

POSITIVE VOICES - April 2013

Your Newsletter by Positive People for Positive People

On April 21st, I will be walking in the AIDS WALK. Walking means more to me than just collecting donations for the Southern Tier AIDS Program (S.T.A.P.); although that is “important”.

For myself walking is a matter of respect and empowerment. I walk to show my RESPECT and to HONOR the memory of all those who did not survive to see this day in the fight against this disease. I walk for those who can no longer. Empowerment from being that “activist” who continues the fight against this disease, to be seen and heard. Empowerment from being an advocate for our community. It feels good to live “Unashamed”.

Recently I became involved with an anti-stigma campaign: No Shame @ riseuptohiv.org. It is exciting to be part of this global movement. So I was thrilled when I was given permission to create “Team No Shame” and use the “Rise Up” logo on our team’s Tee Shirts. I posted photos of them and they were an instant hit. Now a local company has been authorized to reproduce and sell them at a special website they set up at Rise Up.

Team No Shame currently consists of only 2 members, we need donations more than members - but they would be welcome too. I like it this way, Lucia is neg & I am poz, so together we are HIV-neutral. No Stigma - No Shame - No Big Deal.

I believe we can change the way the world views HIV/AIDS, just look at how much it has changed already....

-Crystal

I'm asking that everybody do just a little something, show some support - no donation is too small (a couple of bucks?), what really matters is when we add them all up.

You can use your credit or debit card at the official site below. If you prefer, mail a check to STAP in Johnson City and put Crystal’s name in the memo line. Candace can help with your donation.

www.firstgiving.com/fundraiser/CrystalMorabito/2013-aids-walkrunwith-a-twist

No Increase in Risk of Death for Patients on ART with Well Controlled HIV

PositivelyAware.com - April 2013

For people whose HIV is well controlled by antiretroviral treatment (ART), the risk of death is not significantly higher than in the general population, according to another study published in *AIDS*. The study suggests that patients with undetectable viral loads and near-normal levels of CD4+ T-cells on state-of-the art antiretroviral therapy (ART) can expect to have about the same risk of death as people without HIV.

Dr. Alison Rodger of University College London and colleagues assessed mortality rates in a group of patients drawn from the ESPRIT and SMART trials with “optimally treated” HIV. The analysis included nearly 3,300 patients who were not injecting drug users and who received continuous ART. All had achieved undetectable HIV levels and had relatively high levels of CD4+ cells—at least 500 cells/mm³. (A CD4+ cell count of 500 to 1,000 cells/mm³ is considered normal.) The patients' average age was 43 years; 80 percent were men. Rates and causes of death in these patients with well-controlled HIV were compared with those in the general population.

During an average follow-up of about three years, 62 of the patients died. The most common causes of death were cardiovascular disease or sudden death, responsible for 31% of the deaths; and non-HIV-related cancers, 19%. Only two deaths (3%) were considered AIDS-related. Patients with below-normal CD4+ cell counts (350 to 499 cells/mm³) were at a 77% higher risk of death than in the general population.

“Rodger and colleagues add to the considerable body of evidence on which early treatment initiation guidelines are based,” commented Veronica Miller, PhD, Director of the Forum for Collaborative HIV Research. “Together with studies indicating equal benefit across risk groups, including injecting drug users, as long as individuals are maintained in care, this study further validates universal testing with immediate linkage and retention in care policies.”

Timing and T- Cells - Howard A. Grossman, MD - *PositivelyAware.com*

“The evolution of when to start treatment - through one doctor’s eyes”

Ever since the first antiretrovirals were approved, one of the most vexing questions for patients and doctors has been when to start therapy. In the past two years, a host of new data has been released that is bringing us closer to a time when therapy can be offered to everyone with HIV. I would like to share with you the evolution in my own thinking which may help you make a decision.

When to start has been compared to a pendulum swinging back and forth, with higher and lower limits set for the decision on when to initiate antiretroviral therapy (ART). A pendulum, however, swings back and forth between fixed points. The debate about “when to start” has been more like a playground swing hanging from a decision framework made up of CD4 counts and viral loads. With one major exception, that swing has consistently moved higher, suggesting initiation of treatment earlier and earlier in the disease process.

Making the decision has meant weighing the pros and cons of treatment. On the pro side has been our desire to control and possibly cure the disease. HIV has been one of the only diseases in modern medicine that is not treated immediately upon discovery, one we wait years or even decades to treat.

On the negative side rest much heavier concerns, including drug toxicities, cost of medication, the need for perfect adherence, denial of access by insurance companies and governments, and lack of research data. For most of the last 25 years, the swing swung back towards waiting to start therapy. But while we waited, our thinking evolved.

In the Beginning

When AZT was first available, it was only approved for patients who had experienced an opportunistic infection. After so many years without any therapy, it quickly became clear, however, that people who were suffering from other complications of HIV were going to demand access to the drug. In retrospect, most of the people getting it in those days had very, very low CD4 counts, probably less than 50. We all know now that any benefit from AZT was probably limited to a six-month increase in survival in those very advanced people. More drugs became available during the late 1980s and early 1990s and our comfort level in treating people increased. We progressed to treating everyone with fewer than 200 CD4 cells/mm³. In 1993, the case definition was changed so that a low CD4 count alone meant an AIDS diagnosis. Part of the impetus for this was to ensure access for people with low CD4 counts who weren't yet ill with infections.

HAART arrives

The 200 CD4 limit remained for many years, and in fact, remained in place in the World Health Organization guidelines until 2010. In the U.S. and Western Europe, the 200 CD4 limit began to be called into question with the advent of highly active antiretroviral therapy (HAART) in the late 1990s. There was a great deal of excitement about the benefits we were seeing in those starting on the triple cocktails, despite the very serious side effects and complications of those early treatments. People with CD4 counts over 200 began wanting access to the medications. We also understood more about the dynamics of HIV infection. It became clear that rather than there being a "latent" period when the virus was controlled and nothing much was happening, HIV infection was, instead, a very dynamic process.

By the late '90s, studies were being initiated in people with higher CD4 counts and there was interest in treating early infection. We had clear-cut data from controlled clinical trials and observational studies that the 200 CD4 limit was important, but many of those caught in the middle (not in acute or early infection but above the 200 CD4 level) became increasingly uncomfortable with not being treated. There were serious discussions about moving the bar up to 500, with David Ho and others advocating that we "hit hard, hit early." Not waiting for studies to be completed, many patients, beginning with the activist community, put their bodies on the line to test this in practice. And so the swing got a push and swung upward.

By the turn of the century, the side effects and complications of HAART were becoming more clear, written in the wasted faces and growing bellies of so many patients. An increasing number of those who had chosen to start therapy when the swing swung toward 500 decided to go on extended drug holidays. I treated many of these patients who did well off medications, some maintaining low viral loads and improved CD4 counts for several years. This was the one instance that I can recall when the "swing" actually swung back down.

Many providers who had been willing to treat people with higher CD4 counts were uncomfortable going back to waiting until 200. It was also clear that if one waited to initiate the conversation on starting until patients hit 200, by the time adherence and access issues were addressed, therapy was often not initiated until well below 200. So, many of us started talking about therapy with patients who had between 300 and 400 T-cells and were starting them on meds a little earlier. Observational studies at the time seemed to indicate that

treatment appeared to improve outcomes in this range, but there was little evidence that it was having a big clinical impact above a count of 500.

Data swings toward 500

In 2008, the first presentations were given of the NA-ACCORD trial, a huge retrospective review of some of the largest cohorts in the U.S. and Canada. The results were striking. There was a 70% decrease in all-cause mortality in patients who initiated therapy with a count between 350 and 500. A later analysis showed a 60% decrease in mortality in those who started at a count of 500 compared to those who waited until less than 500. This was paradigm-shattering as it indicated clinical consequences to waiting to initiate therapy.

There are limitations to retrospective observational studies. It is possible that those who started therapy earlier could be longer-lived for reasons having nothing to do with when they started. Retrospective studies also tend to smooth over some big variations. As I mentioned earlier, in the late 1990s and early 2000s, there were large numbers of people who started therapy early but then stopped for extended periods. This was not accounted for and those people were considered throughout as “early starters.”

In any case, data from other retrospective studies has supported the observations in NA-ACCORD. The ART Cohort Collaboration looked at the data a bit differently and there was a clear benefit up to a count of 400 CD4/mm³ but not above. A growing consensus emerged and in the 2009 U.S. Department of Health and Human Services (DHHS) guidelines, it was recommended that therapy should be initiated in all patients below 350 CD4/mm³ and that therapy should be considered between 350 and 500 CD4/mm³, especially in pregnant women and people who were symptomatic, including those with cancers.

By the time the guidelines were rewritten for 2010, many on the panel felt that the accumulated data was really showing a benefit to initiating treatment at 500. Less than 350 still had the most hard data behind it, but there was increasingly more observational data to show decreases in some of the secondary illnesses being observed as people lived longer with HIV—things like cardiovascular disease and cancer.

Treatment reduces transmission

I have to admit that I was skeptical. Starting in 2008, there was increasing evidence that treating HIV-positive people decreased viral transmission in the population. There was increasing discussion of inflammatory markers and the role that inflammation might play in HIV. The idea was also expressed that everyone was going to need drugs in a few years, so why not move it up? I didn't buy it. I failed to see clear-cut evidence of benefit over 500 CD4s and I did not see how to convince individual patients that there were benefits for them in the idea that lowering viral loads served the public good. Many drugs still had significant side effects, we had seen the difficulties when patients developed resistance and had few options, and the last time we pushed the starting line higher it had not been a good idea. This was a very uncomfortable place for me to be—it was the first time I had ever found myself thinking more conservatively than the guidelines. I wondered if I had been at this too long.

Over the last couple of years the lines of thinking mentioned above have become more firmly established and the evidence for them continues to grow. Rates of HIV infection in the U.S.

have continued at the same levels for almost two decades now. In my own practice, I have seen so many young men become positive in the past two years. We have seen high rates of STDs for years, but much of it seemed to be coming from oral sex. In the last two years, I have seen more anal gonorrhea and Chlamydia than I remember seeing in a long time. Some men are looking for any excuse to stop using condoms, the most effective method we have of preventing transmission for people having sex (although pre-exposure prophylaxis, PrEP, adds another tool). It has become very clear that our prevention messages are failing to help people maintain changes in behavior that would lower transmission rates. For young people today, the horrors of the AIDS epidemic are just things they learn about in history books, and the fear of HIV doesn't last beyond the next hook-up. The right wing in the U.S. has destroyed sex education in many places and the level of ignorance about STDs is appalling.

The CDC and public health authorities have undertaken a powerful campaign for treatment as prevention. I think it becomes increasingly clear that reducing viral load across communities by treating as many people as possible may be our only real chance of bringing this epidemic under control. So, government is clearly moving to support universal treatment, thus guaranteeing coverage and access, removing obstacles on the “con” side of the argument.

As a primary care provider however, one has to be able to convince the patient that the therapy being offered is of benefit to him or her. For those in a relationship with someone of the opposite sero-status, treatment as prevention does serve the interest of increasing the chance that the negative partner will stay uninfected. But the reality is that we are experiencing a new kind of apartheid based on viral load status. Over and over I hear from patients that they are questioned by potential partners about their viral load. If they are on meds and undetectable, then they are acceptable sex partners. If they are not on meds, they get rejected. This has pushed some to start therapy earlier.

Trending toward STRs

For real personal benefits to be seen, however, powerful trends needed to come into play. First has been the development of truly tolerable and easy-to-take medication regimens. We have had Atripla for quite a few years now and its once-daily dosing made it easy. But many people still experienced side effects. The development of more once-daily regimens, of two more once-daily fixed dose combinations, the approval of several twice-daily, well tolerated meds in new classes—all of these have suddenly presented us with more options, not just for initial therapy but for sequential regimens as well. And we expect to see a number of new once-daily and fixed dose combinations in new formulations—PIs and entry inhibitors without nucleosides, new integrase inhibitors with next generation nukes, and many others. This is truly the first time in fighting HIV that, as a provider, I can say to a patient that he or she will most likely not have any side effects from the medication I'm prescribing.

Inflammation

The third area of growing consensus has been in regard to the importance of inflammation as a cause of disease. This is a trend across the entire field of medicine. Inflammation appears to play important roles in aging, in the development of cardiovascular disease, in neurologic disease, as well as in rheumatology, endocrinology, and virtually every other area. People

with HIV at every CD4 count have shown elevated levels of inflammation and immune activation, as well as heightened risk for a myriad of diseases from blood clots to early heart attacks. By the time of the International AIDS Conference in Washington, D.C. last year, the evidence for the deleterious effects of inflammation and the positive impact of ART on markers of immune activation was becoming overwhelming. Data continues to accumulate rapidly. As I wrote this article, two new studies appeared in the New England Journal of Medicine which showed significant benefit for patients started on medications very early in the disease process. The 2012 guidelines gave a stronger recommendation than previously to treating all patients with fewer than 500 CD4/mm³. There also appeared to be a growing consensus of expert opinion leading to more universal treatment.

Jumping off

For me, the meeting in D.C. brought a kind of epiphany. It finally seemed that the scales had shifted. The things on the negative side of the scale—the side effects, complicated regimens, drug access issues, and lack of documented benefit—seemed to be lightening if not absent. And the side of the scale in favor of treatment was becoming heavier and heavier with reasons to start early. In fact, it appears to me that it is time to jump off of the swing at the highest point of its arc, to stop using CD4 count as a parameter in deciding when to start, and to offer treatment to all patients who are infected with HIV. I have begun to do this with overwhelming acceptance by many of my patients. Hopefully, we'll land on our feet.

This Newsletter: How to Contribute

I thought I should remind you of “ALL” of the possible topics for a personal article for the newsletter. These are just suggestions to get you thinking, if you feel strongly about something... please write about that. The goal is to get participation!

“STIGMA”, I’m sure most of us are dealing with some form of it right now.

“How I reached out, or helped another POZ, or being that “true friend”.

“Curse or Blessing?”

“Therapist” or “Go it Alone” or “Support Group” - Mental Health Choices?

“Relationships” - to have or to have not, that is the question...

“Sex / Disclosure / When” - “Have you ever used disclosure to your advantage?”

“Denial is not just a river in Africa - it is where I live.”

You could share an article you have found on the web that is relevant to this disease. Share something that made you feel “Proud”.

The easiest way to get it here is to contact your case manager / Stacy / Michelle; anyone will help you get it done, after all that is what this is about!

I would also be interested in any feedback about our newsletter, good or bad. Suggest things to add or remove, or should the newsletter go in a different direction or like I have wondered: Is the newsletter really worth it - does anybody really care?

I have heard the term “burn-out” and how common it is for those involved in HIV/AIDS advocacy to someday get there. Has the newsletter burned out? Or is our desire to fight for our rights slowly burning out? Has the current climate of “cut backs” / “services being taken away” just set us up to “give up” and not try anymore? Some of those who once stood by my side have now been shaken to the point where they have chosen to sit on their hands and say nothing - almost as if they are frozen in time. On some level I understand, we have endured the loss of several strong personalities in our close circle of “Friends” as of late and there is no doubt that pain is profoundly felt.

I’m not ready to give up - that day will come, they call it death and when that day comes I will know it and be ready - I do not fear it. I will know I was given a second chance to make a difference in my life and I did not let myself down. I took chances - (some with good outcomes, others not so) but refused to stop trying. I was also wise enough to walk away, with my head held high, when there was no good to come if I was to continue down that path.

This all comes together with my request that “US” the clients of STAP: Don’t give up! Some of us may have tried in the past to be involved only to have the interest fade away over time. I ask you to try again, especially those who are “long-time survivors” (don’t take this the wrong way - You are living history) your stories of what happened back then & how much better (or not) things are now can be & still are interesting / informative to the “newcomers”.

“HIV is NOT a Crime” - April 30th, 2013 from 4:00 - 5:00pm

At Trinity Memorial Church before the Friend’s Dinner

This session will be presented by Sean Strub. Sean is a writer and long-time HIV survivor and activist, as well as the founder of POZ magazine and the Executive Director of the Sero Project (which combats HIV-related stigma, discrimination, and criminalization).

ON GOING MEETINGS AND COMMUNITY SERVICES

Join/ Attend: Consumer Advisory Committee [CAC] Meetings

The STAP Consumer Advisory Committee is a committee facilitated by and made up of consumers (STAP clients) who welcome other consumers and their significant others, caretakers and family members to join them on any given Tuesday. This collaborative effort provides a confidential space for clients to make recommendations regarding STAP client services and other programs in a non-judgmental environment. The meetings are held during the Friends Dinner at Trinity Memorial Church, downtown Binghamton. Call 1-800-333-0892 for directions or more details.

Friends Who Care Support Groups

Broome County / Binghamton: “Friends Who Care” meets every Tuesday at 3 pm - 4:30/5:00 pm at Trinity Memorial Church located at 44 Main Street, Binghamton. Come join us for Binghamton’s HIV/AIDS Support Group *(open to clients only). Also stay for a good (free) meal afterwards at the “Friends Dinner”.

This group of “Friends” started up years ago when we were unhappy with the “canned” therapy we were getting at mental health. Trinity came to our rescue and allowed us to hold meetings prior to Friends Dinners on Tues. The bonds we have formed have us calling each other “family” - this is truly a “support group”. We consider ourselves “lucky” to be part of something special. New members are welcome. Take a chance. If you’re unsure, then ask Stacy about us - she will even bring you to one of the meetings.

Chemung County: Men Living with HIV Support Group; 2nd Monday of each month; 6-7:30pm; Ivy Clinic, 600 Ivy St., Suite 206, Elmira. For more information people can contact: [Lynn Bassler](#), LMSW Treatment Adherence Counselor, Ivy Clinic, 737-8188.

Tompkins County: The Ivy Clinic is pleased to let all HIV+ men in the Ithaca area know there is a support group that is held the third Tuesday of every month at the Ithaca STAP office. Time for the group is 6-7:30 pm and topics vary. If you are interested in attending please e-mail Shannon Sprague at ssprague@aomc.org for information.

Friends Dinner

“Friends” meet every Tuesday for a time of fellowship and food. Join us at Trinity Memorial Church (corner of Main & Oak Street. - across from the High School) in Binghamton. Doors open at 5PM and dinner is served @ 5:30. No charge, just come with a smile and a friendly attitude - ready to meet friends in a “safe” setting and have a hearty meal. Open to those who are effected and/or affected by HIV/AIDS. Parking is on Oak Street behind the Church Annex & use the Oak Street entrance for the cafeteria. Call your case manager for info. Free bus passes available for transportation to/from the dinner (STAP clients only). For more info about the “Friends Dinner”, call STAP and they will get you in touch with Bill. **Have thought about it, but a little uncomfortable about trying ? Stacy says she will accompany anyone who would like to give a “Friends Dinner” a try. A few who have taken her up on this offer and have now become “regulars” at the dinner.*

Free Rapid HIV Testing

Walk-in *Anonymous* testing is available in the STAP Johnson City office Mondays from 1:00-4:30PM and Thursdays from 1:00-3:00PM. *Confidential* testing is available in the Johnson City office Thursdays from 9:00AM - 12:00PM at 122 Baldwin Street, Johnson City, NY 13790. Walk-in *Anonymous* Testing is also available Tuesdays from 9:00AM-11:30AM, and *Confidential* testing is Thursdays, 9:00AM-11:30AM at STAP's Ithaca office located at 501 S. Meadow Street, Ithaca, NY. For more information and other testing opportunities available throughout the month, please call (607)798-1706.

Tax Time is Upon Us - APRIL 15.

Do you need your taxes done? We are lucky to have the services of a volunteer for STAP to assist those in need with their taxes at no cost. ** This month they need to be done, so don't wait to the last minute. As you can image, Cynthia is busy this time of the year - so if you have not done so yet, call Candace (800-333-0892 x 225) to set up a time with Cynthia.

Free EDUCATIONAL Lunch: April 2013

* The date for April still needs to be determined at the time of printing, therefore we will keep those who attend the Friends Dinner updated as soon as possible. Martha will have final details in the days to come, when you reserve your seat - she can fill you in. From this point on, all these "lunches" will be held at Grandes' on Vestal Ave. If anyone is unsure where this is - Martha will help with that...

* As usual seating is limited (you & a guest only) and must be reserved with Martha at least a week before the event. *R.S.V.P. - Martha # 607-644-7586.*

These are "learning events" - please respect everyone's right to learn.

**** Please turn OFF your cell phones and do not take calls in the room.**

"Ask the Medical Advocates" / Update from the Medical Advocates

** This place in the newsletter is set aside for "US" to ask the Medical Advocates about concerns we are having and for them to share information with our fellow community members .**

POZ.com - January 3, 2013 - *FDA Approves First Drug to Treat Diarrhea in People With HIV*

The U.S. Food and Drug Administration (FDA) has approved Fulyzaq (crofelemer), the first drug to relieve symptoms of diarrhea that is a side effect of HIV antiretrovirals (ARVs). Intended for use among people with HIV who are taking ARVs and whose diarrhea is not caused by a virus, bacteria or parasite, the drug treats watery diarrhea that is a consequence of electrolyte secretion and water in the gastrointestinal tract. The new drug is distributed by Salix Pharmaceuticals in Raleigh, North Carolina, according to an FDA statement. It is derived from the sap of the Croton lechleri plant, commonly known as the Peruvian dragon's blood tree. The clinical trial that proved the safety and efficacy of Fulyzaq involved 374 HIV-positive participants who were all on stable ARV therapy and had a history of diarrhea lasting a month or longer, with a median of 2.5 watery bowel movements per day. Those whose diarrhea was caused by either an infection or a gastrointestinal disease were not admitted into the trials. With patients randomly assigned to take either Fulyzaq or a placebo two times a day, 17.6 percent of the treatment arm experienced two or fewer watery bowel movements each week while 8 percent of those on the placebo reached this clinical benchmark. The most common side effects of Fulyzaq are upper respiratory tract infection, bronchitis, cough, flatulence and increased bilirubin levels.

Science Daily - January 2013

Stopping Smoking Reduces Risk of Bacterial Pneumonia in People With HIV

Bacterial pneumonia is one of the commonest and most serious infections occurring in people infected with HIV. A meta-analysis of cohort and case control studies published in BioMed Central's open access journal BMC Medicine finds that current smokers with HIV were at double the risk of bacterial pneumonia than non-smoking counterparts, but that when people stopped smoking their risk was reduced.

The meta-analysis re-analyzed the data of several thousand participants with HIV, from 14 studies based in USA, Europe and South Africa. Overall it appeared that current smoking was associated with a 70-100% increase in risk of bacterial pneumonia, compared to non-smokers, but that stopping smoking decreased this by about a third. This was independent of CD4 count or antiretroviral therapy.

Prof Paul Aveyard, from University of Oxford who led the study explained that, "Antiretroviral treatment means that people with HIV can have a normal life expectancy. However they still have substantially increased health risks compared to the general population, including risk of pneumonia. Our results show that smokers with HIV have twice the risk of bacterial pneumonia, but that stopping smoking can reduce this risk. In order to prevent this potentially life threatening lung disease we believe that smoking cessation programs should be promoted as part of HIV treatment."

**** DO YOU Know What the C.H.O.I.C.E.S. Program Is?** - If you are or want to be a member of the Speaker's Bureau at STAP you will need to know... it is now required learning. C.H.O.I.C.E.S. is a self-paced educational series designed specifically for YOU to learn and understand HIV and your body. Whether you take one quick course or decide to go through the entire program and take charge of YOUR HIV, ask a Medical Advocate about C.H.O.I.C.E.S. today...

Medical Advocacy Coordinator: Stacy # (607) 798-1706 Ext. 210

Medical Advocate: Autumn # (607) 426-9445

*** Every 4th Tuesday** of the month at 4:30 pm **(New Date & Time)* - just before the Friends Dinner come join us for our monthly educational group (open to everyone). We have found that we get more out of the program when we learn together. Informative questions and discussions are raised.

New Nutrition Class:

On the Third Tuesday of each month, Cornell Cooperative will present a Nutrition / Cooking Class at 4 pm in the cafeteria of Trinity Memorial Church. Open to All, those who are in the "food card" program will get credit for their monthly meeting. Check with Eric to ensure your credit or additional requirements. This is an additional opportunity to stay certified in the program - it is not an additional requirement.

Thursday, February 28, 2013 - HUD LAUNCHES FIRST FAIR HOUSING APP

New app will help the public, housing industry learn about their housing rights and responsibilities

WASHINGTON - The U.S. Department of Housing and Urban Development (HUD) today unveiled the first housing discrimination mobile application (app) for iPhone and iPad. Developed by HUD's Office of Fair Housing and Equal Opportunity (FHEO) and Hewlett Packard (HP), the app uses the latest technology to provide the public with a quick and easy way to learn about their housing rights and to file housing discrimination complaints, and inform the housing industry about its responsibilities under the [Fair Housing Act](#).

The app will also be an important tool to assist fair housing groups and other civil rights advocacy organizations in their efforts to help individuals pursue their housing rights and industry to educate their members on their responsibilities. Several groups indicated their intent to promote the app with their members and in communities where they work, including MomsRising, Illinois Department of Human Rights, Access Living, League of United Latin American Citizens, Asian Real Estate Association of America, National Association of Hispanic Real Estate Professionals, National Association of Real Estate Brokers, and the National Center for Lesbian Rights.

"Having this first fair housing mobile application equips people everywhere with the information they need to combat housing discrimination," said John Trasviña, HUD Assistant Secretary for Fair Housing and Equal Opportunity. "We are maximizing the latest technology to make the process for filing fair housing complaints faster and easier and arming our fair housing partners with the information they need to understand their fair housing rights and responsibilities."

HUD's new fair housing app was unveiled during the 3rd Annual MobileGov Summit in Washington, DC, a conference which brings government and industry IT leaders together to discuss the latest trends and best practices for creating the next generation mobile government workforce.

"HUD needed an efficient and reliable solution to quickly extend existing capabilities to mobile computing devices," said Marilyn Crouther, senior vice president and general manager, U.S. Public Sector, HP Enterprise Services. "The new HP application achieves operational goals of HUD - from concept to deployment - while more effectively addressing discrimination complaints. The mobile app simplifies and increases access to government services for people."

In addition to facilitating real-time delivery of housing discrimination complaints to HUD, the app can be used by individuals researching their housing rights after a natural disaster, when power outages make the iPhone/iPad one of the few ways to access the Internet.

The app also provides information about the fair housing complaint process, and allows the public to access HUD's toll-free discrimination hotline and link to HUD's fair housing website: www.hud.gov/fairhousing

In conjunction with the fair housing mobile application, FHEO has released HTML 5 adaptive mobile pages, which are in English and Spanish and allow web content to display properly regardless of the brand of smartphone or tablet being used. In addition, the adaptive mobile pages allow individuals to complete and submit the fair housing complaint form in Spanish. FHEO also plans to design a "Quick Response code" ad campaign, directing mobile users to the new adaptive pages.