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Dear:

I would like to take this opportunity to introduce you to the National HIV/HCV Co-Infection Coalition, a national body of professional service providers and community advocates with expertise in the area(s) of hepatitis C virus (HCV), HIV infection and substance abuse. Our coalition has had first-hand experience dealing with the clinical and societal impact of HIV/HCV co-infection. To this end we have established a coalition that will work to address the issues of co-infected individuals.

We want to alert you to the issues regarding HIV/HCV coinfection. We believe that these issues should be included in the agenda of the U.S. House of Representatives and the U.S. Senate. We are certain that Congress shares our concern about the growing spread of HCV in communities around the nation and its impact on disenfranchised communities and the healthcare delivery system.

Hepatitis C has been designated as an opportunistic infection of HIV disease. In the HIV community an estimated 30% of the 900,000 HIV-positive individuals are co-infected with HCV. 60-90% of individuals who acquired HIV through intravenous drug use are thought to be HCV infected as well. In 2002, injection drug use was the leading mode of transmission for an estimated 25,000 new HCV infections. Unfortunately, many injection drug users are disenfranchised from the health care system because they are uninsured or underinsured, or dealing with multiple diagnoses: HIV, HCV, addiction and mental illness. Among people of color HCV and HIV are more prevalent. HCV progression may be accelerated by up to five fold in people with HIV. End-stage liver disease resulting from HCV infection has become a leading cause of death among people with HIV.

Access to HCV treatment for HIV-positive individuals has been severely limited. Only seven ADAPs (AIDS Drug Assistance Programs) have been able to include HCV treatment in their formularies. Funding for ADAPs must be increased so that they are able to provide treatment for HIV and HCV to all who require it. HCV diagnostic testing is not universally covered by ADAPs or Medicaid. Funding must be made available to assure that all HIV-positive individuals have access to HCV testing, counseling and prevention (which has been recommended by the CDC).

An environment of HCV awareness must be created at the federal level to insure that funding is available for testing and specialized patient support services at community based organizations. Programming should target service providers working in HIV, medical providers, and the patient community at large. Currently there is no mechanism for providing such crucial funding. Despite the amount of funding and resources devoted to HIV by the federal government, adequate resources for HCV/HIV co-infection continues to be overlooked.

It is clear that we can and should integrate HCV care and prevention programs into existing, government sponsored HIV care and prevention programs, as they provide a good, cost-effective infrastructure for such program development. In addition preventing new infection and increasing access to HCV treatment is more economical than the cost of providing long-term care and possible liver transplantation to individuals who progress to end-stage liver disease.

Congress and the U.S. Department of Health and Human Services must recognize the compelling needs of patients suffering with both HIV and hepatitis C virus. You can begin this important work by funding CDC initiatives incorporating HCV testing at HIV Counseling and Testing sites, funding ADAPs and Medicaid, and funding programs dedicated to patient and provider education and supportive services, which can easily be integrated into existing HIV programs.

We ask that Congress and DHHS address these problems. We implore you to add HIV/HCV co-infection to your national healthcare agenda and respectfully request a hearing in the House and the Senate about HIV/HCV co-infection. Our Coalition is committed to working collaboratively with Congress and the federal government.

Sincerely,

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