amended Pub. L. 110–361, § 3, Oct. 8, 2008, 122 Stat. 4010.)

AMENDMENTS

2008—Subsecs. (d) to (f). Pub. L. 110–361 added subsecs. (d) and (e) and redesignated former subsec. (d) as (f).

FINDINGS

Pub. L. 107–84, § 2, Dec. 18, 2001, 115 Stat. 823, provided that: ''Congress makes the following findings:

''(1) Of the childhood muscular dystrophies, Duchenne Muscular Dystrophy (DMD) is the world's most common and catastrophic form of genetic childhood disease, and is characterized by a rapidly progressive muscle weakness that almost always results in death, usually by 20 years of age.

''(2) Duchenne muscular dystrophy is genetically inherited, and mothers are the carriers in approximately 70 percent of all cases.

''(3) If a female is a carrier of the dystrophin gene, there is a 50 percent chance per birth that her male offspring will have Duchenne muscular dystrophy, and a 50 percent chance per birth that her female offspring will be carriers.

''(4) Duchenne is the most common lethal genetic disorder of childhood worldwide, affecting approximately 1 in every 3,500 boys worldwide.

''(5) Children with muscular dystrophy exhibit extreme symptoms of weakness, delay in walking, waddling gait, difficulty in climbing stairs, and progressive mobility problems often in combination with muscle hypertrophy.

''(6) Other forms of muscular dystrophy affecting children and adults include Becker, limb girdle, congenital, facioscapulohumeral, myotonic, oculopharyngeal, distal, and Emery-Dreifuss muscular dystrophies.

''(7) Myotonic muscular dystrophy (also known as Steinert's disease and dystrophia myotonica) is the second most prominent form of muscular dystrophy and the type most commonly found in adults. Unlike any of the other muscular dystrophies, the muscle weakness is accompanied by myotonia (delayed relaxation of muscles after contraction) and by a variety of abnormalities in addition to those of muscle.

''(8) Facioscapulohumeral muscular dystrophy (referred to in this section as 'FSHD') is a neuromuscular disorder that is inherited genetically and has an estimated frequency of 1 in 20,000. FSHD, affecting between 15,000 to 40,000 persons, causes a progressive and sever [sic] loss of skeletal muscle gradually bringing weakness and reduced mobility. Many persons with FSHD become severely physically disabled and spend many decades in a wheelchair.

''(9) FSHD is regarded as a novel genetic phenomenon resulting from a crossover of subtelomeric DNA and may be the only human disease caused by a deletion-mutation.

''(10) Each of the muscular dystrophies, though distinct in progressivity and severity of symptoms, have a devastating impact on tens of thousands of children and adults throughout the United States and worldwide and impose severe physical and economic burdens on those affected.

''(11) Muscular dystrophies have a significant impact on quality of life—not only for the individual who experiences its painful symptoms and resulting disability, but also for family members and caregivers.

''(12) Development of therapies for these disorders, while realistic with recent advances in research, is likely to require costly investments and infrastructure to support gene and other therapies.

''(13) There is a shortage of qualified researchers in the field of neuromuscular research.

''(14) Many family physicians and health care professionals lack the knowledge and resources to detect and properly diagnose the disease as early as possible, thus exacerbating the progressiveness of symptoms in cases that go undetected or misdiagnosed.

''(15) There is a need for efficient mechanisms to translate clinically relevant findings in muscular dystrophy research from basic science to applied work.

''(16) Educating the public and health care community throughout the country about this devastating disease is of paramount importance and is in every respect in the public interest and to the benefit of all communities.''

REPORT TO CONGRESS

Pub. L. 107–84, § 6, Dec. 18, 2001, 115 Stat. 829, which directed the Secretary of Health and Human Services to prepare and submit to appropriate committees of Congress a report concerning the implementation of Pub. L. 107–84 not later than Jan. 1, 2003, and each Jan. 1 thereafter, was repealed by Pub. L. 109–482, title I, § 104(b)(3)(H), Jan. 15, 2007, 120 Stat. 3694.

§ 247b–19. Information and education

(a) In general

The Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') shall establish and implement a program to provide information and education on muscular dystrophy to health professionals and the general public, including information and education on advances in the diagnosis and treatment of muscular dystrophy and training and continuing education through programs for scientists, physicians, medical students, and other health professionals who provide care for patients with muscular dystrophy.

(b) Stipends

The Secretary may use amounts made available under this section provides[1] stipends for health professionals who are enrolled in training programs under this section.

(c) Requirements

In carrying out this section, the Secretary may—

(1) partner with leaders in the muscular dystrophy patient community;

(2) cooperate with professional organizations and the patient community in the development and issuance of care considerations for Duchenne-Becker muscular dystrophy, and other forms of muscular dystrophy, and in periodic review and updates, as appropriate; and

(3) widely disseminate the Duchenne-Becker muscular dystrophy and other forms of muscular dystrophy care considerations as broadly as possible, including through partnership opportunities with the muscular dystrophy patient community.

(d) Authorization of appropriations

There are authorized to be appropriated such sums as may be necessary to carry out this section.

(Pub. L. 107–84, § 5, Dec. 18, 2001, 115 Stat. 828; Pub. L. 110–361, § 4, Oct. 8, 2008, 122 Stat. 4011.)

REFERENCES IN TEXT

This Act, referred to in subsec. (a), is Pub. L. 107–84, Dec. 18, 2001, 115 Stat. 823, known as the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 and also as the MD–CARE Act. For

[1] So in original. Probably should be ''to provide''.

complete classification of this Act to the Code, see Short Title of 2001 Amendment note set out under section 201 of this title and Tables.

CODIFICATION

Section was enacted as part of the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001, also known as the MD–CARE Act, and not as part of the Public Health Service Act which comprises this chapter.

AMENDMENTS

2008—Subsecs. (c), (d). Pub. L. 110–361 added subsec. (c) and redesignated former subsec. (c) as (d).

§ 247b–20. Food safety grants

(a) In general

The Secretary may award grants to States and Indian tribes (as defined in section 450b(e) of title 25) to expand participation in networks to enhance Federal, State, and local food safety efforts, including meeting the costs of establishing and maintaining the food safety surveillance, technical, and laboratory capacity needed for such participation.

(b) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated $19,500,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015.

(July 1, 1944, ch. 373, title III, § 317R, as added Pub. L. 107–188, title III, § 312, June 12, 2002, 116 Stat. 674; amended Pub. L. 108–75, § 2(1), Aug. 15, 2003, 117 Stat. 898; Pub. L. 111–353, title II, § 205(d), Jan. 4, 2011, 124 Stat. 3939.)

AMENDMENTS

2011—Subsec. (b). Pub. L. 111–353 substituted ''2010'' for ''2002'' and ''2011 through 2015'' for ''2003 through 2006''.

2003—Pub. L. 108–75 made technical amendment relating to placement of section within original act.

§ 247b–21. Mosquito-borne diseases; coordination grants to States; assessment and control grants to political subdivisions

(a) Coordination grants to States; assessment grants to political subdivisions

(1) In general

With respect to mosquito control programs to prevent and control mosquito-borne diseases (referred to in this section as ''control programs''), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States for the purpose of—

(A) coordinating control programs in the State involved; and

(B) assisting such State in making grants to political subdivisions of the State to conduct assessments to determine the immediate needs in such subdivisions for control programs, and to develop, on the basis of such assessments, plans for carrying out control programs in the subdivisions.

(2) Preference in making grants

In making grants under paragraph (1), the Secretary shall give preference to States that have one or more political subdivisions with an incidence, prevalence, or high risk of mosquito-borne disease, or a population of infected mosquitoes, that is substantial relative to political subdivisions in other States.

(3) Certain requirements

A grant may be made under paragraph (1) only if—

(A) the State involved has developed, or agrees to develop, a plan for coordinating control programs in the State, and the plan takes into account any assessments or plans described in subsection (b)(3) of this section that have been conducted or developed, respectively, by political subdivisions in the State;

(B) in developing such plan, the State consulted or will consult (as the case may be under subparagraph (A)) with political subdivisions in the State that are carrying out or planning to carry out control programs;

(C) the State agrees to monitor control programs in the State in order to ensure that the programs are carried out in accordance with such plan, with priority given to coordination of control programs in political subdivisions described in paragraph (2) that are contiguous;

(D) the State agrees that the State will make grants to political subdivisions as described in paragraph (1)(B), and that such a grant will not exceed $10,000; and

(E) the State agrees that the grant will be used to supplement, and not supplant, State and local funds available for the purpose described in paragraph (1).

(4) Reports to Secretary

A grant may be made under paragraph (1) only if the State involved agrees that, promptly after the end of the fiscal year for which the grant is made, the State will submit to the Secretary a report that—

(A) describes the activities of the State under the grant; and

(B) contains an evaluation of whether the control programs of political subdivisions in the State were effectively coordinated with each other, which evaluation takes into account any reports that the State received under subsection (b)(5) of this section from such subdivisions.

(5) Number of grants

A State may not receive more than one grant under paragraph (1).

(b) Prevention and control grants to political subdivisions

(1) In general

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to political subdivisions of States or consortia of political subdivisions of States, for the operation of control programs.

(2) Preference in making grants

In making grants under paragraph (1), the Secretary shall give preference to a political subdivision or consortium of political subdivisions that—