Some companies have, at times in the past, marketed misleading portrayals of HIV treatments, giving the impression that HIV treatments can eliminate debilitating effects and promising unrealistic results. Marketing efforts must contribute to our shared goal of eliminating HIV transmission while we treat all those who need it.

Youth

RECOMMENDATION 20:

Schools and parents must be challenged to tackle discussions of HIV prevention with youth. Federal officials must use the bully pulpit to reinforce the efforts of parents and teachers to help children make healthy choices. We cannot deceive our youth nor hide the truth from them. We must deliver messages they can Relate to, messages that are Relevant to their experience and Real – honest information. We cannot just preach to them, rather we must engage in a dialogue, learning how best to enlist young people in prevention efforts and encourage them to make healthy choices. Young people must support each other and become partners with adults in HIV prevention.

RECOMMENDATION 21:

Young people should be educated about the importance of delaying sexual debut and reducing the number of life-time partners. Young people should be encouraged and educated to make the choice to delay sexual activity until adulthood and to remain faithful to one's sexual partner. It is the number of

life-time partners that is the greatest indicator of HIV risk through sexual activity. The data are clear that delaying sexual debut significantly reduces the chances of HIV transmission.[7] HIV is 100% preventable and young people must be educated that if they are unable or unwilling to limit their sexual contacts, correct and consistent condom use can reduce risk, but not eliminate risk.

RECOMMENDATION 22:

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

RECOMMENDATION 23:

More research is needed on adolescent brain functioning, specifically as it relates to addiction and risk taking behaviors. We recommend to the President that more resources be devoted to help us learn how better to prevent youth from engaging in harmful behaviors and in devising effective intervention strategies to help youth get back on track.

HIV Surveillance

RECOMMENDATION 24:

We need to have *one* standard, CDC compatible data system. Confidential HIV name reporting must be in place in every state and jurisdiction accepting federal dollars. In order for the United States to fight this disease, we must have reliable data to guide policy. We must know where the epidemic is and reliably predict where it is moving to better deploy resources. At present, the CDC accepts data from only 38 states because it deems the data from 12 states unreliable.[8] We have been fighting HIV for 25 years, yet we still do not have reliable data. Having reliable HIV data is essential to deploy resources intelligently.

Furthermore, there must be accurate data so that everyone who is HIV-positive is aware of their status, and health officials are able to follow up with these individuals, to ensure access to medications, HIV primary medical care, medical supportive services, as well as counseling.

RECOMMENDATION 25:

Those states that refuse to adopt reliable, confidential, name-based systems should be required to surrender dollars to states that use sound policies in fighting this disease. We note that the Ryan White CARE Act requires states to have reliable data systems in place in time for appropriations to be disbursed for 2007. Many states will not meet that deadline. These states must be held accountable. States without reliable, confidential name-based systems in place have had years to build these systems, and the statutory deadline imposed by the CARE Act has been in place for five years. Code systems and unique identifier systems have been a waste of desperately needed resources and reflect poor health policy.

Where necessary, laws need to be changed.

RECOMMENDATION 26:

The President and the Executive Branch should encourage states to pass public health laws that advance sound HIV policies. One of the complicating factors in developing a comprehensive national

HIV strategy is that health policies and laws are primarily the province of the state governments. Because of this, America's public health laws represent a patchwork of state laws. The federal government should give serious consideration to creating a task force of experts from the Department of Health and Human Services and the Department of Justice, if necessary, to develop and promote model public health laws.

CONCLUSION

We as a nation are in our third decade fighting HIV, and it is time to renew our efforts with a firm commitment to winning. As we said in the beginning, we cannot treat our way out of this epidemic, and prevention must be central to any comprehensive HIV strategy. As we evaluate where we are and where we must go from here, there can be no sacred cows; no issues can remain unexplored, no matter how sensitive or awkward. All approaches that work must be implemented. We should not be afraid to experiment, but we must also be honest enough to discard approaches that do not work. We understand that resources are often scarce, but that cannot be an excuse for failure. We understand too, the stigma associated with this disease. It must be confronted with compassion and honesty, and it must be overcome. Every American must be challenged to contribute to this fight, and every American must step forward to pledge that "HIV stops with me." This means, at a minimum, knowing your status. If HIV-positive, it means not infecting anyone else. If HIV-negative, it means avoiding risk whenever possible. For doctors, it means pledging that "HIV stops with my patient." For clergy, it means protecting your flock. For parents and teachers it will mean becoming more engaged with young people and discussing HIV honestly. For politicians it will mean changing laws where necessary. It will mean that leaders must step forward and Americans must stand together. It's time to bring this disease into the light.

We need to be aware of HIV, but we cannot accept it as inevitable. Nothing short of eliminating HIV transmission in the United States is acceptable.

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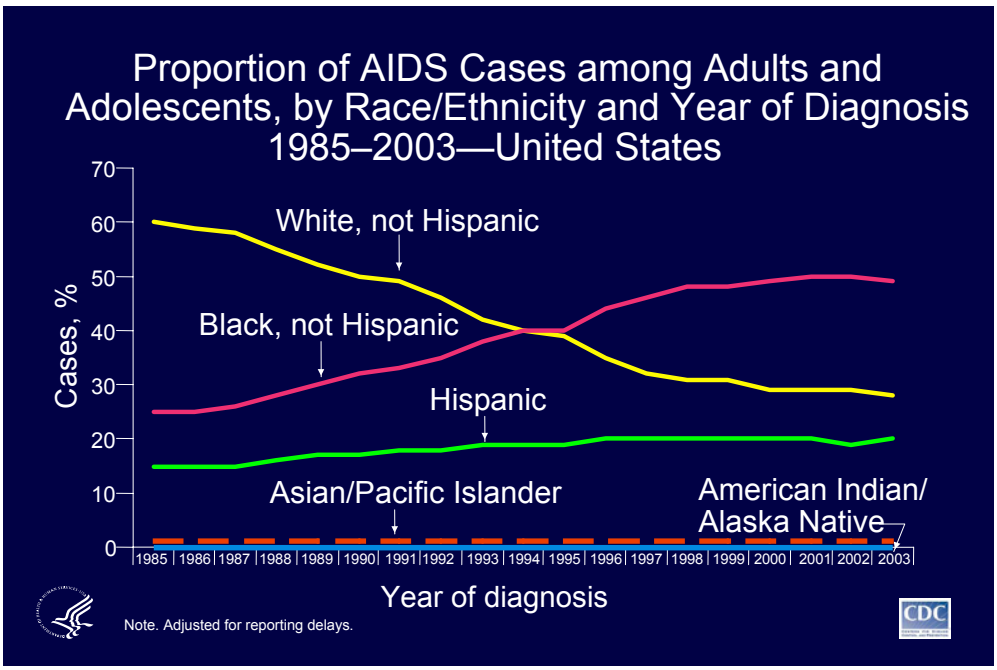
Treatment and Care

Treatment and Care

Since the first cases of what would later be known as AIDS were documented in the United States in 1981, there have been remarkable advances in the medical management of HIV disease. Discoveries, such as therapies to prevent opportunistic infections seen in association with HIV/AIDS and new medications to better manage HIV viral burden have greatly improved health outcomes. Americans living with HIV can now look forward to many years of productive life. As we celebrate this victory, we must not forget: approximately 18,000 Americans die every year from HIV/AIDS; another 40,000 are newly infected[1]; and many that should be in care are not. We must seek two goals simultaneously: to reduce infection rates to zero and to ensure access to appropriate medical care and medications for every American living with this disease.

Why does the United States have a unique commitment to HIV/AIDS Treatment and Care? To date, there have been over 1.5 million Americans diagnosed with HIV infection and over 500,000 deaths due to AIDS.[1] It is difficult for someone not familiar with the history of HIV to understand the level of stigma, suspicion and fear that punctuated the early years of the epidemic when this diagnosis meant certain imminent death. Too many Americans in the prime of life presented with seldom seen diseases that could not be easily explained. Uncertainty as to how this disease was transmitted caused a level of fear that led to a unique type of discrimination that cost individuals their jobs, housing and even precluded access to medical care. President George H.W. Bush recognized the importance of protecting the rights of fellow citizens living with HIV disease when he signed into law "The Americans with Disabilities Act of 1990". On June 25, 1998 the United States Supreme Court decided its first case related to HIV/AIDS and "The Americans with Disabilities Act (ADA). In this case, Bragdon vs. Abbott[2], the Court held that HIV infection, from initial infection to late stage disease, meets the definition of disability under the ADA. The outpouring



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of compassion and concern for people living with HIV and the recognition of the tremendous strain that HIV care was placing on the public health infrastructure led to another landmark piece of legislation, the Ryan White Comprehensive AIDS Resources (CARE) Act. The CARE Act, signed into law by President George H.W. Bush, addresses the unmet needs of persons living with HIV disease by funding primary health care and supportive services. The CARE Act was named for Ryan White, an Indiana teenager whose courageous struggle with HIV/AIDS and against AIDS-related discrimination helped to educate the nation. This commitment on the part of the federal government, in partnership with the states, assures treatment and care for a population that frequently has few treatment options. In June of 2004 and again during the 2005 State of the Union address, President George W. Bush announced his strong support for the reauthorization of the Ryan White CARE Act and a renewal of this nation's commitment to care for those in need. "Because HIV/AIDS brings suffering and fear into so many lives, I ask you to reauthorize the Ryan White CARE Act to encourage prevention, and provide care and treatment to the victims of that disease. And as we update this important law, we must focus our efforts on fellow citizens with the highest rates of new cases, African American men and women."[3]

RESOURCE ALLOCATION

RECOMMENDATION 1:

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

Minority Americans now represent the majority of new AIDS cases (72%) and of those estimated to be living with AIDS (66%) in 2004. Almost half (48%) of all those living with HIV/AIDS in the United States are African Americans. African Americans have the highest AIDS case rates of any racial/ ethnic group in the U.S., 8.4 times greater than whites in 2004. The disproportionate impact of HIV/AIDS on racial and ethnic minorities is further exemplified by the following data: survival after an AIDS diagnosis is lower among African-Americans than other racial/ethnic groups; African American women accounted for 67% of estimated new AIDS diagnoses among women in 2004, Latinas account for 15%; young African Americans less than 13 years of age represented 63% of AIDS cases reported in that age group in 2004; 71% of children born to HIV infected mothers were African American.[1] In June of 2004, the Presidential Advisory Council on HIV/AIDS (PACHA) responded to this devastating data by unanimously passing a motion recommending that programmatic initiatives and resource allocations follow the epidemic to address the devastating and disproportionate impact HIV disease currently has among African Americans. Included in this motion was a call to encourage African American leaders from all sectors, including the political, faith-based, corporate, all media, education, community youth leaders, healthcare, and support services arenas to speak out more forcefully about HIV disease to stimulate discussion about both its consequences and means of prevention. PACHA also recommended expedited funding of additional and targeted behavioral research to identify cultural, institutional, and societal issues that can inform future prevention, care and treatment initiatives to effectively alleviate the impact of HIV in the African American community. It should be noted that during President Bush's administration, the Minority AIDS Initiative has received a three-fold increase in funding.

In the months following the President's call for reauthorization of the Ryan White CARE Act, the Administration unveiled principles to frame the debate accompanying the reauthorization process. Many of these principles were based on a concept fully supported by PACHA, that no matter where you live in the United States you should have access to life-sustaining primary care and HIV related medications.

Among the principles, it is offered that 75% of CARE Act dollars be used for a core set of medical services (see Recommendation 5). The existing Ryan White CARE Act, which serves over 533,000 people nationwide, presently has no such requirement. While some states and Emerging Metropolitan Areas (EMAs) spend over 80% on a core set of medical services, others spend as little as 32%.[4] It is our belief that core medical services should come to define a basket of services designed to keep those needing HIV care in treatment, adhering to HIV medications and leading healthy, productive lives.

LINKING PREVENTION AND TREATMENT

RECOMMENDATION 2:

Treatment and Care should be integrated with Prevention efforts. Effective Treatment and Care is a form of Prevention. Early diagnosis and effective treatment and care are vital to stopping the spread of HIV. Every person living with HIV should acknowledge that "HIV stops with me." We commend the Health Resources Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) for their recent efforts to work more cooperatively to integrate prevention and care; we urge them to continue. We commend the President for calling for a greater role for prevention efforts in the reauthorization of the Ryan White CARE Act. Prevention and Treatment programs cannot be conceived and executed in isolation.

HIV TESTING

RECOMMENDATION 3:

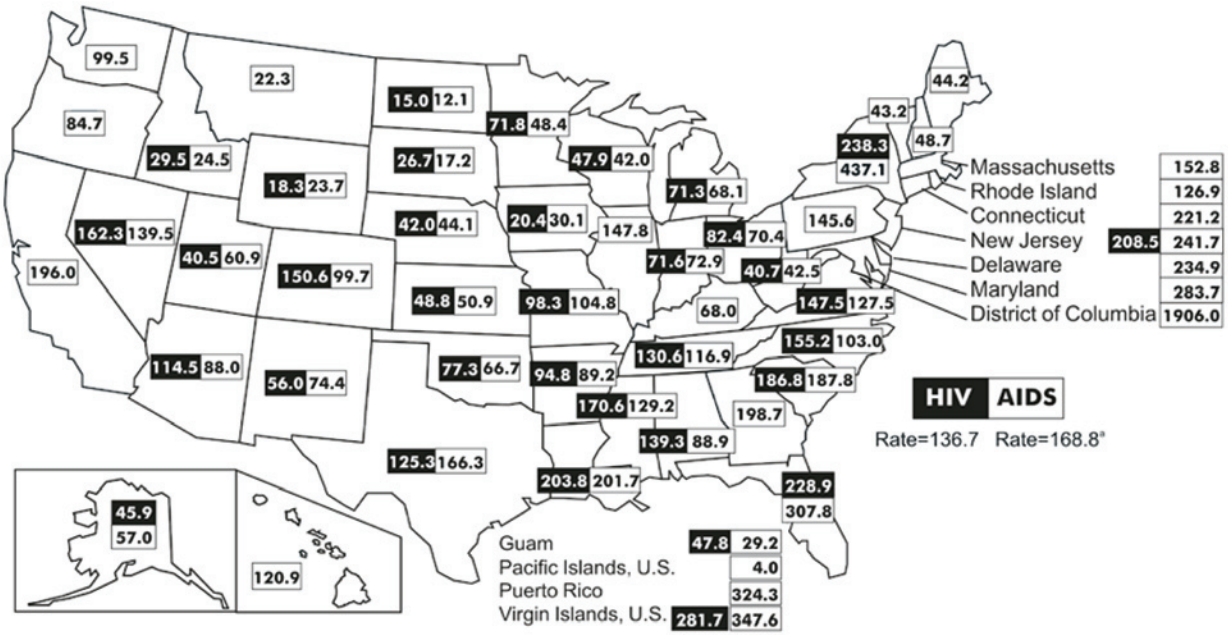
Because HIV testing is the gateway to HIV Treatment and Care, testing should be encouraged wherever possible. We reiterate the recommendations of the Prevention chapter to make HIV testing a routine part of medical care in the United States and to seek out new opportunities to get people tested. Early diagnosis of HIV not only prolongs healthy, productive lives, it also increases the effectiveness of antiretroviral medications and is cost effective over time.[5] If someone is found to be infected, they should immediately be referred for appropriate care. Secondary prevention is a key element in the battle against HIV and efforts must be taken to educate people living with HIV disease on how to protect themselves and others. If a person is found to be HIV-negative, every effort should be made to encourage behaviors that maintain their HIV-negative status.

ADAP

RECOMMENDATION 4:

Funds distributed under the AIDS Drug Assistance Program (ADAP) of the Ryan White CARE Act need to be distributed more effectively. We must be able to ensure access to life-sustaining antiretroviral medications for those that qualify for treatment and services under the Ryan White CARE Act. With more people living with HIV disease in the United States than ever before—an estimated 1,039,000 to 1,185,000 people—judicious use of existing CARE Act resources and a call for additional resources is necessary to maintain a successful system of care. Presently the federal government spends an estimated 19.7 billion dollars on HIV prevention, care, treatment, and research; a remarkable commitment to serve those less fortunate.[6] Overall, we do not have a shortage of federal resources devoted to fighting HIV, but we need to utilize these resources more effectively to address the needs of those most disproportionately impacted by this disease. In many states, ADAP funding shortfalls have led to waiting lists, broken regimens and essential medications being deprived from those who need it most. ADAP waiting lists are also a significant disincentive for routine HIV testing; a break in the link between prevention and treatment. We commend the President for the one-time emergency mechanism he employed in 2004 to deliver $20,000,000 in medications to this population, but a permanent fix must be found for ADAP. The solution may be an additional catch-all provision in ADAP, which would allow states experiencing unexpected financial shortfalls to apply to the Department of Health and Human Services for a discretionary grant program. The Medicare Part D Prescription Drug benefit will provide some relief to ADAP. Regardless of the solution, one must be found. People who are HIV-positive need essential medications.

Estimated rates for adults and adolescents living with HIV infection (not AIDS) or with AIDS (per 100,000 population), 2004—United States



Note. Rates adjusted for reporting delays. Rates of HIV infection include only persons living with HIV infection that has not progressed to AIDS.

Since 2000, the following 35 areas have had laws or regulations requiring confidential name-based HIV infection reporting: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming, Guam and the U.S. Virgin Islands.

*Includes persons whose area of residence is unknown.

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CORE MEDICAL SERVICES

RECOMMENDATION 5:

As previously mentioned, the core medical service model should include a range of services to keep those needing HIV care in treatment, adhering to HIV medications and leading healthy, productive lives. These services should include physician and other medical provider visits including: adherence services; subspecialty care related to HIV and/or HIV treatments related to HIV such as obstetric and gynecological services and pediatric HIV specialists; medically-necessary medications including approved antiretroviral medications; laboratory tests to monitor the effectiveness and safety of treatment, including HIV viral load, CD4+T-cell testing, and medically indicated genotype and phenotype resistance testing prior to initiating and during therapy, as well as clinical pharmacology consultation services. The core medical service model should also include the following: oral health services; mental health services; substance abuse treatment; prevention counseling in HIV clinical settings; nutrition counseling; hospice; and essential support services that enable people living with HIV disease to access and stay in care, such as medical case management. Efforts should be made to provide these services in a culturally sensitive and linguistically appropriate manner.

Mental Health

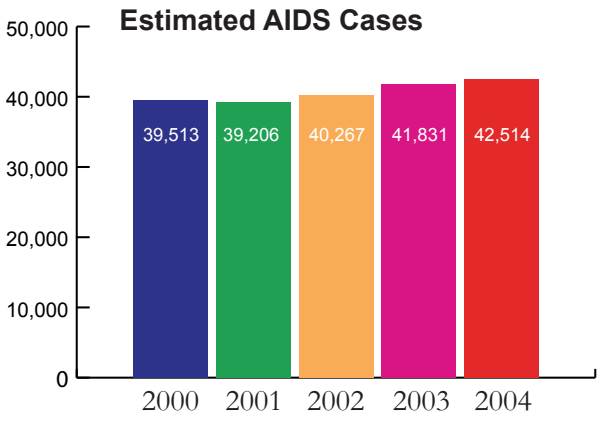
RECOMMENDATION 6:

Mental Health Services need to be included in the core medical services of the Ryan White CARE Act. Many people with HIV are frequently diagnosed with serious mental illnesses that can lead to drug abuse and behaviors that can prove to be a danger to themselves and others. Depression frequently accompanies the initial diagnosis and can hinder access to and retention in care. Complicated medication regimens require stringent adherence to be effective and are most difficult to follow in the presence of significant mental illness. Therefore, mental health screening and comprehensive care, including access to mental health medications must be included in any definition of core medical services.

Substance Abuse

RECOMMENDATION 7:

Substance Abuse Treatment must be part of core medical services available under the Ryan White CARE Act. HIV transmission frequently is accompanied by substance abuse, not only with illegal drugs but also with alcohol and abuse of prescription drugs. Substance abuse is associated with decreased inhibition and impaired judgment, leading to risky behaviors and heightened exposure to sexually transmitted infections. For people living with HIV disease, substance abuse treatment and counseling is essential. It helps them to stay in care, to adhere to complicated medication regimens, and also plays a significant role in secondary prevention.



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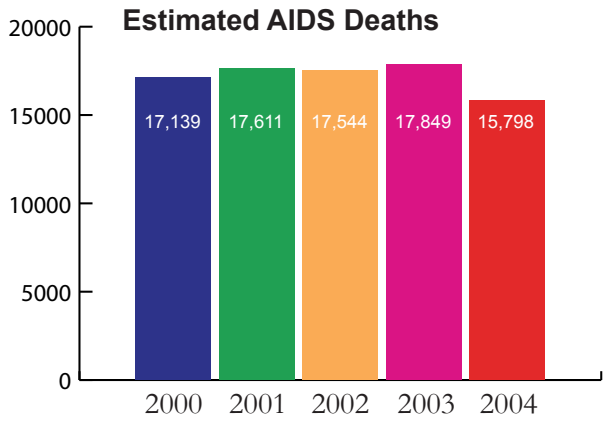

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Treatment of Co-Morbidities (Hepatitis C. etc.)

RECOMMENDATION 8:

Treatment of co-morbid conditions accompanying HIV infection, such as Hepatitis B and C must be covered under core medical services. HIV is increasingly associated with other deadly infections including Hepatitis C (HCV). HCV coinfection is common in the HIV-infected population and can negatively affect survival from the time of both HIV and AIDS diagnoses. It is widely accepted that HIV is a co-factor that accelerates HCV progression leading to more rapid fibrosis and cirrhosis as well as other sequelae of end stage liver disease. In a study conducted by L.I. Backus and others titled "Effects of Hepatitis C Virus Coinfection on Survival in Veterans with HIV Treated with Highly Active Antiretroviral Therapy co-infection," the authors surmised that "HCV seropositivity was independently associated with increased risk of death in a large cohort of HAART-treated HIV-infected veterans.[7] Given the success of HAART in extending the lives of HIV patients, HCV has become an important predictor of their mortality." Whereas the effects of HCV on the natural history of HIV warrants further study, there may be an impact on the management of HIV infection due to the risk of hepatotoxicity, more rapid progression of HIV-related disease and impaired CD4+ T cell recovery while on antiretroviral therapy. In order to increase survival and allow for effective responses to HIV medications for a large subset of those HIV infected, core medical services should include treatments for co-morbidities such as Hepatitis C.

Case Management / Adherence

RECOMMENDATION 9:

Case Management and Adherence Counseling must be covered under core medical services. The HIV-positive patient accessing Ryan White CARE Act-funded services is often in great need of medical case management and medical counseling to increase adherence to medications and to ensure follow-up with primary care visits. HIV medications entail an onerous regimen and HIV-positive individuals frequently confront issues of extreme poverty, substance abuse, other illnesses, malnutrition and impaired judgment that preclude improved health outcomes. In many cases, it is simply not enough to hand these patients a prescription and make an appointment for their return. Peer counselors and outreach workers have a valuable role in connecting patients to care and keeping them in care. The goal of HIV medical case management should be to educate and empower patients to adhere to treatment regimens and maintain behaviors to live longer, healthier lives. People are healthier when empowered, and the goal of medical case management must be to help people regain their independence.

Oral Health

RECOMMENDATION 10:

Oral health care must be a part of core medical services available under the Ryan White CARE Act. Oral health problems were identified as a significant issue early in the AIDS epidemic, and they continue to be so today. In addition to helping HIV-positive patients stay healthy, educating dental providers in oral symptoms of HIV infection can provide a valuable diagnostic tool. For the HIV-positive person who is unaware of his or her serostatus but for whom oral symptoms are developing, properly trained oral health providers represent an opportunity for HIV screening, counseling and testing, and linkage to care. Oral manifestations of HIV disease, such as thrush, warts, gum disease and rapidly progressing dental decay, occur in a very high percentage of people living with HIV/AIDS.[8] Unchecked, oral diseases can lead to malnutrition and the inability to adhere to life-sustaining HIV medication regimens. Yet, care is often not available with reasons ranging from lack of funding and lack of willingness to treat, to geographic isolation and other co-morbidities that are so devastating for the patient that those related to oral health seem relatively unimportant. As stated in the Surgeon General's report, Oral Health in America, "Oral health is integral to general health. You cannot be healthy without oral health."[9]

BEYOND THE RYAN WHITE CARE ACT

Invigorated communication campaign on Domestic HIV/AIDS

RECOMMENDATION 11:

The federal government needs a comprehensive, invigorated communication campaign of our domestic HIV/AIDS policies. A public service awareness campaign to promote HIV prevention, if structured properly, will also serve to increase HIV testing and reduce the stigma associated with this disease, and therefore move more HIV-positive Americans into treatment sooner. Americans must be reminded that HIV is still a life-threatening issue in this country. With all of the great strides in the treatment of this disease, thousands still suffer and many still die from an infection that is preventable. Education about HIV transmission, what can be done to protect ourselves and our loved ones and the importance of getting tested, must continually be communicated in our efforts to reduce HIV infection rates to zero. Also, such a campaign would serve to highlight the compassion and financial commitment exemplified by the Ryan White CARE Act and other federal programs people living with HIV/AIDS rely upon.

Incarcerated populations

RECOMMENDATION 12:

Prisons should have intensive HIV education and counseling programs to protect inmates and the communities to which they will return. This would include, as advocated in the Prevention section of this report, testing of inmates upon incarceration and upon their release. In addition to the tremendous benefit to be gained by gathering more data about HIV infection rates, we must also protect the communities where prisoners are returned once their debt to society is paid. President George W. Bush has shown tremendous concern for the toll incarceration takes on families and communities. His Mentoring Children of Prisoners program and the Prisoner Re-Entry Initiative are a testament to this. Testing prisoners and making sure they are placed in care while incarcerated and integrated into care upon their return to society is a necessary step to advance prevention, protect communities and care for those in need. Special attention must be focused to ensure continuity of treatment and care for HIV-positive individuals returning to society. Linkages must be provided to culturally competent and linguistically appropriate outpatient care upon discharge from federal prisons. This is especially important considering the disproportionate impact that both HIV and incarceration have on minority communities.

Training Medical Professionals

RECOMMENDATION 13:

Creative solutions must be found to encourage more doctors, physician assistants and advanced practice nurses to choose to develop the skills necessary to treat HIV. Finding experienced health care providers trained in the provision of HIV care is often difficult for the HIV-positive patient. HIV is a devastating illness that requires a high level of expertise to properly manage. New technologies, increasing therapeutic options and changing treatment guidelines make treatment and care increasingly complex. HIV-positive patients also can develop many noninfectious complications from their disease and the medicines used to treat the virus. Identifying experienced HIV health care providers with up-to-date knowledge of HIV medicine has become crucial to improving the quality of and access to effective HIV medical care. Patients living with HIV/AIDS have better outcomes when they receive their health care from providers and facilities with more experience in treating HIV-positive patients.[10]

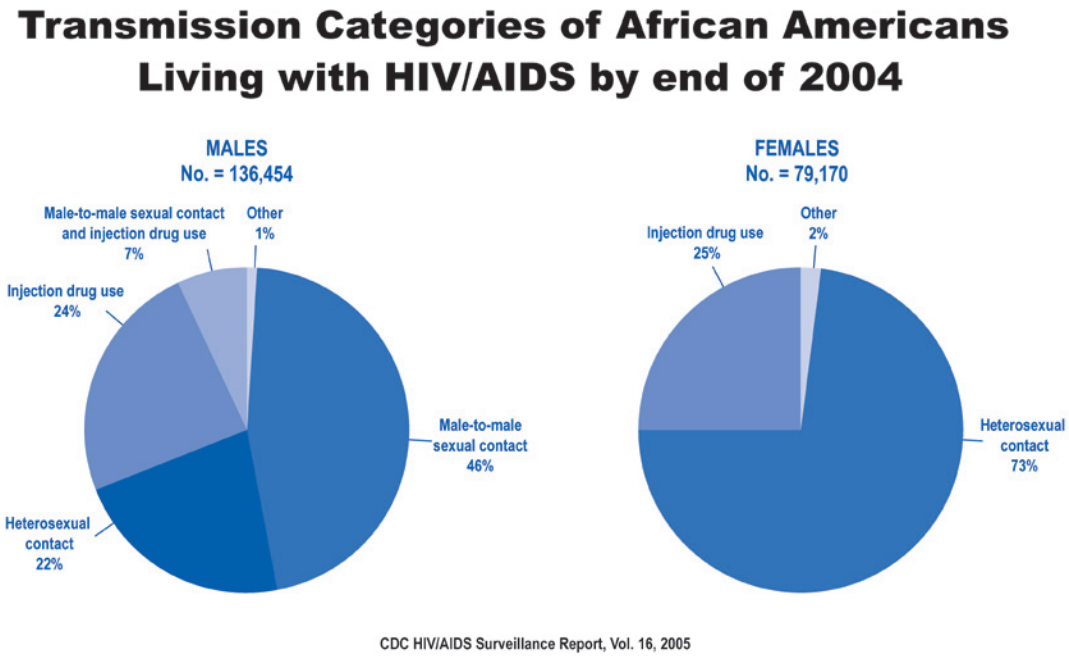
There is a shortage of health care providers both willing to treat HIV patients and with the knowledge base necessary to treat effectively. Additionally, HIV medicine is not a lucrative profession, lacking the financial incentives of other types of care. Potential solutions include, but are not limited to the following:

1. Tuition reimbursement for healthcare workers who choose HIV care in medically underserved areas
2. Encouraging the recognition of HIV care as a medical specialty
3. Provide incentives for more nurses, physician assistants, nurse practitioners and physicians to be certified through their appropriate associations
4. Ensure adequate reimbursements for HIV care
5. Promote programs to increase the diversity of health professionals trained in HIV care

Quality Assurance

RECOMMENDATION 14:

As we attempt to expand out capacity to treat HIV-positive Americans, we must not forget quality. As we move towards mainstreaming HIV care, we must make sure that HIV patients are not broken off from HIV specialists. Outcome measures should be adopted to ensure care is effective and competent. Nurse practitioners and physicians' assistants must be effectively trained in the medical management of HIV disease so more people can access care. Well trained "physician extenders" can exponentially increase the number of people receiving appropriate treatment and care. Continuing Medical Education should be provided, and if necessary, subsidized by the federal and state governments to allow for the latest HIV knowledge to be disseminated.



Research

RECOMMENDATION 15:

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

Although great progress has been made in medical management of HIV infection, we must acknowledge that there is still a long way to go before victory can be declared. Research into new and novel agents to treat HIV must continue at an accelerated pace. We cannot forget the long-term survivors of HIV infection who have run out of treatment options and whose lives depend on pharmaceutical advances. Nor can we discount the future of the recently infected American who may present with some level of resistance. Research must also be focused on limiting toxicities and metabolic abnormalities associated with existing therapies. Specific incentives for treatments that assist small patient groups such as those living with multi-drug resistant virus, should be considered as well as broader incentives to encourage the development of new HIV/AIDS medicines.

As people live longer with HIV infection, we enter uncharted territory and must work to understand new developments that may lead to increases in morbidity and mortality. From the oncology perspective the problems are continuing and increasing in complexity. One certainty is that cancer is an increasing cause of death for persons with AIDS.

Great progress has been made in preventing mother-to-child transmission of HIV infection. However, each life is precious and we have not won this war until there are not any children born with HIV. Continued research into all aspects of HIV care must continue and remain a priority in the United States.

CONCLUSION

Achieving quality treatment and care for all persons infected with HIV/AIDS is the ultimate objective of the recommendations in this report. We have heard from the experts, we have reviewed the literature, and we have thoroughly discussed the issues representing the current state of this epidemic. We now see it as our responsibility to lend our personal energies to advancing this information in every arena. What we have put forth is within the purview of this section; however, we must look forward to future discussions that will address other overarching reasons that this disease continues to spread including poverty, disadvantage, and prejudice. Effective information dissemination, education, housing, economic development, criminal justice, and public health programs are essential issues that must be addressed. The President's understanding of the disproportionate effect this disease is having in the African American and minority communities has been clearly stated, and a major part of our effort in this report has been to frame the issues and recommendations in a fashion that will speak to his concern. Our hope is that these and other efforts lead us to the day when HIV/AIDS will no longer have the devastating impact it is currently having in our nation.

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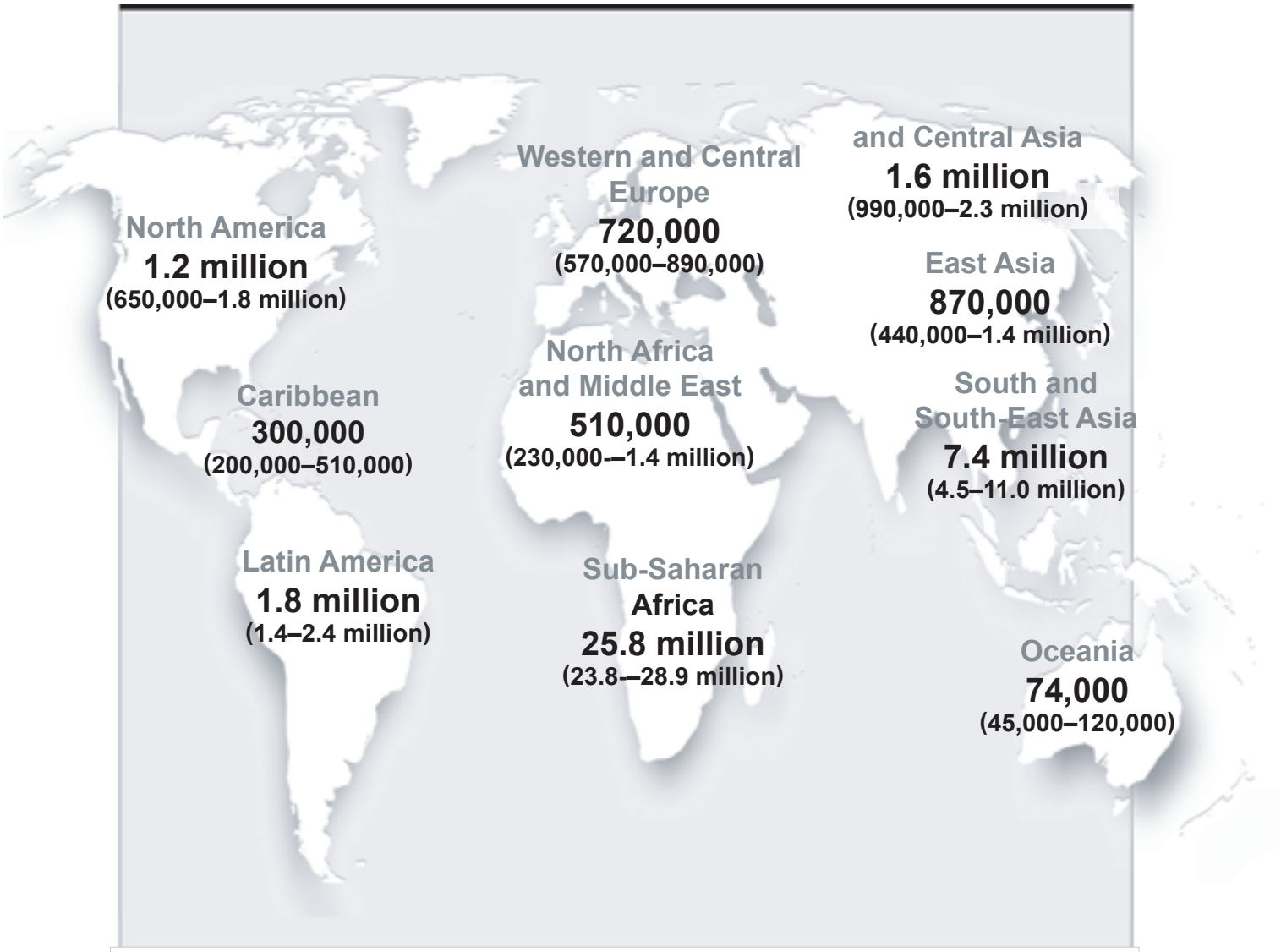
International

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV IN 2005



People living with HIV ..... 40.3 million (36.7–45.3 million)

New HIV infections in 2005 ..... 4.9 million (4.3–6.6 million)

Deaths due to AIDS in 2005 ..... 3.1 million (2.8–3.6 million)

International

The HIV pandemic continues to spread. Estimates of the total number of people living with HIV range between 34.6–42.3 million. HIV has killed over 20 million people since it was identified in the early 1980s.[1] It kills an estimated 8,000 people worldwide each day, yet each day over 13,000 more become infected.

In his January 28, 2003 State of the Union Address, President Bush announced the President's Emergency Plan for AIDS Relief (The Emergency Plan), a five-year initiative that will total $15 billion to combat HIV/AIDS. This initiative continued America's commitment to multi-lateral efforts, like the Global Fund, while creating new, bi-lateral partnerships. He also took on the mantle of international leadership, and challenged other governments and aid foundations to increase their international HIV efforts.

The Emergency Plan is on track to support treatment for two million people with HIV/AIDS by 2008, prevent seven million new infections and provide care for an additional 10 million people affected by HIV.[2] Its contributions make it the largest international health initiative in history. The President's initiative spreads hope in areas where once there was only despair.

Yet we know that in 2008, even with the unprecedented accomplishments being made, we will need to extend that commitment. The five-year Emergency Plan is a beginning, and not an end. We have proven that prevention, treatment and care are possible in the developing world. We also know we cannot treat our way out of the AIDS pandemic. Now it is time to begin discussing the next phase of the Emergency Plan. We must maintain our commitment to sustain treatment beyond 2008, but we must also look to the long-term sustainability of our international HIV efforts. It is impractical for the United States to attempt to provide treatment to 40 million people worldwide who are infected with HIV.

Looking ahead we must continue our extraordinary commitment to prevention and treatment, while broadening our focus from personal health to public health. We cannot merely count the number of patients offered treatment or lives saved directly as a result of U.S. assistance, but we must take a broader view, and focus on the health systems and infrastructure that serve entire populations. We must count local doctors and nurses trained and hospitals and clinics opened. This infrastructure will allow for greater access to treatment and higher standards of care by building partner nations' capacity to treat those in need. Ultimately, it will provide access to life-sustaining treatments for other deadly diseases in the developing world.

Achieving an HIV-Free Generation

The goal in the international arena, just as in the United States, should be an HIV-free generation. We understand this is not a short-term goal, but the world has demonstrated that eradication of infectious diseases is possible.

HIV in the Developing World

It is difficult for those who have not visited the countries hardest hit by HIV to adequately comprehend the challenges of delivering modern medical treatments in areas that lack basic infrastructure. Hospitals, clinics and laboratories are rudimentary, if they exist at all. Understaffed and under-equipped, they often lack reliable electricity, refrigeration, basic laboratory equipment and struggle to maintain sterile conditions. Trained nurses and doctors are scarce. Reliable mail service often does not exist. Transportation, if available, consists of dirt roads. Public transportation is often absent, making getting treatments to patients and patients to treatments, especially in rural areas, difficult.

The Emergency Plan has demonstrated that HIV Prevention and Treatment is possible in this environment, but to effectively fight a disease as complicated and overwhelming as HIV, nations need more than the basics of health care. To fight a disease like HIV over the long-term, nations need basic human rights, free markets, the rule of law, respect for property rights, investments in education and health, and representative governments. It is unrealistic and inhumane to demand that all of these elements be in place before the United States offers assistance to a nation in need, but a mutual understanding must be agreed upon that the United States expects progress in all these areas. Without progress, we will be in a never-ending cycle of aid and dependency. This is not politically or financially sustainable.

The President's Emergency Plan and The Future

The U.S. Global AIDS Coordinator administers the Emergency Plan, and the U.S. Agency for International Development and U.S. Department of Health and Human are its two main implementing agencies. America's assistance flows through two mechanisms: multi-lateral grants through the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral grants directly from the United States. As President Bush envisioned, the flow of aid has increased as partner nations have developed the necessary infrastructure. By the end of Fiscal Year (FY) 2005, the United States will have disbursed $6.88 billion for Emergency Plan activities through direct grants and through contributions to the Global Fund.[3]

The stated goals of the Emergency Plan are to place at least two million people on HIV medications, prevent seven million new infections through prevention initiatives, and care for 10 million people affected by HIV by the end of 2008.[4] In addition to the 15 focus countries where U.S. efforts are most concentrated, 100 other countries receive aid from the U.S. Government to help them fight HIV. The Emergency Plan has made a tremendous difference in the lives of millions of people in the developing world. Now that President Bush and our international partners have demonstrated the feasibility of treating HIV in the developing world, we need to move to the next phase, the long-term sustainability of HIV efforts in the developing world.

RECOMMENDATION 1:

The United States should continue to fund HIV efforts through both multi-lateral collaboration and bilateral agreements. Maintaining the current dual approach of engaging in both multi-lateral and bilateral support for HIV/AIDS programs is essential to achieving an HIV-free generation. This combination motivates other donor nations to support the international effort and allows direct links to countries in need. An essential component of the United States' commitment to the Global Fund is that the U.S. cannot account for more than 33 percent of the Fund's overall contributions; the U.S. should not be asked to bear more than this proportion. This feature ensures that other countries share responsibility for the worldwide HIV crisis. Multi-lateral and bi-lateral agreements, working in tandem, provide the opportunity for comparison and competition, elevating the efforts of both the Global Fund and American bilateral agreements.

RECOMMENDATION 2:

As we maintain our commitment to those we helped place in care, the next phase of the Emergency Plan should broaden the focus from personal health to public health. This will entail helping nations to develop the capacity and infrastructure necessary to assume greater responsibility for their citizens. This does not suggest scaling back efforts to care for and treat those in need. Rather, building host-nation capacity to make and implement public health programs is the most effective means of increasing access to treatment globally. Future Emergency Plan funding should spur the creation of locally managed health and public infrastructure.

RECOMMENDATION 3:

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

When President Bush unveiled the Millennium Challenge Account for economic assistance overseas, he laid out a series of principles to guide our foreign economic aid. Among these were the principles that 1) aid is most effective when it reinforces sound political, economic and social policies, 2) development plans supported by a broad range of stakeholders, and for which countries have primary responsibility, engender country ownership and are more likely to succeed.[5]

These principles are just as applicable to the next phase of the Emergency Plan. As HIV destabilizes governments and cripples economies, so too does it thrive amid dysfunction. HIV assistance cannot simply be a gift of American dollars. Rather, it must be a commitment to work together to aid desperate nations now and build their capacity to address HIV/AIDS in the future. Building a sustainable, local response to HIV will support stable governments.

RECOMMENDATION 4:

The U.S. should broaden partnerships with indigenous faith-based organizations, non-governmental organizations (NGOs) and the private sector to strengthen the non-governmental social safety net of host countries. Just as in the United States, governments cannot take care of a country's citizens without other support. Essential to creating long-term independence, viable philanthropic and faith-based organizations provide access to citizens and support networks that government lacks. At the same time, we cannot allow governments, or NGOs to become indefinitely dependent on America's generosity. We need to help create empowered patients and vibrant health systems in host countries, not dependent ones.

RECOMMENDATION 5:

Host nations must repeal taxes and tariffs on HIV-related medical supplies and pharmaceuticals. As a condition of receiving grants, the United States should require host nations to repeal any taxes or tariffs that apply to medical supplies or pharmaceutical products used to combat HIV/AIDS. Removing these taxes and tariffs should also be a central component of U.S. trade policy, not as a bargaining chip, but as a demonstration of common good will and a commitment to the health of citizens in the developing world.

RECOMMENDATION 6:

Host nations must vigorously combat corruption and bureaucratic red tape in their public health delivery systems. The United States cannot be expected to provide taxpayer dollars to countries that do not allow the dollars to be deployed rationally and quickly for their intended beneficiaries. Left unchecked, corruption in procurement and public finances will weaken the resolve of Americans to provide resources to host countries and understandably so.

RECOMMENDATION 7:

The U.S. Government should consider making basic health education campaigns a prerequisite of HIV assistance. Many countries beset by HIV also have low levels of health awareness among their populations. This limits the success of prevention and treatment campaigns. A major component of Uganda's ABC effort was a commitment to frank, scientifically sound HIV education. Unfortunately, myths and misinformation surround HIV in many countries. Host governments must make basic health education a priority. As Ugandan President Museveni stated, behavior change is a social vaccine for HIV. However, to motivate healthy behavior, people must have access to clear health education and fact-based information on HIV in native languages. Following this example, HIV should be addressed as a behavioral as well as a medical challenge.

RECOMMENDATION 8:

As a demonstration of commitment to fighting HIV, we must encourage prominent political and social leaders of host nations to speak publicly about the causes of HIV and the basic biological facts of the disease. Because leadership is essential, the heads of state of host nations should make personal commitments to elevate HIV awareness. In a few exemplary countries, First Ladies provide invaluable contributions in educating the public and raising HIV awareness. We should ask and encourage governments to involve the spouses of chief executives in fighting HIV. Ethnic, religious and social leaders should be engaged to spread HIV awareness to the communities in which they have social networks and credibility.

RECOMMENDATION 9:

The U.S. Government must support basic research and maintain incentives for companies to invest in preventatives, vaccines and treatments to meet the needs of the developing world. At present, infrastructure is not sufficient to support widespread access to second-line HIV therapies. Developing nations have specific therapy needs including: non-refrigerated second-line therapies; improved, easier-to-use pediatric formulations; safe and effective fixed-dose combinations; and clade- and strain-specific medicines. The threat of increasing resistance to available therapies must be monitored and appropriate responses developed. To realize the pharmaceutical innovation required to develop these medicines, appropriate incentives must be available to spur research and development.

RECOMMENDATION 10:

The U.S. Government should support, in conjunction with other donor nations, the harmonization of data-collection and reporting requirements. To assess different strategies, replicate best model practices, minimize administrative burdens on grant recipients, and deploy global resources more effectively, the United States should lead the international donor community in developing standards of data reporting and collection. Documentation of effective use of antiretroviral drugs, including adherence, prevention of resistance and sustainability of prevention efforts should be required from programs wishing to continue funding eligibility. Once gathered, data must be disseminated and communicated effectively. We cannot simply have scientists talking to each other without communicating the science and the state of HIV care to people working on the ground and to populations affected by HIV.

RECOMMENDATION 11:

Ensure that health professionals are trained in a broad range of interventions and increase economic incentives for trained health professionals to remain in their countries-of-origin. We must continue to train researchers and care providers to work in their countries of origin on a variety of public health challenges, including, but not limited to, HIV/AIDS. We should not create or perpetuate economic rewards for health professionals to treat HIV to the exclusion of other conditions. Training doctors, nurses and lab technicians and community health workers to work on the full range of health problems that confront a host nation is essential. Additionally, too many nurses and doctors leave their countries for higher paying areas. Creative incentives must be provided to keep trained doctors and nurses where they are most needed.

HIV Prevention Successes

As Uganda emerged from civil war and faced the reality of its own devastating HIV epidemic, President Museveni committed himself to reducing HIV. His consistent messaging and courage remains the gold standard for motivating a nation to confront an epidemic. By promoting Abstinence until marriage, Being faithful to sexual partners, and correct and consistent Condom usage, (ABC), Uganda developed a successful and cost-effective prevention campaign. The Ugandan model of AIDS prevention is especially relevant to countries with "generalized epidemics." Thus, delay of sexual debut for youth, partner fidelity and correct and consistent condom use are effective messages.

Uganda proved that clear, consistent messaging, strong community-based programs, mobilization of all segments of society (i.e., all branches of government, NGOs, the private sector, FBOs), and committed leadership can dramatically reduce incidence and prevalence rates. In seeking an HIV-free generation, we cannot be deterred from the fact that we do not have a vaccine at present. HIV is a totally preventable disease and behavior can control exposure—we already have, as President Museveni has explained, a social vaccine.

In Thailand, courageous leadership marshaled public efforts to control a devastating epidemic concentrated among prostitutes and their customers. In Thailand, an intensive intervention promoted correct and consistent condom use and educated the public about HIV, including urging men not to visit prostitutes. Again, behaviors changed significantly within a short time period (1982-1992), and prevalence and transmission rates soon declined. These examples should not be interpreted as the only successes in the developing world, but they show that success is possible.

For general population epidemics, where the majority of transmissions are the result of heterosexual intercourse, the ABC model is the preferred approach to prevention. However, its application must be tailored to different countries, cultures, populations and sub-populations. More research is needed on how best to deploy lessons from the developing world in other countries. We recognize the variety of cultures affected by HIV. We encourage the U.S. Government to be flexible and for NGOs and grantees that work with U.S. dollars to be respectful of the mores and customs of host countries. Particularly in the areas of prevention messaging, we can learn a great deal from other cultures.

RECOMMENDATION 12:

The United States should promote successful prevention strategies. Prevention resources should be allocated based on the demonstrated needs of host nations. Programs should focus on successful, locally-developed initiatives that have demonstrated success, as well as on outside efforts that can be deployed locally against relevant modes of transmission. All prevention programs should be consistently and objectively evaluated to identify and replicate successful interventions. "Success" should be measured by changes in sexual behavior (and related behaviors such as stigma and discrimination) and on HIV incidence and prevalence decline. Assumptions cannot be the basis for measuring effectiveness.

RECOMMENDATION 13:

Prevention of Mother-to-Child Transmission (PMTCT) should be a major component of the Post-Emergency Plan. In the United States, with sound public health policy—including testing pregnant mothers and newborns—and effective perinatal treatments, we are on the verge of eliminating pediatric HIV. In the developing world, pediatric HIV continues to be a major problem. Although effective prevention regimens are available, access to them are not widespread. We must invest in prenatal and neo-natal pediatric HIV diagnostics and treatments. We also must increase the number of trained physicians and nurses that will help to develop the most appropriate measures for prevention and treatment of HIV infection in children. This must include breast-feeding counseling. 2.2 million children under the age of 15 have HIV in the developing world, and 640,000 were infected with HIV in 2004.[6]

Research into new and easier-to-use treatments for children with HIV should continue, but we must place particular emphasis upon developing and distributing therapies to prevent mother-to-child transmission.

Aggressive PMTCT can be the fulcrum to shift from focusing on personal health to public health and transition to next phase of the Emergency Plan. To effectively implement PMTCT efforts, we must address clean water, nutrition—including appropriate, science-driven guidance on breast-feeding—access to perinatal care performed by trained professionals, and testing. Infrastructure is needed to ensure clean water, because unclean water for a baby can be deadly. The same is true for nutrition. Without adequate nutrition, pregnant mothers are more susceptible to the ravages of HIV and newborn babies to infection. Finally, trained medical care must accompany neo-natal and PMTCT interventions.

We are on the verge of eliminating Mother-to-Child Transmission in the United States. Now we need to work toward that goal overseas. If we can achieve that goal, we can cut HIV out of the pre-pubescent population worldwide. If that is achieved, through a combination of effective prevention efforts, sound treatments, and continued research into the therapies of tomorrow, we will be able to see the dawn of an HIV-free generation.

RECOMMENDATION 14:

Human Trafficking must be eliminated. We commend President Bush for the leadership role he has taken in condemning human trafficking and urge him to continue to pursue policies that fight the exploitation of the most vulnerable. Approximately 10 million children worldwide have been trafficked into prostitution.[7] Estimates of the number of women trafficked annually range from 600,000 to 800,000. This practice, reprehensible in its own right, must be fought as a possible contributing factor in the spread of HIV. Further research is needed to understand the dimensions of this link. All civilized nations must stand together to fight this modern form of slavery.

RECOMMENDATION 15:

Careful consideration should be given to the evidence that male circumcision reduces the likelihood of HIV transmission. The latest data, although incomplete, on reduced transmission rates from circumcision are so striking that they warrant careful review. While more research must be done, and concerns about possible behavioral disinhibition, sterile procedures and effective education to accompany the procedure are justified, the recent data from 40 epidemiological studies as well as a randomized clinical trial (RCT) in South Africa are compelling.[8] If these findings are supported by ongoing work in Kenya and Uganda, it is possible that transmission rates can be reduced dramatically, on the scale of a partially effective vaccine. Much thought and discussion will be required to consider the cultural and sociological implications of encouraging circumcision to reduce HIV transmission.

CONCLUSION

HIV will continue to be a deadly enemy for the near future, but we cannot resign ourselves to a world beset by HIV forever. We have seen poor nations develop successful prevention campaigns with little outside assistance, which proves that prevention is possible in the developing world. We have also seen the United States lead the world in proving that HIV medicines can be deployed in areas with few resources. We have been given hope that HIV's spread can be slowed, stopped, and in fact reversed. We cannot let the gains we have made, and the hope we have been given, slip away. As we move into the next phase of the Emergency Plan, and continue our extraordinary commitment to fight HIV overseas, we must make our long-term HIV goal, the ultimate extinction of the HIV virus. If we can imagine the birth of an HIV-free generation, and we commit to achieving it, we can make it happen.

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Appendix A:
Executive Order

Federal Register
Vol. 60, No. 116
Friday, June 16, 1995

Presidential Documents

Title 3—

The President

Executive Order 12963 of June 14, 1995

Presidential Advisory Council on HIV/AIDS

By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby direct the Secretary of Health and Human Services to exercise her discretion as follows:

Section 1. *Establishment.* (a) The Secretary of Health and Human Services (the "Secretary") shall establish an HIV/AIDS Advisory Council (the "Advisory Council" or the "Council"), to be known as the Presidential Advisory Council on HIV/AIDS. The Advisory Council shall be composed of not more than 30 members to be appointed or designated by the Secretary. The Advisory Council shall comply with the Federal Advisory Committee Act, as amended (5 U.S.C. App.).

(b) The Secretary shall designate a Chairperson from among the members of the Advisory Council.

Sec. 2. *Functions.* The Advisory Council shall provide advice, information, and recommendations to the Secretary regarding programs and policies intended to (a) promote effective prevention of HIV disease, (b) advance research on HIV and AIDS, and (c) promote quality services to persons living with HIV disease and AIDS. The functions of the Advisory Council shall be solely advisory in nature. The Secretary shall provide the President with copies of all written reports provided to the Secretary by the Advisory Council.

Sec. 3. *Administration.* (a) The heads of executive departments and agencies shall, to the extent permitted by law, provide the Advisory Council with such information as it may require for purposes of carrying out its functions.

(b) Any members of the Advisory Council that receive compensation shall be compensated in accordance with Federal law. Committee members may be allowed travel expenses, including per diem in lieu of subsistence, to the extent permitted by law for persons serving intermittently in the Government service (5 U.S.C. section 5701–5707).

(c) To the extent permitted by law, and subject to the availability of appropriations, the Department of Health and Human Services shall provide the Advisory Council with such funds and support as may be necessary for the performance of its functions.

Sec. 4. *General Provisions.* (a) Notwithstanding the provisions of any other Executive order, any functions of the President under the Federal Advisory Committee Act that are applicable to the Advisory Council, except that of reporting annually to the Congress, shall be performed by the Department of Health and Human Services, in accordance with the guidelines and procedures established by the Administrator of General Services.

Federal Register
Vol. 61, No. 118
Tuesday, June 18, 1996

Presidential Documents

Title 3—

The President

Executive Order 13009 of June 14, 1996

Amendment to Executive Order No. 12963 Entitled Presidential Advisory Council on HIV/AIDS

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to increase the membership of the Presidential Advisory Council on HIV/AIDS, it is hereby ordered that Executive Order No. 12963 is amended by deleting the number "30" in the second sentence of section 1(a) of that order and inserting the number "35" in lieu thereof.

William J. Clinton

THE WHITE HOUSE,
June 14, 1996.

[FR Doc. 96-15656
Filed 6-17-96; 8:45 am]
Billing code 3195-01-P

(b) This order is intended only to improve the internal management of the executive branch, and it is not intended to create any right, benefit, or trust responsibility, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, it officers, or any person.

William J. Clinton

THE WHITE HOUSE,
June 14, 1995.

[FR Doc. 95–14983
Filed 6–14–95; 4:45 pm]
Billing code 3195–01–P

Appendix B:
Amended Charter

AMENDED CHARTER

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

PURPOSE

The Secretary of Health and Human Services is charged in Titles XXIII-XXVI of the Public Health Service Act with responsibilities for conducting a variety of activities in connection with the prevention and cure of HIV and AIDS and for ensuring that those infected with HIV or AIDS are provided with quality care.

AUTHORITY

Executive Order 12963, dated June 14, 1995, as amended by Executive Order 13009, dated June 14, 1996. The Presidential Advisory Council on HIV/AIDS ("PACHA" and/or the "Council) is governed by provisions of Public Law 92-463, as amended,

5 U.S.C. Appendix 2, that sets forth standards for the formation and use of advisory committees.

FUNCTION

PACHA shall provide advice, information, and recommendations to the Secretary regarding programs and policies intended to (a) promote effective prevention of HIV disease, (b) advance research on HIV/AIDS, and (c) promote quality services to persons living with HIV disease and AIDS. The functions of the Council shall be solely advisory in nature. The Secretary shall provide the President with copies of all written reports provided to the Secretary by the Council.

STRUCTURE

The Council shall consist of not more than 21 members to be appointed or designated by the Secretary. If at the time the charter is made effective, the Council has more than 21 members, such members shall serve through the remainder of their terms and/or until notified, in writing, that their terms have expired. The Secretary shall designate one or more members to serve as Chair, Vice Chair and/or Co-Chairs. The Council membership shall be selected from authorities with particular expertise in, or knowledge of, matters concerning HIV and AIDS. In addition, the Council may include ex officio members from relevant HHS components, as deemed appropriate by the Secretary or designee.

Members shall be invited to serve for overlapping terms of up to four years; terms are contingent upon the authorized continuation of the Council. A member can serve after the expiration of their term until their successor has taken office and/or until notified, in writing, that their term has expired.

Subcommittees may be established, consisting of members of the Council, to perform specific functions within the jurisdiction of this advisory group. Subcommittees shall make preliminary recommendations for consideration by the Council membership. The Department Committee Management Officer shall be notified upon establishment of each subcommittee and shall be provided information on these subgroups, i.e., names/titles, functions, membership, and estimated frequency of meetings.

Management and support services for the Council and its activities shall be provided by the Office of Public Health and Science within the Office of the Secretary.

MEETINGS

The Council shall meet not less than two times each year at the call of the Chair and/or

Co-Chairs with advance approval of a designated Government official. A designated Government official must approve the agenda for the meetings and also must be present at all meetings.

Meetings shall be open to the public, except as determined otherwise by the Secretary. Notice of all meetings shall be given to the public. Meetings shall be conducted and copies of the proceedings kept, as required by applicable laws and Department regulations.

COMPENSATION

The Council membership shall receive no stipend for the advisory services they render as members of PACHA. However, as authorized by law and in accordance with Federal travel regulations, PACHA members may receive per diem and reimbursement for travel expenses incurred in relation to performing duties for the Council.

ANNUAL COST ESTIMATES

The estimated annual cost for Council operations, including per diem and travel expenses for members, is $303,300. An allocation of three (3) FTEs has been projected to provide staff support for Council activities; the annual cost for the projected human resources is $259,300.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

REPORTS

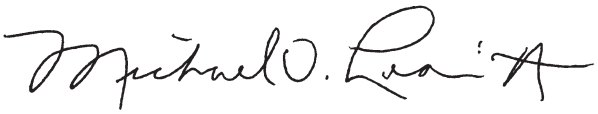
In the event, the entire and/or portion of a Council meeting is closed to the public, a report shall be prepared that shall contain, at a minimum, a list of members and their business addresses, the Council's functions, dates and places of meeting, a summary of the topics discussed and/or Council business conducted, and the resulting recommendations made. A copy of the report shall be given to the Department Committee Management Officer.

TERMINATION DATE

Unless renewed by the appropriate action prior to the date stipulated, the Presidential Council on HIV/AIDS will terminate on July 27, 2007.

APPROVED:

July 26, 2005



Date

Secretary

Appendix C:
Resolutions and Recommendations

August 2003

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

May 1, 2002

President George W. Bush
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President,

The President's Advisory Council on HIV/AIDS met on March 14-15, 2002 with a planned review of the state of HIV/AIDS in America and the world.

After receiving a large amount of information from expert presenters and testimony from the public, the members of PACHA voted unanimously to communicate with you immediately on several key issues that require immediate attention. One recurrent observation that was raised by virtually all participants was the importance of leadership. In the fight against HIV/AIDS, highly elevated, public and visible leadership is absolutely critical if we hope to be successful in our efforts.

Individual leadership for prevention, knowledge of status and treatment would markedly elevate HIV/AIDS awareness, once again, in our country. Strong leadership would be the catalyst to achieving our mutual goals of ending the epidemic as soon as possible and providing care and treatment for those already living with the infection.

We feel that leadership by the President and the First Lady would be an example for other leaders, not only in this country but also around the world, to be proactive as well. This horrific pandemic requires such bold and courageous leadership and could encourage others to renew their efforts in the fight against HIV/AIDS. Such leadership could encourage Americans to be actively involved in achieving our stated goals by avoiding high risk behaviors; being tested if they are at risk of infection; seeking treatment if they are HIV positive; and recognizing their responsibility to not infect someone else.

The specific recommendations to you articulated by the Council are:

1. The Administration should increase funding for the AIDS Drug Assistance Program (ADAP). During his presentation to PACHA, Dr Anthony Fauci spoke of the clear and irrefutable evidence that the new medications can prolong the lives of people living with HIV/AIDS. We also heard testimony that there are

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people in the United States that are on waiting lists to receive these very drugs that can prolong life, decrease suffering, and reduce costly hospitalizations. The members of PACHA feel strongly that no one should be denied access to these medications.

In addition to increasing ADAP funding, we recommend that the Administration modify 1115 waivers on state Medicaid programs to maximize the ability of ADAP funds to serve more people.

2. The United States should increase it's funding to the fight against HIV/AIDS, including the Global AIDS Fund, with the assurance of priorities for prevention and treatment. Increased funding must include transparent and observable tracking of all dollars allocated.

Effective treatment options should include an infrastructure plan, along with the availability of accessible medications. We believe sooner, rather than later, in upgrading the U.S. commitment will save the most lives and result in the fewest new infections.

3. We believe the Administration should outline a plan and goal to markedly decrease new HIV infections in the United States. We are concerned that a sense of urgency seems lacking as we continue to have at least 40,000 new infections each year in the United States, with preliminary reports indicating that 2001 data will likely show an increase in this number.

New infections are a measurement of the effectiveness of prevention programs and the effectiveness of the CDC's present programs.

We hold that it is not enough to want to lower new infections, but we must always strive to eliminate new infections altogether. A plan with a time line for eradication of the epidemic should be developed and implemented immediately. The same is true for maternal-fetal transmissions.

We believe that thoughtful, effective education is key to reducing new infections. Our prevention efforts must continue to adapt to the changes and trends in the epidemic. The continuing high number of new infections suggests that we should revisit current strategies to determine if they are, indeed, still the most effective methods of prevention education.

Sound public health policy based on science and the CDC's reporting mechanism should be the central elements to guide our efforts to identify those who are already infected, bring them into effective care

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and services, educate them about the risks associated with re-infection, and discuss their responsibility not to spread the infection to others.

A rigorous demand of the CDC to institute proven public health policies to lessen the number of new infections is required.

4. Finally, funds for this disease must relate to the demographics and infection trends we are presently seeing. Dollars, therefore, should be prioritized to where the disease is specifically accelerating and where it is anticipated to grow. We believe the Administration should make certain that minority AIDS organizations and seropositive HIV minority individuals are funded appropriately to meet the developing changes of this pandemic.

We are honored to be serving as the co-chairs of the Presidential Advisory Council on HIV/AIDS. We look forward to working with you to improve the health of the American people and to eliminate the scourge of HIV/AIDS.

Sincerely Yours,

Louis W. Sullivan, M.D., Co-Chair	Thomas A. Coburn, M.D., Co-Chair

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RESOLUTIONS APPROVED AT THE AUGUST 8, 2003 MEETING

Prevention Subcommittee Resolution #1:
Whereas, the number of new AIDS cases in the United States has remained stable or risen slightly since 1998; and

Whereas, an estimated one fourth of the 850,000 to 950,000 people living with HIV in the United States do not know their HIV status; and

Whereas, many HIV-infected persons do not get tested until late in their infection, thereby missing the opportunity to obtain early treatment or to adopt behaviors that could reduce the risk of transmitting HIV; and

Whereas, the development of new and rapid tests for HIV create new prospects for expanding HIV testing to identify and treat HIV persons earlier; and

Whereas, it is recognized that new HIV infections are of particular concern in that they have a disproportionate impact on specific communities as identified by CDC data; and

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, Advancing HIV Prevention: New Strategies for a Changing Epidemic. PACHA supports the new initiative, aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality care, treatment, and ongoing prevention services through proven public health approaches to reduce the incidence and spread of contagious diseases.

In addition, PACHA is confident that the CDC will seek the counsel and participation of local public health departments, healthcare providers, community-based service organizations, and community leaders already engaged in HIV prevention programs, care and services to broaden CDC's prevention strategy aimed at HIV positive individuals who know their status, HIV positive individuals who do not know their status and those at risk of becoming infected.

Treatment and Care Subcommittee Resolution #1:
Whereas, Hepatitis C (HCV) has emerged as an important cause of morbidity and mortality in people infected with human immunodeficiency virus (HIV)-infected; and

Whereas, HCV induced liver damage has become the leading cause of liver transplantation in the United States and 10,000 to 12,000 people die each year of HCV-associated end-stage liver disease (ESLD); and

Whereas, up to one-third of all HIV-infected people in the U.S. may be coinfected with HCV and the progression of HCV is accelerated in HIV positive individuals and ESLD has become a leading cause of death in those with HIV disease; and

Whereas, the best current combination therapy for HCV infection succeeds between 50 and 80 percent of the time depending upon genotype of HCV, and the range and severity of its side effects can seriously affect patients' quality of life, adherence and chances for a successful outcome; and

Whereas, the treatment of HCV requires an integrated multidisciplinary approach including gastroenterology/hepatology, infectious disease, mental health, substance abuse treatment and support services; and

Whereas, prevention for any condition is the most efficacious and cost effective treatment; and

Be it resolved that an increase in basic and clinical research exploring novel treatment strategies and targets to combat HIV/HCV co-infection effectively; an expanded emphasis upon research targeting the reduction as well as management of the side effects of HCV treatment; and

Be it resolved that PACHA urges the President of the United States and the Secretary of Health and Human Services to provide strong leadership as demonstrated by: an emphasis upon and funding for community-based screening and education; an integrated multidisciplinary treatment and care approach for those coinfected with HIV and HCV; and

Be it resolved that PACHA recommend that HCV testing be emphasized and continue to be a standard of care as defined by the Public Health Service for all those persons who test positive for HIV; and

Be it further resolved that PACHA recommend to the President of the United States and the Secretary of Health and Human Services to urge states to include medications that treat HCV infection as part of drug formularies to treat the coinfected with HIV; and HCV.

Treatment and Care Subcommittee Resolution #2:
Whereas, medical and palliative care and supportive care are essential parts of any treatment plan for a person living with HIV/AIDS; and

Whereas, the demand for services is expected to rise as patients live longer with HIV/AIDS and as testing initiatives are expanded; and

Whereas, the communities affected by the epidemic and the needs of those infected have changed over time; and

Whereas, the funding for such services, while significant, continues to fall short of the needs of the community; and

Whereas, budget crises, both nationally and statewide, have forced a reexamination of the services provided to people living with HIV/AIDS; and

Whereas, the need to maximize to existing resources, reduce waste, increase accountability, and expand sources of funding is more critical than ever; and

Whereas, the Ryan White CARE Act, one of the most significant sources of federal AIDS dollars, comes up for reauthorization in 2005,

Whereas, the Minority AIDS Initiative (MAI), which seeks to improve access to care for communities of color, will be directly affected by these funding decisions,

Be it resolved that PACHA recommend to the President and the Secretary of Health and Human Services that they support a call for a "National Summit About the Future of AIDS Funding and Priorities"; and

Be it resolved that this National Summit include members of the Administration, the Congress, AIDS Advocacy groups, the pharmaceutical industry, and public health leaders, among others; and

Be it further resolved that PACHA compile a report to the President and the Secretary based on the discussions and recommendations offered during this National summit.

International Subcommittee Resolution #1:
Whereas, the AIDS epidemic is a scourge that threatens the future of many developing countries; and

Whereas, PACHA enthusiastically supports the goals of the President's Emergency Plan for AIDS Relief, and desires that it be wholly successful. In particular, we applaud the emphasis on the outcomes of disease prevented and lives saved through treatment; and

Whereas, PACHA applauds President Bush's readiness to speak publicly about AIDS, as he did on his recent trip to Africa (July 7-12, 2003); and

Whereas, every successful initiative to reduce the incidence of HIV has as a common element the public recognition of the problem, and active leadership to speak about and address the problem, by the governmental authorities of affected countries; and

Whereas, there is a long and storied history of well-intentioned aid initiatives that have not met their full potential for success, some of which have actually exacerbated the problems that they were intended to address, in part because they failed to engage traditional leadership and institutions as partners; and

Whereas, initiatives that have demonstrated the highest levels of success in reducing the incidence of HIV disease have incorporated approaches born and developed in the culture of the country, while adapting modern medical concepts to their cultural contexts; and

Whereas, up to eighty percent of the populations of target countries do not currently engage with the public health infrastructure, but are involved with, and respect the advice of, traditional healers, leaders, and institutions; and

Be it resolved that PACHA urges the President and the Secretary of Health and Human Services, to continue to speak often and forcefully about the need to address the AIDS crisis, and to encourage the leadership of recipient countries to become more involved in, and exhibit more leadership in, the campaign to fight AIDS by doing the same; and

Be it further resolved that PACHA urges the President and the Secretary of Health and Human Services to recognize that a one-size-fits-all approach probably will not achieve the desired outcomes of disease prevented and lives saved, and to insist that countries modify the proposed implementation model in ways that recognize and respect the cultural and social realities of the recipient country. In some cases a regional approach in partnership with other recipient countries should be considered. In particular, we believe that it is critical that plans engage traditional institutions and authorities, including healers, village leaders and chiefs, and religious leaders, as important partners in the development and implementation of any new initiative, or, if not, that the reasons for exclusion be justified.

International Subcommittee Resolution #2:
Whereas, the Center for Strategic an International Studies (CSIS) formed a delegation of health leaders who visited China from January 13-17, 2003 at the invitation of the Chinese Ministry of Health, Zhang Wenkang, to examine China's approach to HIV/AIDS and to explore the possibility of expanded US-Chinese collaboration in this critical area; and

Whereas, Senator Bill Frist, US Senate Majority Leader, served as honorary chair of the delegation and the delegation Co-Chairs were Dr. Louis Sullivan (former US Secretary of Health and Human Services, 1989-1993, and Co-Chair of the Presidential Advisory Council on HIV/AIDS) and J. Stapleton Roy (former US Ambassador to China, 1991-1995); and

Whereas, China has the world's largest population, with 1.3 billion people and is a major and growing, economic, social and political force in the world; and

Whereas, the CSIS delegation found that China is at risk of a generalized HIV/AIDS epidemic that by 2010 could infect between 10 million and 20 million Chinese with HIV, which would seriously impact China's mainstream society and economy; and

Whereas, the Chinese efforts against HIV/AIDS are moving in the right direction, but slowly; and

Whereas, China is presently ill-equipped to preempt a generalized HIV/AIDS epidemic because of a) lack of public health capacity, b) poor baseline data and assessment capacity, c) insufficient high-level political will and financial commitments, d) societal prejudices and lack of awareness, education and prevention, and e) bureaucratic and political obstacles; and

Whereas, it is in the US national interest to enlarge significantly its bilateral and multilateral engagement with China to assist in preempting a generalized epidemic that would have catastrophic consequences for China and the world; and

Whereas, other countries with large populations such as India and Russia have similar urgent threats from the spread of the HIV/AIDS global epidemic; and

Whereas, significant health education, prevention, and other initiatives undertaken at this time could help to avert or minimize the potential catastrophic human, social, political, and economic effects of the HIV/AIDS pandemic which could be possibly more severe than what is being experienced today in sub-Saharan Africa; and

Whereas, President Bush and the US Congress deserve our thanks and our praise for their leadership in focusing attention and resources on the HIV/AIDS challenges in the United States, Africa and the Caribbean; and

Whereas, such Presidential leadership and congressional support is needed for the United States to extend its efforts today to address the HIV/AIDS global pandemic, to avert a catastrophe of enormous proportions; and

Be it resolved that PACHA urges the President, the Secretary of Health and Human Services, and the US Congress to provide strong international leadership and technical assistance to China, India, Russia and other nations to fight the HIV/AIDS pandemic; and

Be it further resolved, that the United Nations and other multilateral organizations be enlisted and supported in this heroic world effort for the 21st Century.

International Subcommittee Resolution #3:
Whereas, the AIDS medications currently available allow for long-term chronic disease management for many patients abating symptoms and prolonging life so that these patients can return to their jobs and the care of their families; and

Whereas, the state of research and development in the HIV/AIDS therapeutic category reveals that a cure for this disease has not been discovered and may take decades to discover; and

Whereas, emerging resistance in the United States and abroad to currently available therapies for HIV/AIDS is causing increasing concern among patients, treatment providers and practitioners, public and private sector researchers; and

Whereas, patients now sustained by current medicines will need new, and better treatments to continue managing their disease in the future; and

Whereas, multiple HIV drugs in the same therapeutic class play a critical role in the treatment of AIDS, providing patients and their caregivers needed flexibility in treatment regimens; and

Whereas, research in AIDS R&D is slowing in the private sector and the number of new products currently in development has declined in the last few years; and

Whereas, private sector development of new medications is increasingly costly due to ever more complex regulatory requirements, technology and the exhaustion of more obvious candidate compounds; and

Whereas, the private sector, in partnership with government and academic institutions, has played a crucial role in development of new HIV medications; and

Whereas, drug development is very uncertain and risky due to the impossibility of predicting whether any compound will be a safe, effective medication until it is actually subjected extensive and increasingly costly laboratory and clinical testing.

Whereas, the private sector has the crucial role in development of new medications because it alone is able to manage successfully the capital risks of drug research and development; and

Whereas, NIH has the crucial role in funding basic science to discover drug leads but does not test and develop medicines because it is not structured to manage the risks inherent in such research and development; and

Whereas, strong and stable intellectual property protections are essential if we are to obtain the private sector risk capital for continued HIV/AIDS drug development; and

Whereas, US health care consumers and taxpayers bear a disproportionate share of the worldwide costs of drug research and development; and

Whereas, these medicines and the discovery of more of them are especially important to the health and well being of patients all over the globe, especially those suffering from and seeking treatment for HIV/AIDS in developing countries; and

Be it resolved that PACHA urges the President and his Administration to maintain and strengthen their commitments to infectious disease research and the intellectual property protections that undergird it; and

Be it further resolved that PACHA urges the President and his Administration to seek to ensure that access to life-saving drugs be as broad as possible.

March 2004

Prevention Subcommittee Resolution #1:

Call for the Establishment of an Office or Designation of Staff at the White House to Address HIV Prevention and Interrelatedness of Risk Factors for Youth

Whereas, an estimated 15,000 of the estimated new 40,000 HIV infections in the United States in 2000 were among youth aged 15 to 24 and (1), and

Whereas, evidence also shows that among this same age group there were 9.1 million new STD infections (48% of the approximately 18.9 million new cases of STD in 2000) (1), and

Whereas, research shows that the earlier young people begin to participate in unhealthy risk behaviors, the greater their overall and long-term risk, for example:

- Young people who participate in first intercourse before age 14 are significantly more likely to have more lifetime sexual partners. Fifty seven percent of girls who initiate sex before age 14 report six or more lifetime partners compared to 10 percent of girls who initiate sex at age 17 or older. Likewise, 74 percent of boys who initiate sex before age 14 report six or more lifetime partners compared to 10 percent of boys who initiate sex at age 17 or older. The number of new sexual partners over time is a key factor in the spread of STDs, including HIV/AIDS ([2]);
- Young people who begin drinking before age 15 are more than twice as likely to develop alcohol abuse and are four times more likely to develop alcohol dependence than those who began drinking after age 21 ([3]);
- Epidemiological and clinical studies suggest that adolescents who begin drug use at early ages not only use drugs more frequently, but also escalate to high levels more quickly and are less likely to stop using ([4]);
- Experts agree and studies show that age of initiation is a powerful predictor of tobacco consequences and dependence. The vast majority of people who become addicted smokers started smoking regularly before 18 years of age and will be addicted for an average of 16 to 20 years ([5]);
- The earlier the onset of a delinquent career, the greater the number of delinquent offences juveniles are likely to commit before their 18th birthday ([6]); and

Whereas, studies reveal interconnections between unhealthy risk behaviors, for example linking alcohol and/or substance abuse with early and unplanned sexual activity among youth putting them at increased risk for acquiring HIV ([7]), and

Whereas, evidence also shows that a child's connections with parents, family, and school are the strongest protective factors for early onset of multiple unhealthy risk behaviors, including those that put youth at risk for HIV ([8]), and

Be it resolved, that PACHA commends the President of the United States for his focus on helping youth make right and healthy choices in his 2004 State of the Union address, and

Be it further resolved, that PACHA urges the President to implement a strategy that will help ensure that America's youth are encouraged to make right and healthy choices by establishing an office or designating a staff person at the White House who is responsible for making sure that all youth risk behavior prevention messages generated by and disseminated through the federal government are cogent, comprehensive and coordinated, focused on risk avoidance and risk reduction (i.e., consistent with Uganda's ABC prevention model for HIV/AIDS) for all youth, with special attention to those at higher risk.

Citations

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2. Trends in the Well-being of America's children and youth: 1996, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
3. Grant BF, Dawson DA. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the national longitudinal alcohol epidemiologic survey. Journal of Substance Abuse 1997; 9:103-110.
4. Johnson RA, Gerstein DR. Initiation of use of alcohol, cigarettes, marijuana, cocaine and other substances in US birth cohorts since 1919. American Journal of Public Health. 1998; 88:27-33.
5. Choi WS, Pierce JP, Gilpin EA, Farkas AJ, Berry CC. Which adolescent experimenters progress to established smoking in the United States. American Journal of Preventive Medicine 1997; 13(5):359-364.
6. Snyder HN, Sickmund M. Juvenile offenders and victims: a national report. Washington: National Center for Juvenile Justice; 1996.
7. Williad JC, Schoenborn CA. Relationship between cigarette smoking and other unhealthy behaviors among our nation's youth: United States, 1992. Advance Data 1995 April 24; (263).
8. Blum RW, Rinehard PM. Reducing the risk: connections that make a difference in the lives of youth. Division of General Pediatrics and Adolescent Health, University of Minnesota, Minneapolis.

UNANIMOUSLY APPROVED.

Prevention Subcommittee Resolution #2:

Call for Bold Leadership in Raising Domestic HIV Prevention Awareness

Whereas, President Bush has heralded the Uganda ABC prevention model as the most effective worldwide for sexual transmission of HIV and has made it the centerpiece of the President's Emergency Plan for AIDS Relief (PEPFAR), and

Whereas, the data shows that between 1991 and 2001 prevalence of HIV infection in Uganda declined by 66 percent, from 15 to 5 percent[i], and

Whereas, by 1995 fully 95 percent of Ugandans were reporting A or B behaviors in the preceding 6 months, meaning they were having sex with only one partner or they were abstaining, or they were faithful within the minority of polygamous marriages found in Uganda,[ii] and

Whereas, there was a highly significant decline in young males and females reporting premarital sex between 1989 and 1995[iii] and

Whereas, the ABC prevention model developed by Ugandan leadership in 1986 contained clear and targeted messages: (1) be Abstinent, (2) Be faithful, and (3) use Condoms 100 percent of the time if you have relations with an infected partner or engage in casual sex, and

Be it resolved, that PACHA applauds and supports the President's commitment to the one prevention model that has shown to be most effective prevention strategy for generalized epidemics around the world; and

Be it further resolved, that PACHA urge the President of the United States to give the "B" portion of the ABC message increased attention, emphasizing personal responsibility since data shows that a reduction in number of partners played a crucial role in Uganda's prevalence decline[iv] and many PEPFAR target countries do not currently focus on the "B" message; and

Be it further resolved, that PACHA urges the President of the United States and Secretary Tommy Thompson to evaluate the United States' domestic prevention strategy outcomes compared to the Uganda ABC prevention model outcomes to identify strategies whereby the United States would realize a short-term goal of annual reduction in numbers of new HIV infections and a long-term goal of no new infections; and

Be it further resolved, that PACHA urges the President of the United States and Secretary Tommy Thompson to exercise bold leadership in raising domestic HIV prevention awareness as a part of the strategy to reduce new HIV infections, again with a long-term goal of no new infections.

Citations

i Low-Beer, Daniel and Rand Stoneburner (2003). Behaviour and communication change in reducing HIV: is Uganda unique? *African Journal of AIDS Research 2003, 2(1): 9–21.* Using weighting for rural-urban population distribution, HIV prevalence feel from 15% to 5% in the same time period. USAID (2003). "The ABCs of HIV Prevention." USAID.

Office of HIV/AIDS. Green, E.C., V. Nantulya, R. Stoneburner, J. Stover, (Hogle, J. editor), **What Hapened in Uganda? Declining HIV Prevalence, Behavior Change and the National Response.** USAID/Washington and The Synergy Project, TvT Associates, Washington, D.C. September (2002).

ii from unpublished Demographic and Health Survey data, Uganda 1995. Cf. table on p. 157, Green, E.C., **Rethinking AIDS Prevention.** Westport, Ct.: Praeger Press, Greenwood Publishers (2003).

[iii] From both WHO and DHS data. Bessinger, Ruth, Priscilla Akwara, and Daniel Halperin," Trends in Sexual and Fertility Related Behavior: Cameroon, Kenya, Uganda, Zambia, and Thailand. Calverton, MD: ORC Macro, the Measure Project. Report to USAID, Feb 20, 2003.

[iv] Bessinger et al op cit; Green op cit; Low-Beer and Stoneburner op cit.

UNANIMOUSLY APPROVED.

International Subcommittee Resolution #1:

Expanding the President's Emergency Plan for AIDS Relief to Include Asia

Whereas, the Asian AIDS epidemic, with more than ten million cases, is second only to the Sub-Saharan epidemic and may be expanding faster, and

Whereas, in Asia, as in Africa, the AIDS epidemic, if unchecked, threatens to destabilize the region --the AIDS destabilization threat to Asia is as real as it is to Africa, the major difference being the timeframe, and

Whereas, Asia is and has long been the most populous continent, is one of the cradles of human civilization, and is becoming the most economically dynamic region on the planet, and

Whereas, Asia is politically less stable and has less healthcare infrastructure than other developed areas such as Europe and North America, and

Whereas, the worldwide economic and geopolitical consequences of destabilization in China, the Indian Subcontinent or Southeast Asia would be exceedingly grave, and

Whereas, the US has long involvement in Asian countries, and our recent history is importantly linked with theirs, and

Whereas, the Asian countries are recognizing the implications and extent of their AIDS epidemics and want to act, and

Whereas, the Asian countries with severe HIV/AIDS epidemic need more than just technical assistance to institute treatment as well as prevention and lack resources to do treatment by themselves, and

Whereas, PEPFAR has no Asian countries among the 14 designated focus countries, and

Whereas, Congress recognized this limitation by requiring the addition of a 15th country outside of Africa and the Caribbean in last year's appropriation, and

Whereas, more AIDS treatment and prevention programs need to be implemented quickly in Asia to prevent a devastating tragedy, which will impact the U.S. national interest and world economy and health, and

Be it therefore resolved, that PACHA recommends to the President that PEPFAR be expanded to include an Asian country particularly those willing to provide high level leadership.

UNANIMOUSLY APPROVED.

International Subcommittee Resolution #2:

Ensuring the Safety, Quality and Effectiveness of Drugs Procured by the President's Emergency Plan for AIDS Relief Funds

Whereas, the President's Emergency Plan for AIDS Relief (PEPFAR) has as its major goal the implementation of a plan to provide lifesaving drug treatment to 2 million people infected with HIV in the 14 targeted countries, and

Whereas, the Office of the Global AIDS Coordinator has been given the responsibility and authority to fund the purchase of drugs, and to determine what drugs will be procured either directly or indirectly with Emergency Plan funds, and

Whereas, the people of Africa and the Caribbean who will receive drugs procured directly or indirectly with Emergency Plan funds deserve drugs that meet a high standard for safety, quality and effectiveness, and

Whereas, even with the best of intentions, allowing a compromised standard of drug safety, quality and effectiveness for Emergency Plan drug procurements will allow, if not ultimately encourage a lower standard of care for African and Caribbean drug recipients, and

Whereas, FDA approved ARV drugs and their generic equivalents have demonstrated their capacity to effectively manage HIV disease, and

Whereas, poor quality, counterfeit, mismeasured, or ineffective drugs can speed development of resistant virus, sicken or harm patients or simply fail to help them, thus jeopardizing the success of the Emergency Plan, and

Be it resolved, that the Presidential Advisory Council on HIV/AIDS recommends that the President direct the Office of the Global AIDS Coordinator to require that any drug procured directly or indirectly with Emergency Plan funds must meet comparable standards for safety, quality and effectiveness as would be necessary for drug approval in the United States or any other country with drug approval standards of comparable scientific rigor.

In addition, the Office of the Global AIDS Coordinator should be directed to create an outside technical advisory panel to advise the Office on clinical outcomes, quality standards and diagnostic and drug treatment guidelines.

Be it further resolved, that PACHA recommends that the Secretary of HHS take all necessary steps to expedite clinical trials on new drugs and formulations, including fixed dose combinations (FDC's) that hold promise for simplifying treatment regimens, decreasing treatment costs, and thereby expanding safe effective treatment.

UNANIMOUSLY APPROVED.

Treatment and Care Subcommittee Resolution #2:

ADAP Funding Crisis

Whereas, AIDS-related medications have been universally accepted as an essential component of medical therapy for a person living with HIV/AIDS, and

Whereas, the AIDS Drug Assistance Program (ADAP) has provided thousands of Americans living with HIV/AIDS access to live-sustaining medications, and

Whereas, thousands of Americans are currently denied access to ADAP programs because of funding shortfalls, and

Whereas, the Presidential Advisory Council on HIV/AIDS (PACHA) wrote a letter to President Bush in June of 2002 describing the dire circumstances of the ADAP funding crisis and the need to bring together a broad coalition to address this problem effectively, and

Be it resolved, that PACHA request that the Secretary of Health and Human Services take appropriate immediate action to resolve the ADAP funding crisis through FY 2004 and to gather information from a variety of sources, such as representatives of the Administration, Congress, state health departments, AIDS advocacy groups, and the pharmaceutical industry in order to make future recommendations, and

Be it further resolved, that the Secretary be willing to consider all practical solutions to the ADAP crisis, including structural reform to encourage the more efficient and effective use of public funds, and

Be it further resolved, that because of the emergency nature of this situation that the Secretary report his findings and recommendations to PACHA within 90 days.

UNANIMOUSLY APPROVED.

Treatment and Care Subcommittee Resolution #3:

White House Summit on Domestic HIV/AIDS

Whereas, it is the responsibility of the Presidential Advisory Council on HIV/AIDS to advise the President on HIV/AIDS related issues and policy, and

Whereas, a White House Summit on HIV/AIDS in 1995 was successful in focusing the nation's attention on prevention and treatment responses to the epidemic, and

Whereas, in the ensuing years since the first White House Summit, the epidemic has dramatically changed both in terms of those who are affected and the treatments available, and

Whereas, the President has made HIV/AIDS, both domestically and internationally, a high priority for his administration, and

Be it resolved, that PACHA request the President to convene a White House Summit on HIV/AIDS in 2005 that would primarily focus on domestic issues, and

Be it further resolved, that PACHA request President Bush continue to highlight the current state of domestic HIV/AIDS in 2004.

UNANIMOUSLY APPROVED.

June 2004

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS
PREVENTION and TREATMENT & CARE SUBCOMMITTEES

The Treatment and Care, AND Prevention Subcommittees have met jointly to consider the state of HIV/AIDS among African Americans;

WHEREAS in 2002, the AIDS annual rate for African Americans was 10 times greater than the rate for white Americans (78.5/100,000 vs. 7.8/100,000);

WHEREAS in 2002, African Americans accounted for 50% of the more than 42,000 estimated AIDS cases diagnosed in the US;

WHEREAS HIV/AIDS is among the top three leading causes of death for African American men ages 25 - 54 and African American women ages 35 – 44;

WHEREAS the leading cause of HIV infection among African American women is heterosexual contact;

WHEREAS the leading cause of HIV infection among African American men is sexual contact with other men, followed by injection drug use;

WHEREAS in 2001, 61% of adolescents, 13 to 19 years of age, with AIDS were African American and 48% of them were females;

WHEREAS in 2002, Sixty-two percent (62%) of children born to HIV infected mothers were African American;

WHEREAS African Americans represented approximately 64% of all AIDS cases among women in 2001;

WHEREAS it is estimated that approximately 1 in 160 African American women is infected with HIV, as compares to 1 in 400 Latina women, and 1 in 3,000 white women;

BE IT RESOLVED that PACHA recommends to the President and the Secretary of Health and Human Services that all programmatic initiatives and resource allocations follow the epidemic and in particular address the devastating and disproportionate impact HIV disease currently has among African Americans.

BE IT FURTHER RESOLVED that PACHA advises that the President and Secretary to encourage African American leaders from all sectors, including the political, faith-based, corporate, all media, education, community youth leaders, healthcare, and support services arenas to speak out more forcefully about HIV disease to stimulate discussion about both its consequences and means of prevention.

BE IT FURTHER RESOLVED that PACHA recommends expedited funding of additional and targeted behavioral research to identify cultural, institutional, and societal issues that can inform future prevention, care and treatment initiatives to effectively alleviate the impact of HIV in the African American community.

UNANIMOUSLY APPROVED.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS
TREATMENT & CARE SUBCOMMITTEE

Whereas the AIDS Drug Assistance Program (ADAP) is the primary source of Public Health Service (PHS) recommended antiretroviral therapies for 136,000+ uninsured or under-insured Americans living with HIV/AIDS each year[1] and

Whereas highly active antiretroviral therapy for HIV-infection has reduced the death rate from AIDS by 72% since 1995 and are cost effective overall, and

Whereas recent scientific studies have found that people living with HIV/AIDS receiving highly active antiretroviral therapy have a 60% reduction in infectivity to partners, making treatment an important tool for prevention, and

Whereas in May of 2004, 11 ADAPs had waiting lists representing 1,629 people, and 8 ADAPs have put cost containment measures in place, and 10 ADAPs are anticipating instituting cost-containment measures including closed enrollment to new clients and reduced formularies[1], and

Whereas any long-term solution to the ADAP crisis cannot be instituted until the Ryan White CARE Act is reauthorized in 2005, a short term resolution to the problem facing Americans awaiting access to life-sustaining drugs must be addressed immediately, and

Whereas any changes to the present formula distribution of federal earmark ADAP funds will not go into effect until FY07,

Whereas the President has recognized the importance of eliminating the ADAP waiting list and recently authorized the expenditure of $20 million to address this issue,

BE IT RESOLVED THAT PACHA thanks President Bush for his leadership to address the ongoing ADAP crisis and for making the elimination of waiting lists a top priority in his AIDS agenda, and

BE IT FURTHER RESOLVED THAT these funds are targeted to those areas demonstrating the greatest need and are spent expeditiously to maximize their benefit to the community, and

BE IT FURTHER RESOLVED THAT the President and Secretary continue to ensure the availability of funds for HIV/AIDS medications until a long-term solution is enacted.

1. *The ADAP Watch*, June 2004; National Association of State and Territorial AIDS Directors (NASTAD)

UNANIMOUSLY APPROVED.

PRESIDENTIAL ADVISORY CUNCIL ON HIV/AIDS
INTERNATIONAL SUBCOMMITTEE

Whereas the Asian AIDS epidemic, with more than ten million cases, is second only to the Sub-Saharan epidemic, is expanding faster, and is expected to overtake the Sub-Saharan epidemic by 2010.

Whereas the XVth International AIDS Conference in Bangkok this July will focus international attention of the hitherto neglected Asian epidemic.

Whereas in Asia, as in Africa, the AIDS epidemic, if unchecked, threatens to destabilize whole countries and is currently a factor in destabilizing Myanmar, and whereas the AIDS destabilization threat to Asia is as real as it is to Africa, the major difference being the timeframe.

Whereas the worldwide economic and geopolitical consequences of destabilization in China, India, and Southeast Asia would be grave.

Whereas Asia, while undergoing rapid economic advances, is politically less stable and its healthcare infrastructure is less well developed than in Europe and North America.

Whereas many Asian countries are recognizing the implications and extent of their AIDS epidemics and want to act.

Whereas these countries often have the basic economic resources to provide ARV treatment but lack the expertise to quickly implement AIDS treatment and prevention programs.

Whereas the US has wide experience and expertise in implementing AIDS treatment and prevention programs.

Whereas there is a window of opportunity in both India and China to block the bridging of HIV infections from high risk groups to the general population.

Whereas appropriate preventive interventions can have significant impact on national HIV prevalence prior to such bridging.

Be it therefore resolved that PACHA recommends to the President that HIV/AIDS prevention and treatment be on the agenda at all appropriate bilateral discussions with these two countries, and that discussions be initiated in the near future with India and China on establishing cost sharing programs to facilitate access to American expertise in implementing AIDS prevention and treatment.

UNANIMOUSLY APPROVED.

November 2004

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS
PREVENTION / TREATMENT & CARE COMMITTEE

HIV REPORTING
MOTION

WHEREAS timely and accurate data are essential elements to the development of sound public health policies, and

WHEREAS the reporting of AIDS cases has been required for many years in all states and territories in the United States, and

WHEREAS the use of such data has been critical in tracking disease trends, monitoring health outcomes, and allocating resources, and

WHEREAS there is an inherent need for uniformity in data reports to ensure greater accuracy, more relevant comparisons, and less duplication of reported cases, and

WHEREAS the use of HIV data has been shown to reflect current trends better than AIDS data,

BE IT RESOLVED THAT PACHA urge the President and the Secretary to work with the Centers for Disease Control (CDC) and the states and territories to develop data systems that report on HIV cases, and

BE IT FURTHER RESOLVED that HIV cases become the standard for data reporting in regards to HIV/AIDS.

PASSED

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS
TREATMENT & CARE SUBCOMMITTEE

WHEREAS the care and treatment of persons living with HIV/AIDS is a high priority for this Administration and an important part of an effective national public health strategy, and

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

WHEREAS the Ryan White CARE Act will need to be reauthorized in 2005 in order to continue to provide federal funding, and

WHEREAS The Ryan White CARE Act has achieved its primary goal of providing comprehensive care to people who would not otherwise have been able to access it with fifty percent of clients living below the federal poverty line; more than 90 percent with no private health insurance and almost two-thirds that are racial and ethnic minorities, then

BE IT RESOLVED THAT the Presidential Advisory Council on HIV/AIDS (PACHA) supports the reauthorization of the Ryan White CARE Act, and

BE IT FURTHER RESOLVED THAT the Secretary of Health and Human Services and the President of the United States work closely with members of Congress to ensure timely reauthorization of the Ryan White CARE Act in 2005 bearing in mind the following principles:

1. Federal resources should focus on ensuring that all underserved HIV+ Americans have access to a core set of services including primary medical care, medications, case management, oral health, mental health/substance abuse treatment and support services that foster adherence to life-sustaining medications and allow people to stay in care.
2. HIV/AIDS care, treatment and prevention should be guided by proven public health strategies and based on current scientific knowledge.
3. Provide greater flexibility to target Ryan White CARE Act resources better to address areas of greatest need, especially emerging populations and the chronically underserved.
4. Strengthen the Minority AIDS Initiative to expand capacity in minority communities and fund minority-serving providers.
5. Ensure access, at best possible pricing, to all medically necessary medications, including antiretrovirals, opportunistic infection treatment and prophylaxis, co-infections including hepatitis C, co-morbidities including mental illnesses and side effects associated with both HIV.
6. Ensure the integration of HIV prevention services into primary care.
7. Ensure accountability for all providers of Ryan White CARE Act funded services.

PASSED

February 2005

Presidential Advisory Council on HIV/AIDS
International Subcommittee Motion

(Passed)

Improving Prevention of Mother to Child Transmission (PMTCT) Efforts while Preserving Current Treatment Options for Women of Childbearing years.

WHEREAS, increasing numbers of women in their childbearing years are being infected with HIV and AIDS; and

WHEREAS, transmission of HIV infection from mother to child (MTCT) decreased dramatically since prophylaxis of HIV-infected pregnant women with zidovudine was initiated in 1994, in the US, and

WHEREAS, transmission of HIV infection from mother to child in resource- limited settings has been significantly reduced since prophylaxis with single-dose nevirapine (NVP) was introduced and

WHEREAS, nevirapine prophylaxis has been proven to be simple, safe and effective and tens of thousands of HIV-infected women already received this therapy without significant problems, and

WHEREAS, recent allegations related to the study which proved the safety and efficacy of nevirapine in preventing MTCT was flawed, were shown to be unfounded by multiple subsequent reviews, as well as by independent studies which confirmed the results of the original study.

BE IT RESOLVED that the Presidential Advisory Council on HIV/AIDS (PACHA) recommends that the usage of single-dose nevirapine (with or without zidovudine) for prevention of MTCT is safe and effective and should continue to be recommended to HIV-infected pregnant women who have no other option for treatment such as with combinations of multiple antiretroviral drugs.

BE IT RESOLVED that the PACHA recommends that nevirapine prophylaxis is an acceptable therapy until more effective antiviral therapy that does not induce drug resistance will be available.

BE IT RESOLVED that the PACHA recommends that the Secretary of HHS take all necessary steps to expedite clinical trials on novel simple, effective, and affordable treatments to prevent MTCT during delivery.

Presidential Advisory Council on HIV/AIDS
International Subcommittee Motion

(Passed)

Improving Prevention of Mother to Child Transmission (PMTCT) Efforts Globally

WHEREAS, the President's Emergency Plan for AIDS Relief, building on the significant work accomplished under the President's 2002 International Mother and Child HIV Prevention Initiative calls for the rapid scale up of PMTCT activities that promote improved access and efficacy of prevention efforts; and

WHEREAS, increasing numbers of women in their childbearing years are becoming HIV infected, the majority living in communities without adequate access to prevention activities such as in the U.S. that have reduced the burden of pediatric infections from perinatal transmission to under two percent annually; and

WHEREAS, significant progress has been made in the global battle to reduce mother to child transmission through strategies such as enhancing safe deliveries, breastfeeding avoidance, and short course antiretroviral therapy, it is recognized that treatment of the mother with highly active antiretroviral therapy (HAART) during pregnancy and the breastfeeding period will be required to achieve a reduction of transmission that resembles the U.S. success; and

WHEREAS, utilization of HAART reduces the viral burden in the mother thus reducing transmission to the infant and allows recovery of the immune system producing a healthier mother and more likely a healthier baby thereby reducing the number of orphaned or vulnerable children; and

WHEREAS, the President's Emergency Plan calls for special attention to mothers and children and the scaling up antiretroviral therapy,

BE IT RECOMMENDED that U.S. Government departments and their implementing agencies involved in HIV/AIDS activities globally intensify their efforts to secure HAART for pregnant and breastfeeding women through the provision of effective medications, training and development of infrastructures that include health care professionals such as nurses, midwives, and members of NGOs to manage medication therapies, and the monitoring and evaluation of the impact on the health of the mother, the child and the prevention of new HIV infections.

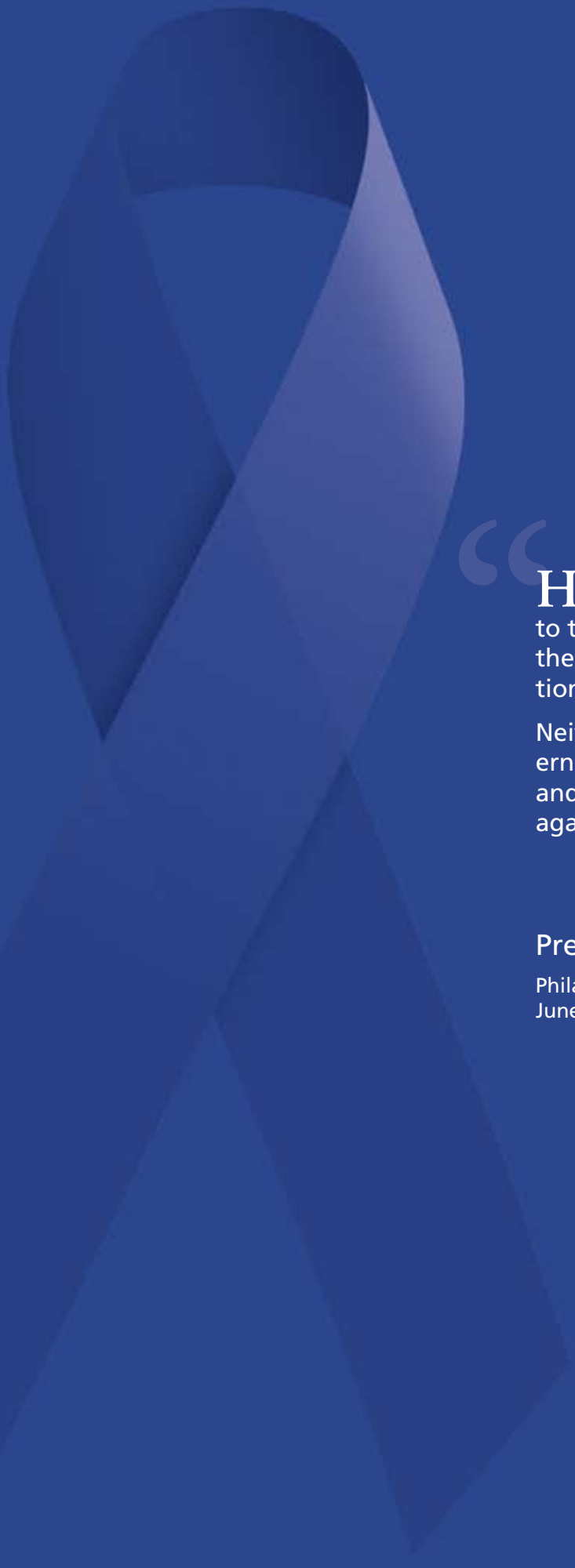
Presidential Advisory Council on HIV/AIDS
Treatment & Care Subcommittee
State of the Union Resolution

(Passed)

WHEREAS the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, first signed into law by President Herbert Walker Bush and subsequently reauthorized in 1996 and 2000, 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 the care and treatment of persons living with HIV/AIDS is a high priority for this Administration and an important part of an effective national public health strategy,

BE IT RESOLVED THAT the Presidential Advisory Council on HIV/AIDS (PACHA) wishes to express our sincerest gratitude to the President of the United States of America, George W. Bush, for bringing national attention to the domestic HIV/AIDS epidemic and the disproportionate impact this disease has on African-American men and women by calling for the reauthorization and modernization of the Ryan White CARE Act in the State of the Union address on February 2, 2005.



"HIV/AIDS is a direct challenge to the compassion of our country, and to the welfare of not only our nation, but nations all across the globe . . .

Neither individuals, nor society, nor government can afford to be complacent, and we will not relent against the battle against AIDS . . ."

President George W. Bush

Philadelphia, Pennsylvania
June 23, 2004