

Presidential Advisory Council on HIV/AIDS (PACHA)

75th Meeting (Virtual)

October 17, 2022

12–2 p.m.

Council Members—Present

Marlene McNeese, PACHA Co-Chair, Assistant Director, Houston Health Department, Houston, TX

John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, Professor, Gillings School of Global Public Health, Health Policy and Management, The University of North Carolina at Chapel Hill, Chapel Hill, NC

Gregg H. Alton, J.D., San Francisco, CA

Guillermo Chacón, President, Latino Commission on AIDS; Founder, Hispanic Health Network, New York City, NY

Tori Cooper, M.P.H., Director of Community Engagement for the Transgender Justice Initiative, Human Rights Campaign, College Park, GA

Raniyah Copeland, M.P.H., Principal, Equity & Impact Solutions, Los Angeles, CA

Alicia Diggs, M.P.H., Manager, Office of Community Engagement, Center for AIDS Research, The University of North Carolina at Chapel Hill, Greensboro, NC

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, Dean and Professor, Duke University School of Nursing, Vice Chancellor, Nursing Affairs, Duke University, Durham, NC

Leo Moore, M.D., M.S.H.P.M., Medical Director for Clinic Services, Los Angeles County Department of Public Health, Los Angeles, CA

Rafaelé Narváez, Co-Founder and Director of Health Programs, Latinos Salud, Wilton Manors, FL

Laura Platero, J.D., Executive Director, Northwest Portland Area Indian Health Board, Portland, OR

Kayla Quimbley, National Youth HIV and AIDS Awareness Day Ambassador, Advocates for Youth, Columbus, GA

John Saperro, Director, Ending the HIV Epidemic, Collaborative Research LLC, Phoenix, AZ

Carl Schmid, M.B.A., Executive Director, HIV+Hepatitis Policy Institute, Washington, DC

Justin C. Smith, M.S., M.P.H., Director, Campaign to End AIDS, Positive Impact Health Centers; Behavioral Scientist, Rollins School of Public Health, Emory University, Atlanta, GA

Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, Lead Provider and HIV Specialist, Eau Claire Cooperative Health Centers (Now Cooperative Health), Columbia, SC

Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., Provost and Senior Vice President for Academic Affairs, Iona College, New Rochelle, NY

Council Members—Absent

Jennifer Kates, Ph.D., Senior Vice President and Director of Global Health & HIV Policy, Kaiser Family Foundation, Washington, DC

Marc Meachem, M.B.A., Head, External Affairs, ViiV Healthcare North America, Washington, DC

Michael Saag, M.D., Associate Dean, Global Health, School of Medicine, and Professor of Medicine, Division of Infectious Disease, The University of Alabama at Birmingham (UAB); Director, UAB Center for AIDS Research, Birmingham, AL

Liaison: Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis, and Sexually Transmitted Disease (STD) Prevention and Treatment

Wendy Armstrong, M.D., FIDSA, Professor of Medicine, Emory University; Executive Medical Director, Ponce de Leon Center, Grady Health System, Atlanta, GA (absent)

Staff

B. Kaye Hayes, M.P.A., Deputy Assistant Secretary for Infectious Disease and Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP); PACHA Executive Director, Designated Federal Officer; Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services (HHS)

Caroline Talev, M.P.A., PACHA Committee Manager, Senior Management Health Analyst, OIDP, OASH, HHS

Federal Partners

Andrea Callow (for Edwin Walker, J.D.), Administration for Community Living, HHS

Demetre Daskalakis, M.D., M.P.H., White House National Monkeypox Response Deputy Coordinator; Director, Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB [Tuberculosis] Prevention (NCHHSTP), CDC

Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development

Timothy Harrison, Ph.D., Deputy Director for Strategic Initiatives and Senior Policy Advisor, OIDP, HHS

Heather Hauck, M.S.W., LICSW (for Laura Cheever, M.D., Sc.M.), HIV/AIDS Bureau, HRSA

David Johnson, M.P.H., Deputy Assistant Secretary for Health—Regional Health Operations, OASH

Jessica Lee, M.D., Medical Officer, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services

Robyn Neblett-Fanfair, M.D., M.P.H., Principal Deputy Director, Division of HIV Prevention, NCHHSTP, CDC

Harold J. Phillips, M.R.P., Director, White House Office of National AIDS Policy (ONAP)

CAPT Samuel Wu, Pharm.D., Public Health Advisor, Office of Minority Health, HHS

Opening Remarks from the PACHA Co-Chairs

Marlene McNeese and John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chairs

Ms. McNeese called the meeting to order at noon ET. She summarized PACHA's listening session during the U.S. Conference on AIDS in Puerto Rico, which offered an opportunity to showcase PACHA and hear from stakeholders. Among the topics raised during that session was

HIV and aging, which was a central theme of discussion at the September 2022 PACHA meeting in Los Angeles, CA, and remains an area of continued focus for PACHA.

This meeting was called to address a resolution brought forth by PACHA's Stigma and Disparities Subcommittee regarding the use of molecular HIV surveillance (MHS) and cluster detection and response (CDR) in the context of *Ending the HIV Epidemic: A Plan for America* (EHE). Over the course of a year, PACHA and the Subcommittee have heard from health departments and others implementing EHE about how they use MHS/CDR to improve response and also from individual people living with HIV (PWH), networks of PWH, and other stakeholders about their concerns around the use of MHS/CDR, especially in light of HIV criminalization. Ms. McNeese emphasized that PACHA has tried to ensure that conversations around the issue are balanced and thoughtful. The draft resolution represents the culmination of PACHA's work and research so far.

Dr. Wiesman explained that PACHA is an advisory council that brings together many voices representing PWH and those at risk for HIV, as well as people who work in the field in various capacities, to advise the HHS Secretary, the Assistant Secretary for Health, and the White House ONAP. Addressing the HIV epidemic will take more than a biomedical approach; it requires attention to the many social determinants of health that affect well-being, including stigma and discrimination. (This meeting was broadcast live online; the recorded broadcast is available [online](#).)

Roll Call

B. Kaye Hayes, M.P.A., Deputy Assistant Secretary for Infectious Disease, Director, OIDP; PACHA Executive Director; OASH, HHS

Ms. Hayes called the roll.

Welcome

ADM Rachel L. Levine, M.D., Assistant Secretary for Health, HHS

ADM Levine recognized the PACHA Co-Chairs for their ongoing leadership and Ms. Hayes' for her outstanding leadership of PACHA and OIDP, as well as all the community members for their individual and collective work to date.

ADM Levine pointed out that EHE is now a part of HHS's work to implement the updated *National HIV/AIDS Strategy*. In the past few months, CDC, HRSA, the Indian Health Service, and the National Institutes of Health have awarded funds to continue implementation of EHE in the 57 priority jurisdictions. EHE is based on four pillars: diagnose, treat, prevent, and respond. Success in each requires using data and following the science. Meaningful community engagement is key to meet the needs of communities, include new voices, and encourage bold and innovative efforts to address barriers and improves outcomes. This meeting embodies the spirit of community engagement and focuses on the fourth EHE pillar, respond.

ADM Levine thanked the members of the Stigma and Disparities Subcommittee, its working group on MHS/CDR, and all those who contributed for their time and expertise in developing the

draft resolution on MHS/CDR. She thanked the PACHA members for the work they do on the Council and in their communities every day to help end the HIV epidemic.

Public Comments

Amir Sadeghi of the Center for HIV Law and Policy (CHLP) said it is clear that the molecular surveillance of PWH cannot continue in its current form. CHLP and many others are raising the alarm about the gaps that fail to protect people's private, identifiable medical information from being weaponized against them. Many States currently have laws that force State and local health departments to cooperate in prosecutions against PWH, including many EHE jurisdictions. There is simply no uniformity in the safeguards shielding some of the most sensitive information that can be used against already stigmatized and overpoliced communities. Allowing molecular surveillance to continue in that context represents a grave danger to everyone, because it threatens the fragile trust that exists in the public health infrastructure. Without public trust, public health goals cannot be achieved. But public trust cannot be maintained while jeopardizing the lives of communities and treating the bodily autonomy, human dignity, and medical data security of PWH as an afterthought. HIV arrests and prosecutions are not declining. According to various reports from the Williams Institute, many States have seen a steady stream of criminal incidents, and some States even show an increase. Every year State lawmakers introduce more bills to increase penalties targeting PWH and people with viral hepatitis.

Mr. Sadeghi noted that fears about data privacy and security, the misuse of public health resources in HIV prosecutions, and bodily autonomy go much, much deeper than just molecular surveillance. However, that is hardly an excuse to continue a practice widely condemned across diverse sectors, including even by some in public health. Many question whether the level of investment in this form of research is the best use of scarce resources in the underaddressed HIV hotspots across the United States where people are dying because of racist and structural barriers to care. At a moment where pre-exposure prophylaxis (PrEP) programs are facing closure due to lack of continued investment, is this the best use of our public health dollars?, Mr. Sadeghi asked. Federal agencies and this administration must make it a priority to implement clear, concrete protections that end the use of public health and personal health data as a vehicle to punish and further criminalize PWH, as well as establish guarantees for PWH to opt out of MHS.

Kelly Flannery said the Positive Women's Network (PWN) supports the draft resolution on MHS/CDR and urges PACHA to pass it. All networks of PWH, as well as many human rights and privacy advocates, have raised deep concerns about incorporating MHS as a cornerstone of the Federal EHE initiative for years. PWN has provided concrete recommendations to address these issues to PACHA, CDC, and ONAP. Public health officials from several States and jurisdictions have expressed significant reservations about the implementation of MHS/CDR due to human rights concerns, the impact on other preventive services, the cost of implementation, and the lack of real-time access to data that would make MHS/CDR data meaningful. They have identified some instances in which the requirement to use MHS/CDR may further exacerbate racial inequities in access to services and programs. The draft resolution is a definite step forward. PWN is happy to see the recommendation that MHS and CDR activities be adapted depending on local contexts and that MHS and CDR activities must not pose harm to PWH. PWN hopes CDC will heed the recommendation to take into account local conditions, including

the legal environment, with respect to public health data protections, Tribal data sovereignty, and the existence of HIV criminalization statutes, as well as general criminal statutes. This is important given the immense variation in the State legal standards and data privacy protections and practices, as well as potential misuse of MHS data within the criminal, legal, and immigration systems. PWN looks forward to seeing jurisdiction-wide moratoriums on MHS/CDR activities until safeguards are implemented and human rights concerns are addressed. These safeguards must include concrete firewalls protecting public health research and surveillance data, including but not limited to MHS-related data, from access by law enforcement corporations, criminal legal courts, immigration enforcement, and youth detention and protective services systems.

Ms. Kelly noted that PWN's work to elevate concerns with MHS is one necessary component of its fight to dismantle systems that perpetuate racism, oppression, and anti-Black violence; to ensure that policy recommendations are driven by priorities set by the most impacted communities; and to craft a favorable and safe human rights environment for PWH, where basic dignity, humanity, and safety are upheld. PWN looks forward to continuing to collaborate with PACHA to demand a Federal response that respects, protects, and fulfills the health and human rights of PWH.

Benjamin Brooks said Whitman-Walker Health welcomes the draft resolution on MHS/CDR and agrees with the identified steps to improve the implementation of these new and emerging technologies. Whitman-Walker Health notes that public health policies should treat humans as partners in public health efforts and not vectors of disease. The particular danger of MHS is the dehumanizing impact of the research, which isolates genetic viral information while simultaneously requiring immense amounts of social and environmental contextual information to be reasonably helpful in ending and responding to the changing epidemic. Whitman-Walker Health encourages PACHA to pass this resolution and urges CDC to invest heavily in incorporating PWH in structured ways that enhance the entire prevention and treatment system's ability to truly realize meaningful involvement of PWH and community-led research and engagement and investment in our public health systems.

Ms. Hayes noted that anyone can provide written public comment up until Monday, October 24, via email to PACHA@hhs.gov. See Appendix A for all written public comments submitted.

MHS/CDR Draft Resolution

Justin Smith, M.S., M.P.H., and Rafaelé Narváez, Co-Chairs, PACHA Stigma and Disparities Subcommittee

Following PACHA discussions in November 2021, the Stigma and Disparities Subcommittee convened a special MHS/CDR working group. In May 2022, the working group convened academics, researchers, clinicians, advocates, Federal partners, and community members to discuss data protection, surveillance, consent, and HIV criminalization, among other topics. The working group drafted a resolution, which it circulated to all the meeting participants and then published on the HIV.gov website. Feedback to date has been incorporated. Mr. Smith emphasized that the resolution is not the end of the discussion; if passed by PACHA, he hoped it would be a step toward more discussion on how to offer solutions to end HIV criminalization and honor the dignity of PWH. Mr. Narváez added that HIV criminalization affects many

communities. Some jurisdictions have addressed the problem, but many have not. He recognized that MHS/CDR is a complex subject, and he appreciated all the hard work that has occurred on this topic.

Discussion

Robyn Neblett-Fanfair, M.D., M.P.H., said CDC participated in the May meeting and has been involved in a lot of community engagement on this issue. She welcomed the opportunity to listen and said CDC will continue the conversation internally. Demetre Daskalakis, M.D., M.P.H., underscored that CDC takes the feedback seriously and is deliberating on what can be done to achieve common goals and how to ensure the work of HIV prevention is conducted with the utmost respect for all communities.

Ms. McNeese acknowledged Mr. Smith in particular for the countless hours he has committed to drafting this resolution. She noted that PACHA and CDC are aligned on many areas but not all. The resolution represents a year's worth of engagement and aims to speak to specific tools and strategies around data collection and use of MHS to identify and respond to HIV networks of transmission. Ms. McNeese noted that PACHA does not recommend dismantling the surveillance systems needed to be responsive to community and end the HIV epidemic. Mr. Smith reiterated his thanks to all who participated, adding that the willingness of all the stakeholders to persevere through some difficult conversations speaks to their integrity.

Several PACHA members expressed support for the resolution and noted the need to continue to address the issues it surfaces. Encouraging jurisdictions to work with their communities to determine what kind of MHS works for them is a good first step, but more attention is needed to informed consent in particular and to the systems of surveillance broadly. PACHA should develop some recommendations that CDC can implement within the next few months to address the concerns raised.

Review of the Draft Resolution

PACHA members offered editorial changes to clarify the resolution. For example, it was suggested that the resolution should incorporate the concept of undetectable equals untransmittable (U=U), and members ultimately agreed to describe it in the introduction.

Vote

The Council voted unanimously in favor of the resolution, as amended.

See Appendix B for the finalized resolution.

Wrap Up Steps and Closing Remarks from the PACHA Co-Chairs

Marlene McNeese and John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chairs

Ms. McNeese thanked the participants for a productive meeting. She expressed gratitude to all those who make the meetings possible. Dr. Wiesman echoed his appreciation and adjourned the meeting at 1:54 p.m. ET.

Appendix A: Written Public Comments

Center for HIV Law and Policy (CHLP)

Thank you again for accommodating CHLP during the public comment period of this PACHA convening. A written copy of CHLP's statement can be found below:

My name is Amir Sadeghi, I'm the National Policy and Partner Strategist with CHLP. Thank you to every PACHA member and especially those of you on the Stigma and Disparities Subcommittee for raising up the issue of molecular HIV surveillance today. CHLP works to address stigma and discrimination at the intersection of HIV, race, disability, class, sexuality, and gender identity, with a focus on criminal and public health systems. We've supported the advocacy power of movements dismantling harmful approaches to public health issues, including those that confront and dehumanize people living with HIV.

The last few years have seen a tremendous mobilization of concern, skepticism, and community power by people living with HIV, advocates, organizations, and coalitions in response to molecular HIV surveillance. I'd like to take special notice of the incredible organizing work led by Positive Women's Network-USA, the US PLHIV Caucus, and the AIDS United Public Policy Council. It's plainly clear to this growing consensus of these networks, also including CHLP's Positive Justice Project, that the molecular surveillance of people living with HIV cannot continue in its current form.

CHLP has joined many others who are here today in raising the alarm about the gaps that fail to protect people's private, identifiable medical information from being weaponized against them. Many states currently have laws that force state and local health and public health departments to cooperate in prosecutions against people living with HIV, including many EHE jurisdictions. There is simply no uniformity in the safeguards shielding some of our most sensitive information that can be used against already stigmatized and overpoliced communities. Allowing molecular surveillance to continue in that context represents a grave danger to everyone because it threatens the fragile trust that exists in our public health infrastructure. Without public trust, we cannot achieve public health goals. But we cannot keep public trust while jeopardizing the lives of our communities and treating the bodily autonomy, human dignity, and medical data security of people living with HIV as an afterthought.

HIV arrests and prosecutions are not declining. According to various reports from The Williams Institute, many states have seen a steady stream of criminal incidents, and some states even show an increase. Every year state lawmakers introduce more bills to increase penalties targeting people living with HIV and viral hepatitis. Fears about data privacy and security, the misuse of public health resources in HIV prosecutions, and bodily autonomy go much, much deeper than just molecular surveillance. However, that is hardly an excuse to continue a practice widely condemned across diverse sectors, including even by some in public health. Many of us, for example, have questioned whether the level of investment in this form of research is the best use of scarce resources in the under-addressed HIV hotspots across the US where people are dying because of racist and structural barriers to care. At a moment where PrEP programs are facing closure due to lack of continued investment, is this the best use of our public health dollars?

Federal agencies and this administration must make it a priority to implement clear, concrete protections that end the use of public health and personal health data as a vehicle to punish and further criminalize people living with HIV, as well as establish guarantees for people living with HIV to opt out of molecular surveillance. Thank you.

Amir Sadeghi National Policy and Partner Strategist

Dear PACHA members,

I am reaching out in support of CHLP's statement which acknowledges that we should be delaying any further MHS-related funding announcements until concrete, written protections are implemented everywhere to ensure public health surveillance data can never be used against PLHIV. MHS represents a reactive and invasive set of tools and strategies that come at a great cost to established, evidence-based, and affirming approaches to retain PLHIV in care and prevent HIV diagnoses.

I call on PACHA and CDC to take further action and preserve the fragile public trust that remains in public health after a long history of approaches that have harmed our most marginalized communities affected by the HIV epidemic. We need to act to protect all public health information, including but not only MHS-data, from ever being accessed by law enforcement, corporations, criminal legal courts, immigration enforcement and youth detention and protective services systems. Those firewalls need to be in place before, not after, MHS is implemented.

I commend PACHA on recommending opt-out options for PLHIV on the use of their drug resistance data being used for CDR activities, and believe CDC must implement those options and more to guarantee informed consent is at the foundation of public health surveillance.

Sincerely,

Galen Baughman

Appendix B: PACHA Resolution

Presidential Advisory Council on HIV/AIDS (PACHA)

Molecular HIV Surveillance and Cluster Detection and Response Resolution

Molecular HIV surveillance (MHS) uses laboratory data to identify networks of people experiencing HIV transmission. HIV cluster detection and response (CDR) has allowed some public health agencies and communities affected by rapid HIV transmission to increase and, more specifically, prioritize HIV prevention and treatment services and programs. After learning of concerns about MHS and CDR expressed by all networks representing people living with HIV, some advocates and privacy experts, and some public health officials, PACHA gathered input from researchers, public health practitioners, and community advocates who have conducted and been affected by MHS/CDR activities. Some shared important successes resulting from these strategies, while others raised substantial human rights concerns about consent, data protections, accountable community engagement, and potentially dangerous unintended consequences should prosecutors gain access to molecular surveillance data and use MHS/CDR information in criminal cases against people living with HIV. Some public health officials also raised concerns about resource allocation required for implementation of MHS/CDR activities.

MHS/CDR activities are currently being implemented in multiple states across the U.S. that actively criminalize persons living with HIV for non-disclosure, exposure, or transmission—often without an understanding or incorporation of basic scientific principles—concerning HIV, including that when a person living with HIV has an undetectable viral load, that person is unable to transmit the virus to sexual partners, commonly known as “undetectable equals untransmittable” (U=U). Through this resolution, PACHA provides recommendations to HHS on the future implementation of MHS/CDR, recommendations that acknowledge the benefits of these activities but are also responsive to the serious concerns raised by community members.

Whereas, Molecular HIV Surveillance (MHS) and Cluster Detection and Response (CDR) activities are a part of the “Respond Pillar” of the Ending the HIV Epidemic in the U.S (EHE) initiative and the National HIV/AIDS Strategy, and have become ubiquitous components of public health surveillance for HIV and other diseases;

Whereas, MHS data has been useful in identifying new HIV outbreaks within specific communities and has allowed public health officials and community organizations to respond to these outbreaks with additional support and resources to the impacted individuals and communities¹;

Whereas, the national rollout of MHS/CDR occurred without significant or meaningful community engagement. No organizations led by people living with HIV were involved in the planning, and few such organizations have been involved in implementation or evaluation of any efforts to educate the community at a national level².

¹ Oster AM, Lyss SB, McClung RP, Watson M, Panneer N, Hernandez AL, Buchacz K, Robilotto SE, Curran KG, Hassan R, Ocfemia MC. HIV cluster and outbreak detection and response: the science and experience. *American Journal of Preventive Medicine*. 2021 Nov 1;61(5):S130-42. Tumpney M, John B, Panneer N, McClung RP, Campbell EM, Roosevelt K, DeMaria A, Buchacz K, Switzer WM, Lyss S, Cranston K. Human immunodeficiency virus (HIV) outbreak investigation among persons who inject drugs in Massachusetts enhanced by HIV sequence data. *The Journal of Infectious Diseases*. 2020 Oct 1;222(Supplement_5):S259-67.

² Castro-Bojorquez M, French M, Lewis O, Minalga B, Ray R, Sprague, L, Sardina C, Spieldenner A, Suttle R. The Meaningful Involvement of People with HIV/ AIDS (MIPA): The Participatory Praxis Approach to Community Engagement on HIV Surveillance. *The Journal of Community Engagement and Scholarship*. 2022 Jul 27;14(2).

Whereas, CDC can and has meaningfully engaged with impacted parties when HIV surveillance technologies have changed in the past. For example, when CDC required name-based HIV reporting for funded public health departments, they engaged in a multi-year engagement of health departments and communities most impacted by HIV to obtain community buy-in;

Whereas, community members, particularly networks of people living with HIV, advocates, and some health department leaders, have voiced for many years substantial concerns about the implementation of MHS. These concerns include the potential for misuse of MHS data within the criminal legal system, the need for informed consent to use private health information in this manner, data security and privacy, the lack of accountable community engagement before roll-out, human rights concerns, the impact of MHS implementation on other HIV prevention activities, the lack of real-time access to data that would make MHS more useful, the concern that in at least some instances the requirement to participate in MHS and focus on people identified as part of clusters may further exacerbate racial inequities in access to services and programs, and the cost of MHS implementation³;

Whereas, networks of people living with HIV, many other people living with HIV, and HIV advocates have demanded an immediate moratorium on all molecular HIV surveillance activities until adequate safeguards protecting the privacy and autonomy of people living with HIV are implemented;

Whereas, medical mistrust is a substantial barrier to engaging the general population of the U.S. in activities proven to enhance personal and public health, and medical mistrust is higher than average within many of the communities disproportionately impacted by HIV due to historical and current medical abuses and inequities;

Whereas, PACHA's Stigma and Disparities Subcommittee convened a Molecular HIV Surveillance and Cluster Detection and Response Workgroup on May 9-10, 2022 in Atlanta, Georgia, in response to concerns brought to PACHA by networks of people living with HIV and other HIV advocates. This convening brought together a group of community members living with HIV, advocates, academics, researchers, clinicians, public health department leaders, and federal partners to discuss issues related to MHS/CDR and inform the development of recommendations;

Whereas, PACHA supports HIV surveillance activities as a core public health function, and the following recommendations are limited to the use of MHS data for the detection of networks of people experiencing HIV transmission and are not meant to be applicable to HIV surveillance as a whole;

Be it resolved, PACHA urges the Centers for Disease Control and Prevention (CDC) to update its guidance to state, territorial, and local health departments and other public health authorities on the implementation of CDR specific to MHS activities through its HIV-related notice of funding opportunity (NOFO) announcements and other channels used by CDC to communicate with recipients of CDC funding to include the following:

- Guidance that directs health departments and public health authorities, in collaboration with CDC, to adapt their MHS approach and strategies through meaningful engagement with key stakeholders and people living with HIV to determine if MHS strategies should be implemented in their

³ Bernard EJ, McClelland A, Cardell B, Chung C, Castro-Bojorquez M, French M, Hursey D, Khanna N, Minalga MB, Spieldenner A, Strub S. We are people, not clusters!. The American Journal of Bioethics. 2020 Oct 2;20(10):1-4.
HIV Justice Worldwide and Positive Women's Network USA. Molecular HIV Surveillance: A Global Review of Human Rights Implications. (2021)

jurisdiction, and if implementation happens, how MHS activities can be implemented in a manner that does not pose harm to people living within that jurisdiction. This adaptation process should be responsive to local jurisdictional trends and allow for better tailoring of the process to meet the needs within a given locality. This adaptation process should include a thorough review of state and local laws and ongoing meaningful engagement and partnership with local persons and networks of people living with HIV, representatives of community-based organizations serving people living with or vulnerable to HIV, and other advocates and community members; and/or tribal consultation when American Indian/Alaska Native (AI/AN) data is involved.

- CDC-funded jurisdictions must take into account local conditions, including the legal environment with respect to public health data protections, tribal data sovereignty, and the existence of HIV criminalization statutes, as well as general criminal statutes, that are used to prosecute people living with HIV for alleged non-disclosure, exposure, or transmission, which often do not require prosecutors to prove that a non-negligible risk of transmission existed or that the person living with HIV acted with any intent to harm. Acceptable local adaptations of MHS should span from full implementation of MHS strategies and activities to a jurisdiction-wide moratorium on all MHS activities until safeguards are implemented and the human rights concerns of people living with HIV are addressed. These safeguards must include concrete firewalls protecting public health research and surveillance data, including but not limited to MHS-related data, from access by law enforcement, corporations, criminal legal courts, immigration enforcement, and youth detention and protective services systems.
- Require jurisdictions that implement MHS activities receive federal funds to establish and maintain a Community Advisory Board specifically focused on MHS/CDR, the membership of which includes a majority of people living with HIV. This requirement could be satisfied through existing HIV-related entities, including local Ryan White Planning Councils, Community Planning Groups, EHE Community Advisory Boards or other health department-supported HIV-related community planning groups. All ideas and feedback from the Community Advisory Board should be elevated to CDC with a yearly report released for public record that includes actions taken to address implementation concerns. CDC should be responsible for providing an annual report about MHS activities across states that includes data on cost analysis.
- Fund and provide technical assistance for conducting and evaluating activities that assess the efficacy and cost effectiveness of MHS activities relative to other HIV surveillance and prevention interventions and activities.
- CDC, in partnership with local health departments, should create a national clearinghouse of MHS/CDR information for providers, people living with HIV, and the community at large to gather success stories, scholarship regarding MHS and CDR, documentation regarding the challenges and concerns currently being raised, and best practices around CDR and methods of addressing the challenges and concerns to inform its impact as a public health strategy to end HIV in the U.S. The national clearinghouse should include jurisdiction-level data that discusses cost-benefit analyses as compared to other HIV surveillance strategies.
- Require that states provide plain language notifications to individuals living with HIV on the types of surveillance and analyses being conducted and opt-out options for the use of MHS patient data for

CDR activities. The types of surveillance and analyses being conducted with mandatorily reported data should be disseminated, at the local, state, and federal level. While the findings may not be published (due to confidentiality concerns), these *types* of surveillance and analyses should be public knowledge.

- Fund academic detailing to providers caring for people living with HIV in the next NOFO, including HIV and infectious disease providers, to explain MHS/CDR and the laboratory test results that are collected and used in these surveillance activities. Require that providers explain MHS/CDR and the laboratory test results that are collected and used in these surveillance activities to their patients. Best practices for informed consent should be included in the detailing, as well as any options (in jurisdictions where permitted by law) patients have to opt out of data sharing for the purpose of MHS. Lastly, it should include guidance on how to protect patient confidentiality in the event of subpoena for medical records.

Be it resolved, PACHA urges the CDC to provide peer-reviewed evidence regarding the effectiveness of MHS in populations most affected by HIV, including but not limited to Black and Latinx cis- and transgender men who have sex with men as well as Black and Latinx cis- and transgender women, and people who inject drugs, including an analysis of the incremental benefit of MHS in comparison to traditional surveillance tools and Geographic Information System mapping of incident cases in areas where persons newly diagnosed with HIV reside.

Be it resolved, PACHA urges CDC to work with states and jurisdictions, alongside community members, providers, tribes, tribal epidemiology centers, members of networks of people living with HIV, and partner agencies within HHS to create a stronger system of informed consent around the uses of molecular HIV data.

Be it further resolved, PACHA urges HHS, the White House Office of National AIDS Policy, CDC, HRSA, NIH, SAMHSA, and IHS to work with states and territories to educate lawmakers and prosecutors on the stigma and harm around HIV criminalization and advances in HIV prevention and treatment and the understanding of HIV exposure risk. PACHA further urges review of HIV criminalization laws through the lens of these advancements, as well as provision of technical assistance to states, local health departments, tribes, community-based organizations, and advocates to repeal all laws that single out people living with HIV for disparate, punitive treatment under criminal and public health laws. Federal public health officials have an affirmative obligation to make it known to lawmakers that such laws are outdated, harmful, stigmatizing, and counterproductive to ending the HIV epidemic in the United States.