



Gay Men's Health Crisis 2007 FEDERAL LEGISLATIVE AGENDA

A national platform for prevention,
access to treatment and care,
civil rights, and human rights

GMHC

I. SCIENCE-BASED PREVENTION, RESEARCH, AND STRUCTURAL INTERVENTIONS

The Microbicides Development Act (H.R. 1420 and S. 823): research and development

From a biological standpoint, women are two to four times more susceptible than men to sexually transmitted HIV infection. For many, lack of economic and social power, including the power to control sexual encounters or insist on protective measures, compounds their risk of contracting HIV, even if they are married and/or have only one partner. The results have been lethal to women, devastating to families, and hazardous to children.

AIDS is now the number one cause of death in the United States among African American women aged 25–34. In New York State, women and girls constitute 48% of newly infected individuals between the ages of 13 and 19. We will only see these rates decline when user-controlled HIV-prevention tools are researched, developed, and readily attainable. One of the most promising prevention tools is microbicides. Microbicides, both vaginal and rectal, are a new class of topical products under development—in the form of a gels, creams, films, vaginal rings or suppositories—that will reduce the risk of transmission of HIV and other sexually transmitted diseases.

Microbicides were hailed as one of the world's most promising new HIV-prevention technologies at 2006 International AIDS Conference in Toronto. Scientists estimate that a safe and effective microbicide could be available within five to seven years and that the impact would be considerable. Mathematical models predict that even a partially-effective microbicide could avert 2.5 million new HIV infections in women, men, and children in any given three year period.

The time to act is now. The Microbicide Development Act (MDA) would strengthen and accelerate microbicide research and development. A decision by the U.S. to exercise leadership in advancing these efforts may well alter the fate of millions of women worldwide. ***GMHC calls for the passage of the Microbicides Development Act to:***

- **authorize funding increases as needed for the development of microbicides at the CDC, NIH and USAID**
- **require coordination between NIH and other federal agencies supporting microbicide development**
- **ensure a single line of administrative accountability and funding coordination through the establishment of a dedicated unit for microbicide research and development within the National Institute of Allergy and Infectious Diseases**

Preventing HIV transmission associated with syringe sharing

Syringe sharing and sexual transmission from HIV+ drug users to their partners account for over one-third of HIV cases in the United States. Outside of sub-Saharan Africa, an estimated one-third of all HIV cases worldwide can be traced to injection drug use.

Syringe exchange, which allows injection drug users to trade used needles for sterile ones, is a proven means of reducing HIV transmission without increasing rates of drug use. Its effectiveness has been borne out by study after study throughout the epidemic, including a recent evaluation of forty syringe exchange programs sponsored by the United States Public Health Service. This survey concluded that these programs:

- help drug users significantly reduce behaviors associated with HIV infection
- produce no increase in injection drug use in communities where they operate
- serve as an effective gateway to drug treatment and other health and social services
- are cost-effective

Nearly twenty years ago, the efficacy of syringe exchange was recognized in a report published by the United States Department of Health and Human Services. Over ten years ago, syringe exchange was endorsed as an effective method of HIV prevention by the National Commission on AIDS, the New York State AIDS Advisory Council, the New York State Office of Alcohol and Substance Abuse Services, and the New York City Department of Health, among others. Yet despite these acknowledgements and two decades of irrefutable evidence, a federal ban on funding domestic and international syringe exchange programs remains in place. This policy imperils the estimated one million people in the U.S. who inject drugs regularly, injection drug users worldwide, and sexual partners of injection drug users. ***GMHC urges an end to the federal ban on syringe exchange and calls for legislative and administrative action to:***

- **strike language in appropriations bills that ban use of federal funds for syringe exchange**
- **direct the Centers for Disease Control and Prevention to allow use of HIV prevention funds for syringe exchange domestically**
- **instruct the Office of the Global AIDS Coordinator to allow use of HIV prevention funds for syringe exchange internationally**

The PATHWAY Act: meaningful HIV prevention for women and girls

Worldwide, new HIV infections among females are rising with staggering velocity. In sub-Saharan Africa, women and adolescent girls make up sixty percent of HIV+ people. In most countries that receive HIV/AIDS funding from the United States it is women who bear the brunt of the epidemic. Many contract HIV in the context of marriage. Yet, the ABC model, “Abstain, Be faithful, use Condoms,” promoted by the United States does not recognize the reality of women’s lives in the U.S. or abroad. It fails women and youth who may not be in negotiating positions when it comes to whether or not they have sex and/or whether or not they use a condom. Not only do current U.S. policies fail to acknowledge factors that put women at increased risk for HIV infection—such as violence and lack of economic opportunities—they undermine comprehensive approaches to HIV prevention. The global consequences of U.S. adherence to ABC continue to devastate women and girls worldwide. The Protection Against Transmission of HIV for Women and Youth (PATHWAY) Act would go a long way toward rectifying this profound lapse in U.S. global AIDS policy. ***GMHC strongly supports the PATHWAY Act which would:***

- **mandate that the President and the Office of the Global AIDS Coordinator (OGAC) to establish a comprehensive and integrated HIV prevention strategy to address the distinct vulnerabilities of women and girls to HIV infection**
- **strike the earmark requiring that one third of all prevention funding be allocated to abstinence-until-marriage programs**
- **remove ideological restrictions on HIV prevention policies**

The REAL Act: comprehensive sex education saves lives

One-quarter of all new HIV infections in the United States occur in people under the age of twenty-one. Each year, U.S. teens contract roughly four million sexually transmitted infections (STIs). Statistics for unintended pregnancies among adolescent girls range between 592,000 and 760,000 annually. These numbers testify to the desperate need for age-appropriate, comprehensive education on HIV, STIs, and pregnancy protection. Yet, from 1996 through 2005 Congress committed over \$1.1 billion to abstinence-only-until-marriage programs and no funds whatsoever to comprehensive sex education.

Researchers have not identified a single “abstinence-only until marriage” program that has been successful in reducing sexually transmitted infections or pregnancy. Evaluations from thirteen states indicate that abstinence-only programs have no long-term impact on teens’ sexual behavior and, in fact, may produce deleterious results. Virginity pledges have proven particularly ineffective, with over than 88% of participants breaking their pledge and having premarital sex. More troubling, pledge takers were less likely than their non-pledging peers to use contraception and/or condoms.

On the other hand, studies have consistently shown that comprehensive sex education helps young people to make healthy decisions about sex. Adolescents who receive accurate information about contraception and condoms are more likely than those who receive abstinence-only messages to use contraceptives once becoming sexually active. They are also, in point of fact, more inclined to delay sexual activity. Research has confirmed that comprehensive sex education programs do not encourage teens to start having sexual intercourse; do not increase the number of a teen’s sexual partners; and do not increase the frequency with which teens have intercourse. ***GMHC calls for passage of the Responsible Education About Life (REAL) Act. The REAL Act would:***

- **establish a \$206 million federal grant program (administered by the Department of Health and Human Services) for states for comprehensive sex education**
- **permit states to secure this funding without having to promise to teach an exclusive abstinence-only-until-marriage curriculum**

In addition, GMHC supports the Prevention First Act (H.R. 819/ S. 21).

The JUSTICE Act (H.R. 178): slowing the epidemic and expanding care in U.S. prisons

HIV infection is ten times more widespread in U.S. prisons than in the general public. According to a 2003 Bureau of Justice Statistics report, 1.9% of prisoners nationally were HIV+; while in New York State the numbers are much higher at 7.6%.

Prevention efforts in U.S. prisons are stymied by the unavailability of condoms—a critical factor in fueling HIV transmission. Treatment and services for many prisoners living with HIV remain grossly inadequate. In many instances, an individual's status is revealed, leaving him or her susceptible to violence and harassment from prison staff and other inmates, segregation, and other institutional policies founded on HIV discrimination and stigma. Finally, underreporting, a lack of up-to-date and comprehensive research, and inconsistencies between stated policy and institutional practice have long hindered the development of effective HIV prevention and treatment policy in U.S. prisons.

GMHC is committed to ending the spread of HIV within U.S. prisons and to the well-being of prisoners living with HIV and AIDS. We call for a broad, effective strategy to address HIV in prisons. This must include policies that: expand HIV testing based on informed consent; protect confidentiality; improve HIV education for prison inmates, officers, and staff; make effective HIV prevention strategies available to prisoners; guarantee access to comprehensive treatment for HIV+ prisoners; and develop effective discharge policies for prisoners living with HIV. ***To these ends, GMHC strongly endorses the Justice for the Unprotected against Sexually Transmitted Infections among the Confined and Exposed (JUSTICE) Act which would:***

- **permit community organizations to distribute condoms in federal prisons**
- **recommend states to do the same**
- **call for annual review of prevention policies for HIV and other STIs in federal and state correctional facilities**

Likewise, GMHC calls for further legislation that would:

- **provide comprehensive HIV education and services for all prisoners and prison staff**
- **guarantee access to comprehensive treatment and care for all prisoners living with HIV and Hepatitis C**
- **protect the confidentiality of the HIV status of prisoners**
- **develop effective re-entry programs that safeguard continuity of care**
- **expand HIV testing for prisoners with the provisos of pre- and post-test counseling and written informed consent**

II. Access to Treatment and Care

Safeguarding Medicaid

Medicaid is the number one public payer of HIV and AIDS care and treatment in the United States. Without it, there would be no meaningful HIV care for poor and low-income people with HIV. Nationwide, 55% of all people living with AIDS (including 90% of all children living with AIDS) access health care through Medicaid. We can do more.

Early access to care and treatment can delay the progression from HIV to full-blown AIDS. Yet, many states withhold Medicaid benefits until applicants are disabled by AIDS, effectively shutting low-income people with HIV out of treatment that can slow the advance to AIDS and prevent debilitating—and often life-threatening—opportunistic infections. ***GMHC strongly endorses passage of the Early Treatment for HIV Act (ETHA) with would allow states to amend their Medicaid eligibility requirements to include uninsured, predisabled poor and low-income people living with HIV.***

Merely enrolling people in Medicaid is not enough. States must be required to provide Medicaid recipients with access to comprehensive treatment consistent with the HIV standard of care and other fundamental medical practice standards. This must not be contingent on ability to pay. We urge Congress to make this a federal budget priority. The Deficit Reduction Act (DRA) passed in 2006 cleared the way for states to eviscerate Medicaid; to restrict, and in many cases eliminate, health care for the nation's poor. The imposition of cost-sharing and benefit limits have already resulted in diminished care and outcomes around the country. Furthermore, less than a year after its enactment, the DRA's citizenship documentation requirements have reversed a decade of progress in streamlining access to Medicaid eligible people. Several states across the country are reporting enormous drops in enrollment, as applicants and beneficiaries are unable to supply the requisite documentation. Overwhelmingly, these are U.S. citizens, primarily children and the working poor. Proof of citizenship criteria has become an insurmountable obstacle to those who are in most need of Medicaid. ***GMHC calls on Congress to maintain the federal government's matching financing for Medicaid and to repeal the Medicaid cuts and citizenship requirements in 2006 DRA.***

Strengthening Medicare and ADAP

Medicare is the nation's second largest public payer of HIV and AIDS care and treatment. The vast majority of recipients with HIV/AIDS are dually eligible for Medicare and Medicaid. Medicare Part D, launched one year ago, imposed increased cost-sharing, decreased formularies, and near insurmountable bureaucracy on an already vulnerable population (both dual eligibles and those qualified for the low income subsidy) whose very lives depend on uninterrupted access to prescription drugs.

CMS guidelines require that Part D plans cover "all or substantially all" drugs in six designated classes, one of which is antiretrovirals (ARVs). This is insufficient to guarantee HIV+ Medicare recipients ongoing access to their current medication or access to ARVs that may become available in the future. Part D plans must be required to cover ARVs within thirty days of their approval by the FDA. Newly approved ARVs must be added to plan formularies on an accelerated schedule to assure people with HIV who are resistant or nonresponsive to older drugs can get the treatment they need. ***GMHC calls for the enactment of legislation that would:***

- **permanently protect these six classes**
- **allow for the inclusion of additional classes as necessary**
- **legislate prohibitions on prior authorization and step therapy for ARVs**
- **mandate the inclusion of all newly approved ARVs in all Part D formularies within 30 days of their approval by the FDA**

ARVs are just the beginning. HIV+ individuals have multiple chronic conditions and complex medication regimens that must be carefully balanced and maintained. Protocols around HIV drug interactions are frequently adjusted as new information becomes available and patient needs change. According to Health and Human Services guidelines, incorrect pairings can alter the potency of both the HIV and non-HIV drugs. Medical providers have reported that their HIV+ patients are having difficulty accessing prescription drugs for pain, hepatitis, hypertension, HIV-related opportunistic infections, mental illness, and side effects caused by HIV medication. Proper management of medication demands the ability to access the right drug regardless of cost without delay. Even 'nominal' co-payments of \$3 or \$5 add up to an impossible burden for poor and low-income recipients who may take upwards of fifteen medications daily. Co-pays are not the means toward Medicare savings. ***GMHC calls for a cap on cost-sharing for Medicare recipients eligible for the low income subsidy program. We further call on Congress to pass the Medicare Prescription Drug Price Negotiation Act of 2007 to:***

- **require the federal government to negotiate drug prices on behalf of Medicare recipients**
- **prohibit the establishment of a formulary**

AIDS Drug Assistance Programs (ADAPs) have stepped in to help Part D recipients in some states cover co-payments, deductibles, and other cost-sharing. Currently, this ADAP supplement cannot be counted toward an individual's "True Out Of Pocket" (TrOOP) costs which must be met before a recipient can climb out of the "doughnut hole" and again receive Part D coverage. Consequently, ADAPs may be covering beneficiaries' entire prescription drug costs for the remainder of a given calendar year. In other words, ADAPs—already under-funded—are, in effect, underwriting Part D plans. This is untenable. ***GMHC strongly recommends that these ADAP payments count toward the TrOOP limit.***

Expanding access for people with disabilities

Under the current system, people who have been deemed seriously and permanently disabled by the Social Security Administration must endure a waiting period of nearly two and half years before they can receive Medicare. The resulting financial burden shifts to individuals and families who may be under- or uninsured, and to Medicaid. Most disturbing is that this policy forces many people with HIV/AIDS to delay vital treatment and care, leading in turn to compromised—even life-threatening—health outcomes. When they do finally receive care, their condition has often deteriorated to the point where treatment is more costly. ***GMHC calls for an end to the two-year Medicare waiting period for non-elderly people who meet federal disability criteria.***

Protecting patient privacy and confidentiality in medical data management

Currently, many states' privacy protections for HIV/AIDS and Medicaid/Medicare information are stronger than the Federal Health Privacy Rule. Previous attempts have been made to have these tougher state laws automatically default to the weaker federal protections. ***GMHC calls on legislators to ensure that federal legislation on health information technology and data management maximizes protection of patient privacy and confidentiality.***

III. Legislative and Administrative Responses to Discrimination

Immigration policy that protects public health and human rights

2007 will mark the 20th year that U.S. policy has banned HIV+ noncitizens from entering the U.S. and barred those already living here from attaining most types of legal status (except in extremely limited circumstances). The longevity of this policy rests on two resilient myths, namely that it protects public health and that it protects public coffers. The truth is, the bar undermines public health and drives up the cost of health care. It forces HIV+ immigrants to go underground, actively discourages immigrants who don't know their status from getting tested, from seeking preventive care, from seeking any care until they end up in the emergency room with full blown AIDS—all things that undermine individual health and public health and that ultimately put more strain on the public coffers.

The HIV bar has wrought AIDS-related fatalities abroad, as individuals are unable to access life-saving medications or are targeted for violence based on HIV status or real or presumed sexual orientation; and significant health risks inside the U.S., as immigrants, and visitors either are actively deterred from seeking HIV testing and treatment or avoid contact with providers out of fear of putting their immigration status in permanent limbo. If they are low-income or poor, they either don't have recourse to the full slate of public programs and services they need to stay healthy or are unaware of what services they are entitled to access.

In 1991, bowing to the expertise of roughly two hundred health organizations, including the American Medical Association, the World Health Organization, and the American Public Health Association, the Department of Health and Human Services reversed its position and tried to overturn the bar. Congress responded by writing the policy into law.

The HIV bar was born of fear and intolerance and fails even by its own logic. At GMHC we view this policy as a violation of human rights and a threat to public health inside and outside the U.S.—Congress can right this wrong. This has been done before: tuberculosis and leprosy were removed as grounds for exclusion decades ago (unless active or infectious, respectively). Epilepsy was deleted as grounds for exclusion in 1965 because medical advances brought this condition under control with medication. HIV too is treatable and for most infected individuals undergoing treatment, it is now a manageable, chronic illness. ***We call on Congress to change the Immigration Naturalization Act to eliminate HIV/AIDS as grounds for inadmissibility as a communicable disease of public health significance. We further urge passage of legislation granting permanent residence to immigrants facing extreme medical hardship in their countries of origin.***

Ending discrimination against gay and MSM blood donors

Despite dangerous shortages in the nation's blood banks, the Food and Drug Administration (FDA) continues to adhere to its ban on male donors who have sex with men. Under FDA guidelines, a man who has had sex with another man (MSM) since 1977 is ineligible to donate blood. Ever.

The bar on MSM donors is a holdover from a time when panic and discrimination drove health policy. In the twenty-plus years since the ban was enacted, scientific knowledge on blood screening and assuring the safety of transfusions has grown significantly. In March 2006, The American Association of Blood Banks, America's Blood Centers, and the American Red Cross (a one time backer of the ban) petitioned the FDA to repeal its lifetime prohibition against blood donations by men who have sex with men, calling it "medically and scientifically unwarranted."

The cost of discrimination is high. In California, officials in one school district have recently indicated that they may end blood drives in city schools if students are compelled to disclose information about their sexual activity. In the New York region, the blood supply is at five-year low. While this policy stigmatizes MSM and men who identify as gay, anyone who needs blood will pay the price. ***GMHC calls for end to the unjustifiable ban on MSM blood donors.***

ENDA: guaranteeing civil rights for all workers

Currently, federal law provides basic legal protection against employment discrimination on the basis of race, gender, religion, national origin, and/or disability. Notably absent from this list of protected categories are sexual orientation, gender identity, and gender expression. In thirty-three states it is legal to fire someone based on their sexual orientation. In forty-three states it is legal to discriminate in employment on the basis of gender identity or expression. The Employment Non-Discrimination Act (ENDA) would make it unlawful to refuse employment to, or fire, an individual based on that individual's real or perceived sexual orientation or gender identity or expression.

Passage of ENDA is an essential step towards securing fundamental civil rights protections. Because health insurance is tied to employment for many people in the U.S., enactment of this legislation is particularly urgent for lesbian, gay, bisexual, and transgender workers with HIV and AIDS. ***GMHC urges passage of the Employment Non-Discrimination Act.***

IV. Appropriations and Implementation of Critical Services

FY 2008 appropriations for federal HIV/AIDS programs

A meaningful commitment to stemming the epidemic and securing the well-being of people with HIV cannot be met without adequate appropriations for effective prevention; comprehensive research; affordable, quality health care and support services; and housing.

The Ryan White CARE Act (RWCA)

The Ryan White CARE Act (RWCA) was enacted to address the complex realities of people living with HIV and AIDS: medical and emotional needs as well as social and financial barriers to care. Reauthorized this year, the RWCA provides critical funding for primary health care and support services for people with HIV and AIDS in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. These include outpatient medical care, housing assistance, psychological counseling, dental care, legal services, home health care, transportation, and life-saving prescription drugs. Title I funds cities designated as Eligible Metropolitan Areas (EMAs); Title II funds states; Title III funds community health centers; and Title IV funds services for HIV+ children and their families.

In reauthorizing the RWCA this year, Congress has recognized and responded to new high need areas whose funding requirements have been overlooked for too long. Unfortunately, because the RWCA was not sufficiently funded at the outset, much of this money was moved from other locales, including HIV/AIDS epicenters. For example, New York City and New York State stand to lose roughly \$25 million and \$9 million respectively. These numbers represent devastating cuts to desperately needed programs. ***HIV/AIDS care and support must not be reduced to a zero sum equation. Moving forward, GMHC calls for full funding. The RWCA must be appropriated at sufficient levels.***

Housing for People Living With HIV and AIDS (HOPWA)

For people living with HIV and AIDS, a stable home can mean the difference between life and death. Without it, medical appointments are missed; the likelihood of hospitalization increases; treatment adherence is compromised; and nutrition and hygiene become impossible to maintain. The Department of Housing and Development's Housing for People Living With HIV and AIDS (HOPWA) program supports local jurisdictions in developing a broad range of housing to meet community needs. It is the only federal program dedicated to the housing needs of HIV+ low-income people and their families. This year's appropriation of \$286 million funds 122 grantee areas nationwide. The President has proposed a \$14 million increase in HOPWA funding for FY08. This request is represents a gross underestimation of the centrality of housing in HIV/AIDS care and treatment. ***GMHC urges Congress to increase HOPWA funding by \$138 million for a total allocation of \$454 million and to allow localities the flexibility to use HOPWA allocations for construction and/or operational and support services.***

GMHC requests funding at the following levels as per the AIDS Budget and Appropriations Coalition's request.

(Increases or decreases from previous fiscal year are shown in parentheses; fiscal year 2008 requests reflect increase over FY 2007)

	FY 2005 Final¹	FY 2006 Final²	FY 2007 Joint Resolution	FY 2008 President's Budget Request	FY 2008 Coalition Request		
HRSA	HRSA: Ryan White CARE Act Total	\$2,048 m (+ \$28.4 m)	\$2,036 m (- \$10 m)	\$2,112 m (+ \$75.8 m)	\$2,133 m (+ \$21 m)	\$2,794.3 m (+ \$682 m)	
	Title I	\$610.1 m (- \$4.92 m)	\$604 m (- \$6.1 m)	\$604 m (+ \$0 m)	\$604 m (+ \$0 m)	\$840.4 m (+ \$236.4 m)	
	Title II: Care	\$334.3 m (- \$2.73 m)	\$331 m (- \$3.3 m)	\$406 m (+ \$75.8)	\$400.98 m (- \$5.02 m)	\$463.4m (+ \$56.9 m)	
	Title II: ADAP	\$787.3 m (+ \$38.41 m)	\$789.1 m (+ \$2.2 m)	\$789.1 m (+ \$0 m)	\$814.5 m (+ \$25.4 m)	\$1,022 m (+ \$232.9 m)	
	Title III	\$195.6 m (- \$1.6 m)	\$193.5 m (- \$2.0 m)	\$193.5 m (+ \$0 m)	\$199.82 m (+ \$6.32 m)	\$281.3 m (+ \$87.8 m)	
	Title IV	\$72.53 m (- \$0.58 m)	\$71.8 m (- \$0.73 m)	\$71.8 m (+ \$0 m)	\$71.8 m (+ \$0)	\$118.2 m (+ \$46.4 m)	
	Part F: AETCs	\$35.06 m (- \$0.28 m)	\$34.7 m (- \$0.36 m)	\$34.7 m (+ \$0 m)	\$28.7 m (- \$6 m)	\$50.0 m (+ \$15.3 m)	
	Part F: Dental	\$13.22 m (- \$0.11 m)	\$13.1 m (- \$0.12 m)	\$13.1 m (+ \$0 m)	\$13.1 m (+ \$0)	\$19 m (+ \$5.9 m)	
	(SPNS)	(\$25.0 m)	(\$25.0 m)	(\$25.0 m)	(\$25.0 m)	(\$25.0 m)	
	HRSA: Community Health Centers	\$1,734 b (+ \$116.4 m)	\$1,782 b (+ \$48 m)	\$1,989 b (+ \$206.9 m)	\$1,944 b (- \$45 m)	\$2,189b (+ \$200 m)	
	HRSA: Title X	\$286 m (+ \$7.7 m)	\$283.14 m (- \$2.86 m)	\$283.10 m (- \$0.4 m)	\$283.1 m (+ \$0 m)	\$385 m (+ \$101.9 m)	
	Total-HIV, STD, TB, Hep line	\$960.7 m (- \$2.2 m)	\$963.8 m (- \$14.2 m)	\$963.8 m (+ \$0 m)	\$1,056.8 m (+ \$93 m)	\$1,597.3 m (+ \$633.5 m)	
	CDC	HIV Prevention & Surveillance	\$662.3 m (- \$5.6 m)	\$651.7 m (- \$11.2 m)	\$651.7 m (+ \$0 m)	\$745.1 (+ \$93.4 m)	\$1,049.2 m (+ \$397.5 m)
		STD Prevention	\$159.6 m (+ 1.0 m)	\$157.3 m (- \$1.6 m)	\$157.3 m (+ \$0 m)	\$157.3 (+ \$0 m)	\$267.3 m (+ \$110 m)
TB Prevention		\$138.8 m (+ \$1.4 m)	\$136.7 m (- \$0.8 m)	\$136.8 m (+ \$0 m)	\$136.8 (+ \$0)	\$252.4 m (+ \$115.7 m)	
Viral Hepatitis		\$17.91 m (+ \$.31 m)	\$17.58 m (- \$0.24 m)	\$17.59 m (+ \$0 m)	\$17.59 (+ \$0)	\$28.4 m (+ \$10.8 m)	
DASH-HIV Prevention Education		\$42.5 m (- \$4.52 m)	\$42.09 m (- \$0.41 m)	\$42.09 m (+ \$0 m)	\$42.09 m (+ \$0)	\$66.64 m (+ \$24.55 m)	
HUD		HOPWA	\$281.8 m (- \$13.1 m)	\$286.1 m (+ \$4.3 m)	\$286.1 m (+ \$0 m)	\$300 m (+ \$13.9 m)	\$454 m (+ \$137.9 m)
	Minority HIV/ AIDS Initiative (across multiple programs)	\$398.9 m (- \$5.05 m)	\$398.9 m (- \$4 m)	\$399.2 m (+ \$0.3 m)	\$398.2 m (- \$1 m)	\$610 m (+ \$210.8 m)	
Other HHS Programs	NIH³	\$28.49 b (+ \$830 m)	\$28.35 b (- \$ 45 m)	\$28.93 b (+ \$619.5 m)	\$28.62b (- \$310 m)	\$32.83 b (+ \$1.65 b)	
	AIDS Research⁴	\$2,920 b (+ \$75 m)	\$2,903 b (- \$17 m)				
	ACF: Abandoned Infants Assistance	\$12.05 m (+ 0)	\$11.84 m (- \$0.21 m)	\$11.84 m (+ \$0 m)	\$11.84 (+ \$0)	TBD	
	ACF: Community-Based Abstinence Education	\$104.5 m (+ \$31.5 m)	\$113 m (+ \$8.5 m)	\$113 m (+ \$0 m)	\$141 m (+ \$28 m)	\$0 (- \$113 m)	
	SAMHSA: Center for Substance Abuse Treatment	\$422.5 m (+ \$3.3 m)	\$398.95 m (- \$23.55 m)	\$399 m (+ \$0 m)	\$352 m (- \$47 m)	\$410.0 m (+ \$11.1 m)	
	Substance Abuse Block Grant	\$1,776 m (- \$4 m)	\$1,758.6 m (- \$17.4 m)	\$1,758.6 m (+ \$0 m)	\$1,758.6 m (+ \$0)	\$1,858.6 m (+ \$100 m)	
	SAMHSA: Center for Substance Abuse Prevention	\$198.7 m (+ \$0.3 m)	\$192.9 m (- \$5.8 m)	\$193 m (+ \$0 m)	\$156 m (- \$36 m)	\$210.0 m (+ \$17.1 m)	
	SAMHSA: Center for Mental Health Services (CMHS)	\$901.3 m (+ \$38.9 m)	\$883.2 m (- \$17.05 m)	\$883 m (- \$0.2 m)	\$807 m (- \$76 m)	\$959.3 m (+ \$75.1 m)	
Subset of CMHS: Mental Health Block Grant	[\$432.7 m] (- \$2.1 m)]	[\$428.65 m] (- \$4.05 m)]	[\$428.47 m] (- \$0.18 m)]	[\$428 m] (+ \$0 m)]	(+ \$75.1 m) [+ \$32.3 m)]		

1 The Omnibus FY 05 Appropriations bill calls for an across the board 0.8% rescission and is reflected in these figures

2 The FY 06 Appropriations bill calls for an across the board 1% rescission and is reflected in these figures

3 This refers to the NIH Discretionary Budget Authority as defined by the Administration.

4 The House and Senate Appropriations bills do not include a funding line for the Office of AIDS Research. This number is determined by the NIH Director and OAR Director after the final appropriation is received. Funding for AIDS research is approximately 10% of the NIH budget.

Health worker initiative: addressing the critical shortage of doctors, nurses, midwives, pharmacists, and community health workers in Africa

Over sixty-two percent of people living with HIV live in Africa, but the continent has just three percent of the world's health care workers. The World Health Organization (WHO) reports that Africa is experiencing a shortfall 1.5 million health workers—a scarcity attributable to inadequate training capacity, insufficient funding for wages, widespread emigration of health workers seeking stable employment in better-resourced countries, and AIDS itself which has killed thousands of health workers across the continent.

The global AIDS epidemic will never be stemmed as long as the hardest hit countries must cope with desperately impoverished health care systems. According to WHO, thirty six African nations are very unlikely to meet health-related Millennium Development Goals with their current numbers of health workers. The U.S. has the power to change that outcome. ***GMHC supports the addition of \$8 billion in new funds over five years for training, retention and support for the healthcare workers necessary to ensure universal access in focus-countries in Africa. As a first step towards this goal, we support the African Health Capacity Investment Act of 2007 which would authorize \$150 million for FY08, \$200 million for FY09, and \$250 million for FY10.***

Protecting health care from sunset commissions and the line item veto

GMHC is extremely concerned about attempts to grant the President line item veto authority and to establish sunset commissions—two measures that pose serious risks to people with HIV and to the millions of children, seniors, people with disabilities, pregnant women, and working families who rely on Medicaid, Medicare, and the State Children's Health Insurance Program (SCHIP).

Presidential authority to reject individual items within spending bills passed by Congress would pose a grave threat to critical discretionary and entitlement programs. Likewise, the establishment of sunset commissions would jeopardize not only Medicaid and Medicare, but key social services that beneficiaries rely on, such as food assistance, housing, employment, and training. Medicare, Medicaid, SCHIP, and other programs that enjoy broad support throughout the country could be revamped or even eliminated by a narrow, partisan majority should Congress allow these commissions to move forward. Significant changes and cutbacks to Medicaid, Medicare and SCHIP could be fast-tracked through Congress with very little debate. Congress already has a method for reviewing federal programs and making necessary legislative changes. Committee members (and their staff) responsible for authorizing and appropriating develop substantial policy knowledge about programs under their jurisdiction(s) that would exceed the grasp of a short-lived commission. ***GMHC calls on Congress to oppose any attempt to grant the President line-item rescission authority and to reject any attempt to establish a sunset commission that would subvert the political process and place recipients of Medicaid, Medicare, and other life-sustaining social services in jeopardy.***

Addressing medical, social service, and housing shortages in Puerto Rico

People with HIV and AIDS in Puerto Rico are being compelled to ration their medication. Others take whatever medication is available. Many are still on waiting lists for prescription drug assistance. Medical providers are operating with little or no money; some have not been paid in six months. The reason is the unstable distribution of Ryan White CARE Act (RWCA) Title I and Title II funds. Shortfalls in money for care and treatment have raised charges of corruption and negligence.

The situation on the Island is a calamity for HIV+ people and GMHC fears it will further deteriorate if action is not taken. ***We call for the implementation of system of fund dispersal through a third party and a federal presence on the Island with oversight responsibilities for RWCA funds.***

Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. Our Mission is to reduce the spread of HIV disease, help people with HIV maintain and improve their health and independence, and keep the prevention, treatment and cure of HIV an urgent national and local priority. In fulfilling this Mission, we will remain true to our heritage by fighting homophobia and affirming the individual dignity of all gay men and lesbians.

For more information, please call the Hotline or visit our Web site.

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