Putting a Price on Life Saving Housing
A MESSAGE OF THANKS

I want to take this opportunity, on behalf of The AIDS Institute, to thank our ActionLink readers who have participated in advocacy efforts during the first half of 2008. It has been a year in which we have asked you to contact elected officials numerous times. Issues of prevention, care, treatment, and research have all been in the forefront, both internationally and domestically. Your voices have helped secure some important victories - such as the recent passage of an improved Medicare bill and the PEPFAR bill. Your voices have raised awareness overall in the halls of Congress and state legislatures, and in administrative agency offices. The challenges posed by HIV/AIDS, hepatitis, malaria, and tuberculosis - key areas of concern for The AIDS Institute - will continue to need your involvement and your voice. Likewise, we will be depending on your continuing participation in our attempts to address the issues underlying these health concerns - poverty, discrimination, stigma, homelessness and inadequate housing, lack of access, and, of course, the need for domestic health care reform.

Please take some time to congratulate yourself for the compassion and the advocacy you have demonstrated. You are part of a cutting edge movement to change business as usual in the provision of health and social services in the United States and in the developing world. We have much more to accomplish together in the coming months of 2008 and in the years ahead. Together and untied we will continue to make progress.

Best Wishes,

A. Gene Copello
NEWS FLASH
JULY 24, 2008

PEPFAR BILL PASSES
THE HOUSE OF REPRESENTATIVES
303 TO 115

The House voted to adopt the Senate version of the PEPFAR reauthorization bill.

It will now go to President Bush to sign into law. The AIDS Institute thanks everyone who advocated for this very important legislation.

ABOUT ACTIONLINK

ActionLink represents one part of a national news service launched by The AIDS Institute to inform and educate the public about HIV and AIDS issues at home and abroad. ActionLink, news service of The AIDS Institute, is also comprised of news releases, action alerts and newsflashes – updates that keep the public informed, strengthening the bonds within the AIDS Community. To subscribe or for questions please contact: ActionLink@theaidsinstitute.org
Policy Has Negative Impact on HIV Housing Services

In a moment of cruel irony, at the very time when powerful new research findings are incontrovertibly confirming the role stable housing plays in HIV prevention and healthcare, the Health Resources Services Administration (HRSA) has codified a cumulative 24 month lifetime cap on the use of Ryan White funding for emergency and transitional housing through a housing policy amendment which took effect March 27, 2008. The 2006 Ryan White Care and Treatment Modernization Act wisely left to communities, decisions about how to prioritize supportive services that could be funded with the 25% of CARE Act dollars not restricted to the provision of core medical services.

Historically, though proportionately a small amount of CARE Act dollars are used for housing, in those communities which have prioritized housing it is helping to meet critical need. In 2006, for example, only $29.3 million of the overall $2.06 billion Ryan White appropriation was expended on housing assistance and housing related expenditures by Title I grantees. Nevertheless, in client assessments housing assistance remains one of the greatest unmet needs.

Although much of the current housing crisis is focused on mortgage foreclosure and homeowners, the plight of the poorest renters – the income category in which many low income people with HIV/AIDS fall -- has long been neglected by policymakers. According to the National Low Income Housing Coalition’s 2008 Out of Reach report, in no jurisdiction in the United States can a household earning the federal minimum wage working 40 hours a week, 50 weeks a year, earn enough to afford a two-bedroom unit for at the fair market rent. The 2008 national housing wage is $17.31. An American worker must earn this hourly wage to afford housing at the fair market rent paying 30% of income. These costs make clear that for low income people with HIV/AIDS – many of whom subsist on Social Security disability income -- the two-pronged challenge of affordability and availability, often result in simply no housing options.

For low income people coping with HIV/AIDS the specter of homelessness and housing instability loom large as evidenced by the persistent presence of housing at or near the top of the list of needs routinely identified by HIV/AIDS clients across the country. For example, in urban settings like the Hartford TGA, the New Haven/Fairfield TGA and statewide in Connecticut, housing and housing search assistance consistently appear among the top five issues in client needs assessments. Similarly, in rural and much less densely populated Alabama, where 5% of the state’s HIV positive population is interviewed every three years, housing need is always ranked at the top.

In initially publishing the proposed policy notice in December 2006, HRSA asserted that an Office of Inspector General audit encouraged HRSA to clarify the definition of short-term housing and emergency housing assistance and that the amendment would “help align the HRSA definition of short-term housing with the widely accepted program standard used by the U.S. Department of Housing and Urban Development, Continuum of Care Homeless Assistance Programs and the Housing Opportunities For Persons With AIDS program. The Housing Opportunities for Persons With AIDS Program (HOPWA) imposes no such “program standard” or limitation. In fact, only one HUD program, the Supportive Housing Program under the McKinney Vento Homeless Assistance Grant Programs, includes a 24 month time limit and, more importantly, includes a waiver which affords HUD discretion to extend the period. The governing statute goes further in establishing that the HUD Secretary can only deny housing assistance based on a violation of this provision upon a determination that a substantial number of homeless individuals or families have remained in the housing for a longer than the prescribed period.

AIDS housing advocates acknowledge the rationale underlying the short-term and emergency nature of the HRSA housing program and that the HRSA housing program should reasonably be a “stop” on the path to permanent housing options. This is particularly true as AIDS housing has evolved from respite care as people are living longer. However, in an environment where affordable permanent housing options simply don’t exist and in which the law explicitly authorizes grantees to deploy the non-core medical services portion of CARE Act funds consistent with identified local priorities, the cumulative 24 month lifetime cap is ill-conceived and short-sighted.

Data-based research –much of which was been presented at the National AIDS Housing Coalition’s Third National Housing and HIV/AIDS Research Summit convened in Baltimore, MD in March 2008 in collaboration with the Department of Health, Behavior and Society of the Johns Hopkins School of Public Health – is proving more powerfully than ever that housing is an effective and cost-saving health care intervention for homeless and unstably housed persons with HIV and other chronic health conditions.

The preliminary results of two major multi-year studies released at the Summit link the availability of housing assistance to better health outcomes for homeless and unstably housed persons living with HIV and other chronic health conditions. Moreover the studies, the first of their kind specifically designed to examine the significance of housing as an independent determinant of health, confirm that public investment in housing saves taxpayer money.

The Housing and Health study (H&H), a large-scale longitudinal study conducted by the Centers for Disease
Control and Prevention (CDC) and the HUD HOPWA program, examined the impact in terms of disease progression and risks of transmission, of providing housing assistance to persons with HIV who are homeless or at imminent risk of homelessness. The Chicago Housing for Health Partnership (CHHP), a multi-disciplinary collaboration of healthcare, respite care and housing providers, is a large scale, comprehensive examination of the impact of supportive housing on the stability and health of homeless persons living with HIV/AIDS and other chronic illnesses, as well as their health services utilization rate.

The H&H Study compared, over an 18 month period, results between two cohorts, one receiving actual housing assistance, typically in the form of a housing voucher, and one receiving “usual care”, such as housing search assistance. In both groups significant improvements in health outcomes were registered over time, including a 34% reduction in emergency room visits, 21% reduction in hospitalizations, 44% reduction in self-reported opportunistic infections; 40% reduction in sex trade; and slightly improved mental health status.

In the CHHP study, which employed a Housing First model, the housed group used almost half as many nursing home days as those who received “usual care”, a system of emergency shelter stays, family and recovery programs. Those housed were nearly two times less likely to be hospitalized or use emergency rooms. An annual average of $12,000 was spent per housed client to provide permanent supportive housing. According to preliminary estimates, annual medical expenses for the housed cohort were, in the aggregate, at least $900,000 less than their usual care counterparts, after offsetting the cost of housing.

Beyond these groundbreaking studies, additional empirical data powerfully confirms that homelessness is a major risk factor for HIV and HIV is a major risk factor for homelessness. Rates of HIV infection are three to sixteen times higher among persons who are homeless or unstably housed compared to similar persons who are stably housed. The all-cause death rate among homeless HIV positive persons is five times the rate of death among housed persons with HIV/AIDS: 5.3 to 8 deaths per 100 persons years for HIV positive homeless persons, compared to 1 to 2 deaths per 100 person years for HIV positive persons who are housed.

The National AIDS Housing Coalition led a grassroots effort by AIDS housing supporters urging the withdrawal or mollification of the negative impact of the proposed policy amendment. More than 200 commenters, overwhelmingly opposed, provided their views to HRSA. The commenters included a number of influential members of Congress. Of particular concern was the feature of retroactivity in the proposed policy amendment. Had it been enforced thousands of people with HIV/AIDS faced the prospect of immediately hitting the 24 month cap and losing their housing assistance with no permanent housing to which to transition. HRSA withdrew the proposed policy amendment in early 2007 only to reinstate it as final a year later. Though the March 27, 2008 final policy amendment has been revised to eliminate retroactivity and take effect prospectively, its issuance has lead to understandable confusion among Ryan White grantees some of whom are interpreting HRSA’s action as, for practical purposes, disallowing housing as an eligible activity.

It is incumbent upon HRSA to develop a housing policy that meaningfully recognizes housing’s role as a critical component of HIV/AIDS healthcare and addresses the need to afford communities the flexibility to identify and address critical housing need as an eligible supportive service.

(Guest Writer: Nancy Bernstine, Executive Director, National AIDS Housing Coalition)

Please contact author for references.

About the National AIDS Housing Coalition

Since NAHC was founded in 1993, its coalition of national and community-based organizations and individuals provides strong advocacy, representation, and training for thousands of consumers, community leaders, and social service/health providers.

NAHC’s active relationship with its members enables its small staff in Washington to fulfill its mission. Together they work on policy analysis, advocacy, and special initiatives that support the work of our members and consumers.

NAHC works at the federal, state, and local levels to educate and inform advocates, service providers, the business community, and policy makers about the funding priorities that impact housing options for the most vulnerable.

The AIDS Institute Comments On Healthy People 2020

The US Department of Health and Human Services is currently developing the framework for Healthy People 2020, the national health goals for the next decade. As part of that process, HHS is conducting regional meetings across the country. Carl Schmid, Director of Federal Affairs for The AIDS Institute recently attended the DC area stakeholders meeting and presented comments urging the HHS “to effectively address the domestic HIV/AIDS epidemic in a coordinated manner.”

In his remarks, Schmid commented, “While Healthy People 2010 included a number of objectives that addressed HIV/AIDS, sadly we have not made much progress as a Nation in preventing new infections and providing care and treatment to keep people alive and well. In fact, the overall annual number of new infections has most likely increased, and we know it is increasing in certain populations. We know that 1 out of 4 (over 250,000 people) who are living with HIV in the US are not aware of their status and 233,000 people who know their status are not receiving drug treatment who should be.”

(continued on page 6)
The AIDS Institute believes Healthy People 2020 must include in its objectives efforts to:

1) Prevent the number of annual new infections, focusing on ethnic and racial minorities and men who have sex with men;
2) Increase the number of people who know their HIV status;
3) Provide adequate healthcare, drug treatment, and support services to people living with HIV/AIDS;
4) Provide housing, substance abuse, and mental health services to people living with HIV/AIDS;
5) Provide the necessary research to prevent HIV infections that includes behavioral research based on evidence based science, vaccines and microbicides;
6) Provide research that supports new drug development and eventually a cure for HIV/AIDS.

We voiced our support for Healthy People 2020’s mission to consider social determinants to health and another proposed mission to “improve results by providing priorities, measuring goals and objectives, and guidance on effective strategies and tactics”. The latter, we said are similar to the current rallying cry from the HIV/AIDS community for a National HIV/AIDS Strategy.

So that the document can better be used to guide policy decision makers we recommended that, when possible, it include for each specific goal or objective the costs to society of not carrying out the proposed objective and the estimated cost of attaining the proposed objective.

Finally, we called for an annual review and report card to measure progress in meeting the objectives. (Carl Schmid)

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Proposed Funding For Domestic HIV/AIDS Prevention Doesn’t Fare Well For FY2009; Ryan White & NIH See Gains

Both the House and Senate have begun to advance bills to fund domestic HIV/AIDS programs in FY2009 and while there are some positive first steps for increased funding for the Ryan White Program in the House and NIH research in both the House and Senate, at the moment there are absolutely no increases for CDC HIV prevention funding.

In reaction to this news, The AIDS Institute immediately issued press releases which were sent to every House and Senate office to express our deep disappointment. In our release Dr. Gene Copello, Executive Director of The AIDS Institute, said, “We as a Nation must do more to recommit to fighting the domestic HIV/AIDS crisis and that should begin with a greater focus on prevention.” He continued, “In order to prevent the 40,000 plus new infections each year, the CDC is going to need greater resources to help educate people about HIV/AIDS, develop new behavioral and biomedical prevention methods and technologies, identify through testing the estimated 250,000 people who have HIV in the U.S. but do not know their HIV status, and ensure that people testing positive are referred to effective care and medical treatment.”

The AIDS Institute will be encouraging both the Senate and the House to increase funding for the CDC as the bills move through the Congress. No increase for domestic HIV prevention is unacceptable.

The situation for Ryan White Programs is a little better. The House has proposed an increase of $100 million with each part of the Program receiving an increase, but the bulk for Part A and B, including ADAP. On the other hand, the Senate is proposing an increase of only $6.5 million, with all of the increase for Part B, including ADAP. In reaction to this action, in The AIDS Institute release, Carl Schmid, Director of Federal Affairs commented, “Given the existing strains on the program due to limited funding increases in the past, together with the growing demand due to increased patient caseloads and costs of medical care and treatment, we thought the Senate would respond with an appropriate increase in funds. Cities most affected by HIV/AIDS, states and clinics all need increased resources, not flat funding or cuts. They can’t even keep up with covering increased costs let alone increased demands due to new infections and HIV testing campaigns.”

Under the bills proposed by the House and Senate, funding for medical research at the National Institutes of Health is proposed to increase by over $1 billion. Copello commented, “This will be a much needed boost which we trust will be funneled, in part, into HIV/AIDS and Hepatitis research. Not only do we need new drug therapies that can prolong and improve peoples’ lives, but the NIH can do much more in the area of prevention, including the development of behavioral interventions and such biomedical technologies as microbicides and vaccines.”

In the House bill funding for abstinence only until marriage programs would be flat funded in FY2009 while the Senate is recommending a cut over $28 million. The House does not allow spending for the controversial Early Diagnosis Grant Program, while the Senate does not.

The House also proposes to increase funding for Hepatitis prevention and surveillance at the CDC by $1.4 million while the Senate is recommending no increase.

Both the House and Senate Labor, HHS and Education Appropriation bills are over $9 billion higher than the President’s proposed budget, which makes the situation more disappointing since Subcommittee Chairs David Obey (D-WI) and Tom Harkin (D-IA) obviously choose to increase certain programs in their bills, while at the same time flat funding HIV prevention. (continued on page 7)
The full Senate Appropriations Committee has passed the bill and the House bill remains stalled in the Appropriations Committee. It is uncertain when these bills will make it to their respective floors. Since the President will not go along with such large increases in the overall Labor HHS bill, Congress will have to fund these programs under a Continuing Resolution. Congress may wait until the next President to finalize the funding levels for FY2009. (Carl Schmid)

Lifting Us HIV Entry Ban Faces Hurdles But Support Rises

As the log jam over reauthorization of PEPFAR is broken, there seems like an excellent opportunity for the United States to finally lift the long discriminator HIV entry ban for travel and immigration into the country. Language to lift the ban is included in the Senate version of the bill and House leaders have signaled they will support the provision when the bill goes to conference. Sen. John Kerry, one of the principle advocates of lifting the ban had confirmed with the White House that the Bush Administration supports lifting the ban.

In order to get over the Congressional Budget Office (CBO) estimate that lifting the ban will cost the federal government $83 million over ten years, Senate Foreign Relations Chair Joe Biden (D-DE) has identified an appropriate offset. Without that offset, any Senator could have raised a point of order and 60 votes would be required to overturn the objection and keep the provision in the bill.

The probably next obstacle will be on the Senate floor where Sen. David Vitter (R-LA) is expected to offer an amendment to strike the language lifting the HIV entry ban. The AIDS Institute is working hard for the defeat of the Vitter amendment.

The US and other nation’s HIV travel and immigration restrictions was the subject of much discussion at the recent UN high level meeting on AIDS in New York. At the meeting the Secretary General called on the international community to end discrimination against HIV-positive people, including travel restrictions, describing such practices as "an affront to our common humanity." He also said that such discrimination "drives the virus underground, where it can spread in the dark; as important, it is an affront to our common humanity."

Sen. Kerry and Sen. Gordon Smith (R-OR), in an effort to educate the public about the current entry ban penned an Op-Ed in the Washington Times titled, "America's unfair HIV/AIDS policy." They wrote, "There are approximately 32 million people outside of the United States living with HIV/AIDS. Since 2003, America has extended a helping hand to these individuals by spending more than $15 billion on the largest international health commitment ever to fight a single disease. Unfortunately, as we open our wallets to fund lifesaving treatments to those living with HIV/AIDS overseas, we will not open our doors. Today, HIV is the only medical condition that renders people inadmissible to the United States. In fact, we are just one of 12 countries that prohibit, almost without exception, HIV-positive non-citizens from entering the country (China has recently overturned its ban). This policy places the United States in the same company as Sudan, Russia, Libya and Saudi Arabia. Such a discriminatory policy has no basis in public health, let alone common sense." (Carl Schmid)

Congress Fails To Correct ADAP TrOOP Problem

The highest priority for the HIV Medicare/Medicaid working group has been Congressional legislation to allow ADAP expenditures to count as part of the Medicare Part D drug program. Currently, ADAP’s are allowed to wrap around the Medicare drug program but they don’t count as TrOOP and the beneficiary never gets out of the so-called “donut hole.” Despite countless pleas from the HIV/AIDS community, Congress has failed to insert this low-cost, easy fix to Medicare legislation moving through the Congress.

The most likely legislative vehicle to attach the fix to has been a bill that would prevent a reduction in Medicare payments to doctors that was set to go in effect on July 1st. When Senate Finance Chairman Max Baucus (D-MT) released his bill, we were met with great disappointment after learning our simple Medicare Part D fix did not make it into his bill. To date, the bill has not been debated on the floor due to a Republican filibuster, but if it were, Sens. Jeff Bingaman D-NM) and Gordon Smith (R-OR), were set to offer an amendment which included the ADAP TrOOP legislation.

While the House passed a Medicare reform bill last year, which included the ADAP TrOOP fix, the Senate never passed a corresponding bill to go to conference. In an effort to move a bill closer to passage, the House came up with another less expensive bill, but much to our dismay, it did not include the ADAP TrOOP provision.

In reaction to the new House bill, the Medicaid/Medicare Working Group sent a strongly worded letter to Speaker Nancy Pelosi (D-CA). In the letter, we wrote, “We urge you to step in and use your prerogatives as leader of the House to have this tiny policy change inserted into the legislation.” The group also requested a meeting with her “to discuss this issue, and going forward, a better way to communicate and work together on high priority issues for the HIV community that acknowledges both your special role in advocating for and strong personal commitment to people living with HIV/AIDS and your responsibility in leading the House of Representatives.” At press time, the House and Senate still have not passed a bill that would stop the July 1st Medicare payment reduction to doctors. When they do, it does not appear the AIDS community’s simple fix will be included and other alternatives will have to be found. (Carl Schmid)

The AIDS Institute Lends Support To Changing VA HIV Testing Laws

Current law requires the Veterans Administration in administering HIV tests to obtain separate written request for HIV testing and perform pre- and post-testing counseling. In order to comply with new CDC routine HIV testing recommendations in medical settings, the VA is seeking legislation to delete these requirements. A bill, the “Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus Act of 2008” (HR 6114), has been introduced by Congressman Michael Doyle (D-PA) and Charles Dent (R-PA) to accomplish this and was subject to a recent hearing by the House Veterans Health Subcommittee. (continued on page 8)
Creating a National AIDS Strategy for the U.S.

When the United States helps other countries tackle HIV/AIDS we insist their governments have a strategy in place to coordinate programs and accomplish measurable progress on HIV incidence and care access. But over a quarter century since the epidemic was identified in the US our country still does not have its own National AIDS Strategy (NAS).

Wikipedia defines the word “strategy” as “a long term plan of action designed to achieve a particular goal.” That does not describe the current federal response to HIV in the US. Federally funded prevention and treatment programs have prevented hundreds of thousands of infections and saved thousands of lives. Other disease groups look at the accomplishments of AIDS advocacy as a model to be envied. But we know that the federal effort is in many ways a patchwork, not well coordinated, inadequately funded, and often not using resources most effectively to get the job done.

The outcomes of our national effort are unacceptable: about half of people living with HIV in our country are not in care; about half who qualify for ARVs are not getting them; infection rates have not fallen in well over a decade and in fact are probably going up; gross racial disparities continue to define our epidemic. We need a plan of action to do better.

Support for creation of an NAS has been gaining momentum over the last year. In 2007, The CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC) called for development of a comprehensive national AIDS plan. The Open Society Institute published a monograph on the need for a US national AIDS plan. A group of seven AIDS organizations -- AIDS Action Council, AIDS Foundation of Chicago, Balm in Gilead, Black AIDS Institute, CHAMP, GMHC, and the San Francisco AIDS Foundation -- came together to spearhead efforts for a NAS.

The seven groups created a website with information on the NAS concept and a Call to Action that has now been endorsed by over 200 organizations and hundreds of individuals.

www.nationalaidsstrategy.org

The Call to Action outlines key principles necessary to make an NAS effective. NAS supporters also reached out to all major Presidential Candidates, and by the first primary every major Democratic candidate had pledged to develop a NAS if elected. Senator Obama's AIDS platform promises he will develop an NAS that involves “all federal agencies...[and includes] measurable goals, timelines, and accountability mechanisms,” to address HIV incidence, care access, and racial disparities.

In April of this year the Ford Foundation hosted a meeting of 42 leaders in the domestic epidemic to discuss the NAS concept. Out of that meeting has grown a much broader effort that is open to everyone interested in advancing the NAS. Starting in June there have been monthly conference calls to discuss progress on the NAS. Five Working Groups have also been formed: Allied Stakeholder Engagement; Communications; Grassroots Organizing; Political Support; and, Transitional Proposal to the Next Presidential Administration. In May there was a well-attended Congressional Briefing on the NAS proposal (a summary is available on the NAS website).

You can receive more information on the Working Groups and the monthly NAS calls at info@nationalaidsstrategy.org.

All those who endorse the National AIDS Strategy at www.nationalaidsstrategy.org will receive regular updates on the effort and ways to be involved.

(Guest Writer: Chris Collins, Writer, policy and communications consultant to national and international health organizations.)
The Stand Against AIDS will occur in Oxford, MS on September 24-26, 2008 where activists from around the country will converge to demand that the next president seriously addresses the HIV/AIDS epidemic in the US and develop a national plan to end AIDS within his first 100 days. This will be done through rallies, affinity groups a national town hall meeting on HIV/AIDS and demonstrations.

Eight HIV activists came together in Washington DC to brainstorm and develop solid strategies in organizing eight separate caravans originating from all corners of the country and aimed at Oxford, Mississippi – September 24th – 26th - the site of the first Presidential Debate which will be held September 26th 2008 @ 8:00 pm.

The week of June 16th, 2008 was used by the organizers - Greg Fordham (Norfolk, VA), George Kerr (DC Fights Back), Richard Wallace (Test Positive Aware Network, Chicago), Shirlene Cooper (NYC AIDS Housing Network), Marsha Jones (the Afiyah Center, Dallas), Janet Johnson (Loon Lake, WA), Eric Bartley (Housing Works, NYC), Eric Bailey and Valencia Robinson (AIDS Action In Mississippi), and David Bond (Positive Vegas) - to solidify the caravan routes, develop and implement outreach strategies, work out basic logistics, brainstorm on fundraising opportunities, and to polish off effective media packets.

All of these tools will be used to build participation locally, regionally, and connecting nationally through the caravans and to Mississippi where our messages will be delivered at the steps of our soon to be President. "Sending this message to our Presidential candidates is important," says Housing Works National Organizer Larry Bryant. "However, it is just as important that this message is carried by people who are living with HIV/AIDS and those who represent this epidemic from across the country".

The caravans are as follows:
- The Great Northwest Caravan starting in Seattle (WA),
- The Bay Cities Caravan starting in SF/Oakland (CA),
- The Southwest Trail starting in San Diego (CA),
- The West Gulf Caravan starting in Brownsville (TX),
- The East Gulf Caravan starting in Key West (FL),
- The Hampton Roads Caravan starting in Virginia Beach (VA),
- The Northeastern Link Caravan starting in Augusta (ME) and
- The Mississippi River Caravan starting in Minneapolis (MN),

There is also a walking caravan through Mississippi from Jackson to Oxford being organized by AIDS Action In Mississippi. Check out www.campaigntoendaids.org to see which caravan goes through your region. For information about the national caravans and the contact nearest you, please contact the Campaign To End AIDS at 1877-END-AIDS or at info@campaigntoendaids.org. (Guest Writer: Christine Campbell, Director of National Advocacy and Organizing at Housing Works, Inc)

Dr. Kwakwa joined The AIDS Institute’s board of directors in June 2008 and is a physician providing care to adolescents and adults with HIV infection at the Mercy Hospital in West Philadelphia and the Jonathan Lax Center in Center City Philadelphia. She received her undergraduate degree from Bryn Mawr College in Pennsylvania where she majored in chemistry, and went on to Yale University where she received her M.D. as well as an M.D.H. focusing on the epidemiology of infectious diseases. Her internship and residency were completed at Brown University in Rhode Island where she participated actively in providing care to patients in the HIV treatment center at Miriam Hospital. Her main interests are HIV in underserved populations and in women. Having been born in Ghana, she also has an interest in HIV in Africa.
ONC-Coordinated Strategic Plan Released Setting Health IT Milestones Across Federal Agencies

The Office of the National Coordinator for Health Information Technology (ONC), part of the U.S. Department of Health and Human Services (HHS), released a comprehensive plan for advancing health information technology (IT). The plan will serve as a guide to coordinate the federal government’s health IT efforts, which seek to achieve nationwide implementation of an interoperable health IT infrastructure throughout both the public and private sector.

The ONC-Coordinated Federal Health IT Strategic Plan focuses efforts along two primary goals: patient-focused health care, and population health. The first goal envisions a transformation to higher quality, more-cost efficient care, meeting patients’ needs, through electronic health information access and use. The second goal, related to population health, envisions the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement and emergency preparedness.

“Significant work has been completed to date to advance the nationwide health IT agenda. The plan provides an extensive documentation of the work completed by ONC and other federal partners over the past five years,” stated Dr. Robert Kolodner, national coordinator for health information technology. “It also establishes the next generation of health IT milestones to harness the power of information technology to help transform health and care in this country.”

Objectives, strategies and milestones have been established for each goal. They portray the totality of what must be done across the federal government to address privacy and security concerns, achieve an interoperable health IT architecture to ensure reliable data exchange, accelerate IT adoption and foster collaborative governance.

The plan was developed by ONC, working in collaboration with 12 agencies and staff divisions within HHS, the Departments of Commerce, Defense, and Veterans Affairs, and the Federal Communications Commission. Two federal advisory bodies, the National Committee on Vital and Health Statistics and the American Health Information Community, also contributed to some of the strategies and milestones that are cited in the plan. A copy of the complete plan as well as a plan synopsis can be found at www.hhs.gov/healthit.

Radio-Wave Devices May Play Havoc With Medical Equipment

In lab setting, they caused some machines to turn off, others to malfunction

Those magic little devices that allow you to enter your hotel room or pay a toll electronically could interfere with the operation of critical medical equipment in a hospital. In a laboratory setting not involving actual patients, Dutch scientists found that the radio frequency identification devices -- which are increasingly used in medicine -- caused potentially hazardous problems with some medical tools. The findings were published in the June 25 issue of the Journal of the American Medical Association. However, the scope of the danger is not yet clear. “This leaves us concerned, [but] we have to see if this pans out in a real intensive care unit,” said Dr. Donald M. Berwick, president and CEO of the Institute for Healthcare Improvement in Cambridge, Mass., and author of an accompanying editorial. “These [devices] are brought in for a reason, and are doing things for the good. Just to shut them down would be overreacting. Let’s get serious about finding out whether this is a replicable finding, and if it occurs in the presence of real patients. I believe food and drug administrations and manufacturers have a duty to investigate, and I’d say urgently.”

The use of these devices is increasing in medical settings. For example, in respirators or IV pumps they help locate and keep track of inventory; they could also be used in drug blister packs to prevent counterfeiting or to ensure the quality of blood products. “They’re so tiny now that they can be put in surgical gauze pads, so at the end of the operation, the nurse can count up all pads and notice if one is missing and might have been left in the patient,” Berwick said. “There are all sorts of applications in hospitals, and the devices are proliferating.”

But there might be a dangerous downside to such sophisticated technology. This study took place in a simulated, one-bed intensive-care unit at the University of Amsterdam in the Netherlands. There were no patients involved, but there were 41 medical devices typically used in such a setting such as respirator machines, IV pumps, dialysis devices, defibrillators and external pacemaker devices.

Two radio frequency identification device systems, one active (with a battery and able to transmit information continuously) and one passive (powered by the electromagnetic field of the reader) were moved around the room while researchers assessed electromagnetic interference (EMI) on the medical devices. In all, researchers conducted 123 EMI tests, and 34 EMI incidents were recorded: 22 were considered hazardous (for example, the turn-off of a mechanical ventilator or malfunction of external pacemakers), two as significant (an inaccurate blood pressure reading or alarm wrongly going off which might divert attention from the patient), and 10 as light (“snow” (“snow” on the monitor, which didn’t need attention). The passive signal resulted in a higher number of total incidents (26 out of 41, or 63 percent), as well as more hazardous incidents (17). All incidents occurred at a median distance of 11.8 inches between reader and device. For hazardous incidents, the median distance was 9.8 inches.

“This ought to teach us a lesson about technologies in medicine in general,” Berwick said. “Anything new is going to introduce both good news and bad news. There will always be consequences. We have a love affair with technology, and that’s a little bit dangerous if we’re not keeping our eyes wide open. This is a good heads up. (By Amanda Gardner, HealthDay Reporter)
Carl Schmid has been Director of Federal Affairs for The AIDS Institute since February 2004. Prior to his current position, he served as a consultant to a number of HIV/AIDS and gay civil rights organizations. He has worked in Washington for over 20 years, and began his public policy work in the oil and gas industry, which continued through 2003. Mr. Schmid is co-chair of the AIDS community’s Budget and Appropriations Coalition; he co-chaired the Ryan White CARE Act Reauthorization Work Group, and is active in coalitions that advocate on Medicaid, Medicare, HIV Prevention, ADAP and Hepatitis issues. He is a member of the Presidential Advisory Council on HIV/AIDS and Chairs its Domestic Subcommittee. Mr. Schmid earned a B.A. in Public Affairs and a M.B.A. in International Affairs from the George Washington University in Washington, D.C.

As mentioned in June’s edition of ActionLink, seven senators, lead by Senator Tom Coburn (R-OK), had placed a hold on the bill to prevent any action until their objections to the bill had been addressed. Early last week, Senator Harry Reid (D-NV), Majority Leader of the Senate, had expressed his desire to bring the bill to the floor for a vote before the July 4th recess by saying, “We also are going to bring before the body within the next 24 hours the PEPFAR legislation - that’s the AIDS legislation that the President is in favor of.

Large turnout at the PEPFAR Rally in Washington, DC

It's been held up on the other side by a senator or two and we hope that we can complete that. I will ask consent that this be passed today. It is my understanding, having spoken to Senator Enzi, that he and Senator Biden have worked something out on that, and hopefully the Senator on the other side who’s objected to this will no longer object to it.” On Wednesday, June 25, Senator Reid issued a statement saying an agreement, in effect, had been reached with the dissenting Senators, “Five years have passed since we began this effort and we must reauthorize the global AIDS program. Unfortunately, this critical bill has been blocked by a small group of Republican Senators who have placed a hold on this legislation, preventing us from moving forward. That is why, several months ago, I asked Chairman Biden and Ranking Member Lugar to negotiate a compromise. They have worked tirelessly on this challenge and I thank them for all of their hard work. Given the importance of this legislation, I set a deadline of yesterday for the negotiations to be completed. I am pleased to announce that we have mainly completed those negotiations and reached a deal in principle. I want to thank Senators Biden and Lugar for their leadership during these negotiations and for their hard work over the past few days to close the deal on the final issues. Senators Coburn, Enzi, Burr, Kennedy, and the White House have all taken part as well. I appreciate the compromises that all of have made so that we can move this critical legislation forward. We still need to get a complete final text from legislative counsel, which we are working hard to do right now. Now that we have an agreement in principle, my strong preference would be to get this bill done this week. We should be able to do this quickly and easily – and it should be done before President Bush goes to the G-8 Summit next week. That would send an important message to the world that our country’s commitment to fight HIV/AIDS has not wavered. I hope, that once all the parties have read the final text, both sides can agree to pass this bipartisan legislation by unanimous consent. I will confirm with my side – but I am confident that we will be able to clear such an agreement.

(continued on page 12)
I would certainly hope that my colleagues on the other side would not block this bipartisan agreement – especially with the G-8 Conference coming soon. If the other side does choose to block us from moving forward, I am determined to move forward and plan on offering a consent agreement so that we can complete this legislation early in the next work period.”

Unfortunately, the bill, still, was not scheduled for a vote before the recess. The AIDS Institute, along with our partners in the advocacy community will be working hard over the next few weeks to ensure this bill is passed with an all important eye on the details of the amendments and changes to the bill to minimize the perceived negatives inherent in ambiguous language known to inhabit such monumental pieces of legislation. (James Sykes)

The AIDS Institute Applauds the U.S. Senate for Passing PEPFAR
A Victory for Global Health Advocates Across the Country

The U.S. Senate, by a vote of 80 to 16, passed the Tom Lantos and Henry J. Hyde U.S. Global Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. The bill, which renews the President’s Emergency Program for AIDS Relief (PEPFAR), was approved by the Senate Foreign Relations Committee in March and had the support of President Bush and congressional Democrats and Republicans. PEPFAR provides assistance to the regions of the world hit hardest by HIV/AIDS, malaria, and tuberculosis - scourges that kill approximately 6 million people a year. The program has been successful in saving lives and fostering good will toward the United States in countries where it has been implemented. To date, 1.7 million more people are receiving life-saving HIV/AIDS drugs than in 2003 when the program was proposed.

“I commend Senate Majority Leader Harry Reid and Senators Biden and Lugar for their leadership in getting this vital legislation passed in the Senate,” commented Dr. Gene Copello, Executive Director of The AIDS Institute. He continued, "The bill expands this successful program and also removes the discriminatory HIV entry ban. The commitment of the President, Senate, and House, which passed a similar bill earlier this year, to the fight against HIV/AIDS, TB, and Malaria is commendable."

The bill authorizes $48 billion over the next 5 years to address HIV/AIDS, TB, and Malaria and it contains a provision lifting the long-standing statutory ban on HIV-positive people traveling or immigrating to the United States. Several amendments were attempted, including one striking the provision to lift the HIV travel and immigration ban. Of the amendments actually offered, most failed with the exception of a few provisions. One reduced the original $50 billion funding level to $48 billion, directing the $2 billion difference to domestic Indian health care. Others that passed included cost-share agreements, establishment of an Inspector General’s Office, and an amendment on medical transmission of HIV. It should be noted that the amendment concerning medical transmission of HIV was a substitute amendment offered in place of striking the provision lifting the HIV travel and immigration ban.

James Sykes, Global AIDS Coordinator at The AIDS Institute, said: "We want to thank those advocates across the country who took the time to contact their Senators over the past several weeks. The voices of people living with HIV/AIDS, physicians, nurses, other healthcare professionals, students, and many other concerned Americans, helped to bring this bill to a vote and an overwhelming victory."

After the process is determined for how the Senate and House versions of the bill will be reconciled, the President is expected to sign the final bill and it will become law.

### BIO International Convention
The Global Event of Biotechnology

The 2008 BIO International Convention, produced by the Biotechnology Industry Organization (BIO), was recently held June 17-20 in San Diego, California. More than 20,108 attendees hailing from 70 different countries and 48 states made this year’s convention memorable. More than 6,000 business leaders met at the convention and participated in the Business Forum and an excess of 14,500 one-on-one partnering meetings were held. A total of 1,500 companies participated in the Business Forum. The convention featured the largest gathering of biotech exhibitors in history, upwards of 2,100 companies, 126 of which were new, in more than 208,000 square feet of exhibition space, the largest ever at the convention. The exhibition included more than 60 domestic, country, and regional pavilions representing every aspect of the biotechnology industry.

Many high-profile VIPs were featured speakers at the Convention, namely, the Honorable Deval Patrick, Governor of the Commonwealth of Massachusetts, Jeb Bush, former Governor of Florida, Neil Cavuto, V.P., Fox News, Governor Arnold Schwarzenegger, Governor of California, James C. Greenwood, President and CEO of BIO, former Secretary of State and Chairman of the Joint Chiefs of Staff, General Colin Powell, and J. Craig Venter, Ph.D., Founder, Chairman, and...
President of the J. Craig Venter Institute (JCVI) – a leading genomics research center. Each of these speakers addressed what government can do to foster innovation and growth in the life science industry.

The AIDS Institute was an invited exhibitor in the “Patient & Health Advocacy Display” at the convention. This area was positioned as one enters the exhibit hall so that as many of the convention attendees as possible could pass through the display and interact with the patient groups represented there. The Global Program of The AIDS Institute has been working with BIO to increase awareness within the health advocacy community about threats to the pipeline of new drugs and innovations to not only treat HIV/AIDS, Tuberculosis, Malaria, and Hepatitis, but a host of other health conditions affecting both the developing and developed world. TAI’s work on the recommendations suggested by the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property (IGWG) of the World Health Organization/World Health Assembly is one example.

The BIO International Convention helps to support the Biotechnology Industry Organization’s programs and initiatives. They work throughout the year to create a policy environment that enables the industry to continue to fulfill its vision of “bettering the world through biotechnology innovation.” The AIDS Institute is proud of the partnership we have forged with BIO in this endeavor. (James Sykes)

The Episcopal Church Takes an Active Role in Ending the Global HIV Pandemic

The Office of Government Relations and the Public Policy Network of the Episcopal Church, the political action center of the Episcopal Church in the United States, continues to see fighting HIV/AIDS as a top priority in the United States and abroad. The Church remains a strong advocate for prevention, education, and treatments as key components in ending the HIV/AIDS crisis globally.

Recently, The Episcopal Church, through a resolution at its General Convention, called upon its members and its congregations to take the lead in insuring that all methods used to prevent the spread of HIV are taught in school curricula, church school curricula, and in other educational settings.

As for the global pandemic, AIDS remains the number one cause of death in Africa. Incidentally, Africa is home to over half the world-wide Anglican Communion. In sub-Saharan Africa, home to more than 35 million Anglicans, 25.4 are infected. With this and the larger pandemic in mind, and in response to widespread humanitarian needs in Africa, the Church commends those parishes in Africa fighting AIDS, poverty and injustice, and calls on the larger Episcopal Church at all levels to partner with the Anglican Churches in Africa and other agencies to implement the United Nations Millennium Development Goals in Africa.

With this, the Office of Government Relations has continually urged the government of the United States to work with other governments and non-government organizations to find ways to make affordable drugs available while providing for continued research and development of HIV/AIDS-related medications.

For more information, or to join the National Episcopal AIDS Coalition, visit their website at: http://www.neac.org/join/. (Brock Thompson)

Disclaimer about contents: Guest articles, and any opinions expressed, do not necessarily reflect the views of The AIDS Institute. The information contained herein has been obtained from sources believed to be reliable, however, its accuracy and completeness are not guaranteed.
The ABC’s of HIV Prevention

HIV is spread through the transmission of sexual fluids, blood or breast milk of an infected person. Therefore, HIV prevention must involve a comprehensive approach which includes prevention of mother-to-child transmission, harm reduction for injecting drug users, precautions for health care workers, and prevention for individuals who engage in high risk activities. Among the strategies for preventing sexual transmission of HIV, is the much-discussed “ABC” approach. Three questions that often surface regarding the ABC approach include: what exactly is the ABC approach, why does it cause such controversy, and is it an effective strategy?

The ABC approach originated in the late 1990’s by the Botswana government, however one of the challenges noted today is the lack of a clear definition. The use of slogans that were first adopted by the Botswana government during the 90’s included billboards that exalted the fact that “Avoiding AIDS as easy as...Abstain, Be faithful and Condomize”. Although there have been other variations which have more specific definitions, most notably those adopted by the US-funded President’s Emergency Plan for AIDS Relief (PEPFAR) initiative, and others adopted by UNAIDS are well-known and promoted today.

For example, PEPFAR follows an ABC strategy through "population-specific interventions" that emphasize: Abstinence for youth, including the delay of sexual debut and abstinence until marriage, Being tested for HIV and being faithful in marriage and monogamous relationships and Correct and consistent use of condoms for those who practice high-risk behaviors. Furthermore, the definition explains those who practice high-risk behaviors include "prostitutes, sexually active discordant couples [in which one partner is known to have HIV], substance abusers, and others". One of the disadvantages of the PEPFAR definition is that it does not include the promotion of condoms to young people in general. However, PEPFAR promotes that its funds may be used to support programs that deliver age-appropriate "ABC information" for young people, provided they are informed about failure rates of condoms, and provided the programs do not appear to present abstinence and condom use as equally viable, alternative choices.

In contrast, the UNAIDS approach to ABC is defined as Abstinence or delaying first sex, Being safer by being faithful to one partner or by reducing the number of sexual partners and Correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.

The controversy arises from the differences between the two definitions of ABC, and in particular the fact that with the PEPFAR definition there is no promotion of condoms for young people (or anyone else outside the "high risk groups"), and that with abstinence the emphasis is on abstaining until marriage.

Although today there has been criticism in regards to the effectiveness of the ABC approach, during its early years an increasing number of countries including Uganda, Thailand, Kenya, Cambodia, Zimbabwe, India, Rwanda, Ethiopia, Dominican Republic, and Haiti, have experienced national or sub-national declines in HIV associated with the widespread adoption of “A,” “B,” and/or “C” prevention behaviors, all of which had previously been attributed to the ABC approach.

The AIDS Institute continues to promote HIV prevention education that includes a comprehensive approach. A message that is consistent and includes abstinence that promotes the delay of one’s first sexual encounter, being faithful to your partner as well as knowing your HIV status by getting tested, and the correct and consistent use of protective measures for everyone engaging in high risky activity. (Michelle Scavnicky)

GLOBAL WEBSITE OF THE MONTH

WWW.CCIH.ORG

The mission of Christian Connections for International Health is to promote international health and wholeness from a Christian perspective. CCIH provides field-oriented information resources and a forum for discussion, networking, and fellowship to the spectrum of Christian organizations and individuals working in international health.

CCIH began in 1987 as a forum for Christian agencies and individuals concerned about international health to discuss areas of mutual interest. It serves all Christians, as it:

• facilitates networking among Christian programs and individuals working internationally.
• relates to secular, professional and government international health organizations.
• shares information, experiences and learning from one another.
• seeks ways to promote interagency cooperation and partnership.
• develops relationships with religious and secular organizations with common interests.
• raises awareness and addresses key international health issues facing the Christian community at large.
• provides field-oriented information resources and a forum for discussion.
• promotes Christian health work in developing countries, focusing on national and indigenous programs.
• fosters the nurture and renewal of Christians working in international health, and fellowship among them.
State Policy Update
State Profiles: A New Undertaking

The AIDS Institute’s State Policy Program is thrilled to announce its ambitious plans to publish state profiles by the end of 2008. The mission for the State Policy Program, and the goal of this publication, is to enhance local advocates’ capacity to undertake important advocacy work. The goal that the State Policy Program has intended for this publication is to help empower local/state advocates to be as effective as possible in engaging their state officials, both legislative and administrative. Whenever progress for a better tomorrow is sought after, advocacy is a critical component to such effort. Furthermore, there is no reason why the HIV/AIDS advocacy community should limit itself to advocacy efforts in Congress. There are over 50 other legislative bodies across the United States, each of which hold potential to help achieve a future that is not ridden with HIV.

Each year, the contents of the state profiles and the resources they provide will continue to evolve and grow. The AIDS Institute welcome input from the HIV/AIDS community regarding the formulations of the state profiles project. I am looking forward to incorporating your expertise and your feedback of these drafts into the profiles, including what you would like to see included in an initial publication and objectives for years to come. Currently, the profiles are planned to be composed of four elements:

I. An epidemiological overview that provides users with an easy to read, graphical representation of their states latest end-of-year epidemiological report.

II. An Overview of Federal Resources (i.e. funds) within the State listed by program.: The information currently included in this draft is obviously outdated. Its contents are made available through AIDS Action’s publication entitled, State Facts. I am currently engaged in conversations with AIDS Action staff about incorporating the information from State Facts in our state profiles and I am hoping to work with them to update this information as much as possible.

III. A Digest of Statutes Governing HIV/AIDS and Hepatitis C Policy: The information herein contained is groundbreaking research conducted by The AIDS Institute and is intended to help advocates identify strengths and shortcomings within their state and to help compare best practices from across jurisdictions in a particular policy area.

IV. A Digest of Legislation Proposed within the current legislative session: Again, the information contained in this section is original research conducted by The AIDS Institute with similar intentions as the previous section. Additionally, however, this section helps advocates measure/evaluate the policy discussions that have been occurring within their legislature.

Clearly, there is much room for improvement within these profiles. The first year’s publication is likely to be rough around the edges. However, it is my hope to build community investment into this recourse that will help polish it into the strong tool that it has the potential to be. Again, I look forward to your feedback and thank you for your review. (Jason Kennedy)

State Legislative Digest

Note from the Editor: The AIDS Institute is excited to present this new section to ActionLink. The information contained herein is a sampling of state legislation relating to HIV/AIDS and Hepatitis C. The criteria for the selection of a piece of legislation is that it “moved” in the month of June. We hope that this digest will help advocates engage policy discussions taking place in their state capitals and to provide prospective on the kinds of discussions that currently taking place around the country. For more information about any of these bills or for any questions, please contact Jason Kennedy, State Policy Coordinator.

California
Assembly Bill 184:
Synopsis: Requires the State Department of Public Health, as part of its budget proposal for the 2009-10 fiscal year, and in consultation with specified private and public stakeholders, to submit a budget and plan for the prevention of liver cancer and diseases, and the control of viral hepatitis.

Status: This measure was introduced in the Assembly in January of 2007 and passed that chamber on June 5, 2007. Since then the bill has spent a year being referred and re-referred to various committees nine times. Most recently, on June 11, 2008 the Committee on Health sent the bill back to the senate with a recommendation to pass this measure.

Assembly Bill 1894:
Synopsis: Requires health care service plans, health insurers, and general acute care hospital or health clinics that provide emergency medical care to provide patients testing for the HIV antibodies and the AIDS regardless of whether the testing is related to a primary diagnosis.

Status: This bill was introduced in the Assembly on February 7, 2008 and quickly passed that body on May 27. After being assigned to the Committee on Health the measure received a favorable report from that committee on June 18th and was sent to the Committee on Appropriations for consideration.

Assembly Bill 2899:
Synopsis: Allows publicly funded HIV test sites to advise certain people who have been tested before and are following appropriate public health risk reduction measures that they do not need any further education services, determined whether a person should be allowed to self-administer any data collection forms required by the Department of Public Health. Provides prevention education through video, small groups, individual interaction, or other methods to small groups or couples.

Status: Assembly Bill 2899 was introduced on February 22, 2008 and passed that chamber on April 14th. In the Senate the Bill has been referred to the Committee on Health three times and has been amended three times. On June 18th the bill received a favorable recommendation from the Committee on Health and was sent to the Committee on Appropriations for further consideration.

(continued on page 16)
Senate Bill 1184:
Synopsis: Relates to AIDS reporting. Requires each clinical laboratory to report all CD4 count test results to the local health officer. Requires the local health officer to report to the Department of Public Health if the test result is related to a case of HIV infection or AIDS.
Status: This measure was introduced on February 12, 2008 and passed the Senate on April 21st. In the Assembly the bill passed the Committee on Health as amended and was sent to the Committee on Appropriations for further consideration.

Delaware
House Bill 424:
Synopsis: Requires the defendant to submit to HIV testing at the request of the victim if the defendant has compelled the victim to engage in sexual activity either through force or threat of force; allows the State to continue receiving Violence Against Women Act (VAWA) grant funds.
Status: House Bill 424 was introduced on May 15, 2008. After being considered by the Committee on the Judiciary, this bill was reported without a recommendation and was passed on by the House on June 18th after being amended. The measure is now to be considered by the Senate.

House Bill 486:
Synopsis: Removes the stigma of HIV testing for pregnant women by including it in the standard battery of tests administered for all pregnant women; preserves the right of a pregnant woman to opt out of receiving the test.
Status: This measure was introduced on June 12, 2008 and was assigned to the Committee on Health and Human Development for consideration. On June 19th the committee reported the bill back to the full House without a recommendation.

Senate Bill 305:
Synopsis: Relates to increased HIV testing; authorizes healthcare providers in clinical settings to adopt an HIV opt-out policy in which a patient will have the opportunity to choose to be tested for HIV as part of the patient's routine medical care; eliminates the redundancy in specified provisions of law in order to more seamlessly integrate STD/HIV services.
Status: This bill was introduced on June 12, 2008 and was referred to the Committee on Finance for consideration.

Florida
Senate Bill 1648:
Synopsis: Relates to human immunodeficiency virus testing; requires that when consent cannot be obtained within the time necessary to conduct an HIV blood test on a person and begin prophylactic treatment of exposed medical personnel, the results of the HIV test shall be documented only in the medical file of the medical personnel and not in the medical file of the patient without the patient's consent; requires documentation of the significant exposure requiring testing without valid consent.
Status: This measure was prefiled in the Senate on February 7, 2008. It passed that chamber on April 16th, when it was sent to the House. The House passed the bill on May 2nd and was sent to Governor Crist for his signature on June 13th.

Louisiana
House Bill 1245:
Synopsis: Extends the termination date of the State Commission on HIV, AIDS, and Hepatitis C through September 1, 2010.
Status: House Bill 1245 was introduced on April 22, 2008 and passed that chamber on May 7. The bill then passed the Senate on June 10th and awaits gubernatorial action.

Senate Bill 717:
Synopsis: Provides for blood and saliva testing of a person, at the request of the victim, when there is a bill of information or indictment against such person for certain offenses; relates to testing for sexually transmitted diseases, AIDS, HIV, HIV-1 antibodies or any other probably causative agent of AIDS; provides that a victim may request a follow-up test; provides that test results be disclosed to the victim and the defendant; provides that the results not be disclosed to the court.
Status: This measure was introduced in the Senate on April 21, 2008 and passed that chamber on June 6th. The bill was then adopted by the House on June 20th, and was sent to the governor on June 23rd.

Massachusetts
House Bill 2056:
Synopsis: Requires all state, county and municipal public health facilities to provide services to individuals through the use of hollow-bore needle devices or other technology which minimize the risk of injury to health care workers from hypodermic syringes or needles; require the Department of Public Health to develop rules for implementation.
Status: This measure was introduced in the House in January, 2007. Over the past year and a half, the bill was considered by the Joint Committee on Public Health and the Joint Committee on Health Care Financing; it received a favorable recommendation from both committees. The House took up consideration of the bill on June 11, 2008.

New Hampshire
House Bill 1395:
Synopsis: Establishes the AIDS drug assistance program fund which is to be composed of drug rebates received on drugs purchased under the AIDS drug assistance program; provides the Fund will be nonlapsing and be continually appropriated for the purposes of continuous support for the Program as required; changes a member of the Health Services Planning and Review Board with a representative of county government nominated by the State Association of Counties.
Status: This bill was prefiled in December, 2007 and passed the House on March 18, 2008. The Senate adopted the measure on May 8th after making an amendment. After the House concurred with the Senate’s changes, the Governor signed the bill on June 6th, giving it the force of law.

Senate Bill 395:
Synopsis: Establishes a commission to review the state’s statutes on human immunodeficiency virus education, prevention, and control.
Status: Senate Bill 395 was prefiled in December, 2007. The Senate passed the bill on February 14th, and the House did the same on May 7th. After the Senate concurred with the House’s amendments, the Governor signed the measure on June 11th, giving it the force of law.
New York

Assembly Bill 4813:
Synopsis: Relates to HIV related testing; removes provisions relating to the required written consent for HIV testing; requires a local health officer providing or arranging for an individual diagnosed as having HIV infection to be compelled to disclose confidential HIV related information; increases the penalty to $10,000 for a person who discloses confidential HIV related information.

Status: This measure was introduced on February 6, 2008. After being considered by the Committee on Health, where it was amended three times, the bill was assigned to the Committee on Codes on June 17th.

Assembly Bill 8849:
Synopsis: Requires HIV testing, counseling and education to persons prior to release from a correctional facility on temporary release, parole or supervision.

Status: Assembly Bill 8849 was introduced in June of 2007. After a sitting in the Committee on Corrections for over a year, the assembly passed the measure on June 16, 2008. The Senate adopted it three days later on June 19th. It now awaits gubernatorial action.

Assembly Bill 11461:
Synopsis: Relates to HIV testing; provides consent for such testing; requires offer for such testing; provides confidentiality of HIV related information and disclosure of confidential HIV related information.

Status: This bill was introduced on June 5, 2008. It was considered by the Committee on Health, after which it was assigned to the Committee on Codes on June 17th.

Assembly Bill 11602:
Synopsis: Authorizes the Dormitory Authority and the Department of Health to forgive loans provided to VidaCare, Inc., and its member companies, in 2002 for the preparation of its special needs plan that provides health care services designed to treat people with HIV/AIDS.

Status: This measure was introduced and assigned to the Committee on Corporations, Authorities and Commissions on June 16, 2008.

Assembly Bill 11614:
Synopsis: Provides that demonstration rates of payment for telehealth services by home health agencies, long term home health care and AIDS home care shall be paid to providers in an equitable and direct manner.

Status: Assembly Bill 11614 was introduced and assigned to the Committee on Health on June 16, 2008.

Senate Bill 8604:
Synopsis: Authorizes the dormitory authority and the Department of Health to forgive loans provided to VidaCare, Inc., and its member companies, in 2002 for the preparation of its special needs plan that provides health care services designed to treat people with HIV/AIDS.

Status: This bill was introduced and assigned to the Committee on Rules on June 18, 2008.

Pennsylvania

House Bill 2316:
Synopsis: Makes an appropriation of $214,000 to the Wistar Institute, Philadelphia, for operation and maintenance expenses and of which $92,000 is designated for AIDS research.

Status: This measure was introduced in the House on March 10, 2008 and was assigned to the Committee on Appropriations. That committee reported the bill back to the full House, where it is awaiting further consideration, on June 3. A companion measure (Senate Bill 1472) was introduced in the Senate on June 10th.

Senate Bill 1138:
Synopsis: Amends the Workers’ Compensation Act of 1915. Defines occupational disease. Provides that if a sheriff or deputy sheriff contracts Hepatitis C, there is a presumption that such disease is an occupational disease.

Status: Senate Bill 1138 was introduced in November on 2007 and was assigned to the Committee on Labor and Industry. On June 17, 2008 that committee reported the bill back to the full Senate where it awaits further deliberation.

Rhode Island

House Bill 8271:
Synopsis: Adds a new chapter on the prevention and supervision of contagious diseases, specifically HIV/AIDS; makes technical amendments affected by that new chapter; takes effect on July 1, 2008.

Status: This Bill was introduced on May 13th and was assigned to Committee on Health, Education and Welfare. On June 4, the committee recommended that the measure be held for further study.

South Carolina:

Senate Bill 970:
Synopsis: Relates to confidentiality of sexually transmitted disease records; deletes a provision requiring the department of health and environmental control to notify the school district superintendent and school nurse if a minor is attending a school in the district and has acquired immunodeficiency syndrome or is infected with the human immunodeficiency virus; provides that all records of blood borne diseases are confidential; provides for persons providing care under the Good Samaritan Act.

Status: Senate Bill 907 was introduced on January 9, 2008 and was adopted by that chamber on February 19th. The House then passed this bill on May 29th. However, the Governor vetoed this legislation on June 11th.
NEW YORK

New York's Free Condom Craze Is Stretching To Women

The Health Department signed off on a nearly $2 million deal last week to buy 2 million female condoms, which will be distributed by clinics and organizations throughout the five boroughs, the Daily News has learned.

"I want to make sure there is a female condom in the hands of anyone who wants to use it," said Monica Sweeney, assistant commissioner of the Health Department's HIV Prevention and Control Bureau. "We want females to have this as an alternative if they can't negotiate with their male partner to use a male condom."

The city began offering free female condoms, which are inserted like diaphragms, about 10 years ago but said they have become so popular in the last year that officials had to increase the stash. In 2007, the city distributed 659,000 female condoms, 200,000 more than in 2006, according to the Health Department.

Traditional male condoms continue to dominate the market: The city handed out 37 million last year. Unlike the female condoms, the city's male condoms are branded "NYC Condoms" and are handed out on streets as part of massive promotions, such as February's Valentine's Day campaign.

The agency is doing more education about female condoms to community-based groups and clinics in neighborhoods with high HIV rates, Sweeney said. Already, several of the groups keep them in baskets at HIV awareness fairs alongside male ones. "Many women did not know it was an option - and many women could not afford to purchase them - so we decided to make them available," said Sweeney.

The female condoms run about $3 each, compared with $1 for ones for males, Sweeney said. A spokeswoman for Planned Parenthood of New York City praised the city for purchasing $1.9 million worth of female condoms, saying, "The more it becomes available and the more it becomes mainstream, I suspect more women will use it. It gives them a choice."

New Yorkers who want a free female condom can contact the Department of Health at nyc.gov/html/doh or call 311, Sweeney said. (By Kathleen Lucadamo, Daily News City Hall Bureau)

DELWARE

Bill Would Allow HIV Testing Of Rape Defendants

The Delaware House of Representatives has passed legislation that would help rape victims get health information about their assailants. The bill sponsored by Rep. Debbie Hudson, would require that the defendant in a rape case take an HIV test if the victim requests it. The Greenville Republican says having the test done quickly can allow a victim to begin immediate treatment, if needed. If it becomes law, the bill would also allow the state to apply for federal grant money under the Violence Against Women Act. (Associated Press)

ALASKA

Alaska Rates Rank High In Chlamydia, Low In HIV
There Were 1,206 Known HIV Cases In State From 1982 To 2007

Fairbanks, Alaska continues to rank high nationally in the rate of Chlamydia cases but relatively low in the most serious sexually transmitted diseases, HIV, according to reports by the state Division of Public Health. The 2006 figures were compiled by the Centers for Disease Control. Alaska ranked first or second in Chlamydia, 25th in gonorrhea and 28th in syphilis but low in HIV. "We have a low prevalence rate in the state and we would like to stay that way," said Mollie Rosier, manager of the Section of Epidemiology's HIV/STD program. The most common method of HIV transmission in Alaska was men having sex with men. Other categories included heterosexual contact with a partner known to have HIV or injection drug use. Rosier said statistics were divided into two time periods because there were not enough cases for year-to-year analysis: 1982-2002 and 2003-2007.

There were 1,206 known HIV cases in Alaska from 1982 to 2007. Thirty-seven first-known HIV diagnosis cases occurred in 2007. Of the cases reported, 81 percent of people with the disease were males and 58 percent were white. The Chlamydia bulletin said the disease plays a role in facilitating HIV transmission. However, with such a high rate of Chlamydia and such a low rate of HIV, it was impossible to tell if Chlamydia played a role in contraction of HIV in Alaska, Rosier said The bulletin stated that 4,911 cases of Chlamydia were reported in Alaska during 2007, an 8 percent increase over 2006. That was part of a significant increase of Chlamydia cases in Alaska since 1996, reaching a rate of 49 cases per 100,000 people on average.

The program's Donna Cerere prepared the bulletins and said there was no easy or simple answer to why Alaska has such a high rate of Chlamydia and gonorrhea. The rise could be a byproduct of a more sensitive test, she said. Chlamydia and gonorrhea can be treated with antibiotics. However, the more times a woman contracts the disease, the higher the risk of infertility, Cerere said.

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The city began offering free female condoms, which are inserted like diaphragms, about 10 years ago but said they have become so popular in the last year that officials had to increase the stash. In 2007, the city distributed 659,000 female condoms, 200,000 more than in 2006, according to the Health Department.

Traditional male condoms continue to dominate the market: The city handed out 37 million last year. Unlike the female condoms, the city's male condoms are branded "NYC Condoms" and are handed out on streets as part of massive promotions, such as February's Valentine's Day campaign.

The agency is doing more education about female condoms to community-based groups and clinics in neighborhoods with high HIV rates, Sweeney said. Already, several of the groups keep them in baskets at HIV awareness fairs alongside male ones. "Many women did not know it was an option - and many women could not afford to purchase them - so we decided to make them available," said Sweeney.

The female condoms run about $3 each, compared with $1 for ones for males, Sweeney said. A spokeswoman for Planned Parenthood of New York City praised the city for purchasing $1.9 million worth of female condoms, saying, "The more it becomes available and the more it becomes mainstream, I suspect more women will use it. It gives them a choice."

New Yorkers who want a free female condom can contact the Department of Health at nyc.gov/html/doh or call 311, Sweeney said. (By Kathleen Lucadamo, Daily News City Hall Bureau)
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