

Presidential Advisory Council on HIV/AIDS (PACHA)

73rd Meeting (Virtual)

March 14–15, 2022

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 (*Day 2 only*)

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

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

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

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

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

Adrian Shanker, Founder and Executive Director, Bradbury-Sullivan LGBT Community Center, Allentown, PA

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

Juliet K. Choi, J.D., President and CEO, Asian & Pacific Islander American Health Forum, Washington, DC

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

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

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 (*Day 2 only*)

Staff

B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer; Acting Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP), 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, Public Health Analyst, OIDP, OASH, HHS

Federal Partners

Laura Cheever, M.D., Sc.M., Associate Administrator, HIV/AIDS Bureau, HRSA

Demetre C. Daskalakis, M.D., M.P.H., Director, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention (NCHHSTP), CDC

Antigone Dempsey, Director, Division of Policy and Data, HIV/AIDS Bureau, HRSA

John W. Gilford, Ph.D., Regional Health Administrator, Region 4, OASH, HHS

Maureen M. Goodenow, Ph.D., Associate Director for AIDS Research, Director, Office of AIDS Research, National Institutes of Health

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, HIV/AIDS Bureau, HRSA

Rick Haverkate, M.P.H., National HIV/AIDS & Hepatitis C Program Coordinator, Indian Health Service

Jessica Lee, Medical Officer, Center for Medicaid and Children's Health Insurance Program Services, Centers for Medicare & Medicaid Services (CMS)

RADM Jonathan Mermin, M.D., M.P.H., Director, NCHHSTP, CDC

Chinedu Okeke, Acting Chief Medical Officer, and Division Lead, Viral Hepatitis, OIDP, HHS

James Macrae, M.A., M.P.P., Associate Administrator, Bureau of Primary Health Care, HRSA (*Day 1 only*)

Jin Park, Director, President's Emergency Plan for AIDS Relief (PEPFAR) Office, Office of Global Affairs, HHS (*Day 1 only*)
Harold J. Phillips, M.R.P., Director, White House Office of National AIDS Policy (ONAP)
Kristen Roha, M.S., M.P.H., Public Health Advisor for HIV, Substance Abuse and Mental Health Services Administration
Crystal Simpson, M.D., Medical Officer, Office of Medicare, CMS

Day 1

Opening Remarks from the PACHA Co-Chairs

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

Dr. Wiesman called the meeting to order at 10:00 a.m. and described the agenda for the meeting. (This meeting was broadcast live online; the recorded broadcast is available [online](#).) Ms. McNeese welcomed all those attending and offered some updates from the Consolidated Appropriations Act passed by the U.S. Senate. The legislation would increase funding for *Ending the HIV Epidemic: A Plan for America* (EHE initiative), CDC's NCHHSTP, HHS HIV prevention and adolescent health programs, the Ryan White HIV/AIDS Program, the Office of AIDS Research at the National Institutes of Health, and the Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS program, among others. The legislation recognizes the need for more research, better collaboration across agencies, and mitigation of health disparities that affect people with HIV and those at risk for HIV. (The act was signed into law by President Joseph R. Biden on March 15, 2022.)

Roll Call

B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer; Acting Director, OIDP, OASH, HHS

Ms. Hayes called the roll.

Welcome

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

ADM Levine thanked the Council members and community partners for their contributions and service in national and global efforts to end HIV. She noted that the updated *National HIV/AIDS Strategy* (NHAS) was published on World AIDS Day (December 1, 2021). It reflects a commitment to a whole-of-society response and provides a roadmap for reaching the goal of ending the HIV epidemic in the United States by 2030. ADM Levine hoped the NHAS would inspire implementation activities at all levels and in all types of organizations, because Federal action alone is not enough. OASH is drawing focus to the intersection of HIV, sexually transmitted infections (STIs), and viral hepatitis with the ongoing EHE initiative, updated NHAS, and forthcoming STI and viral hepatitis national strategy implementation plans.

During Black History Month (February) and Women's History Month (March), OASH took the opportunity presented by National Women and Girls HIV/AIDS Awareness Day (March 10) and the first HIV Criminalization Awareness Day (February 28) to call for repeal of laws that criminalize HIV and disproportionately affect women and Black people.

OASH continues to engage with communities to work toward collaborative solutions. OIDP and the HHS Office of Minority Health hosted a national competition, the HIV Challenge, to fund efforts by individuals, organizations, and communities to combat HIV-related stigma, increase HIV prevention and treatment, and decrease racial and ethnic disparities around HIV. ADM Levine noted that community engagement is a key component of PACHA's work, and she appreciated the Council resuming its "PACHA to the People" approach by launching an interactive virtual community engagement session during this meeting.

ADM Levine described progress toward overcoming barriers that transgender people face around gender-affirming care, including the lack of access to providers with sufficient knowledge on the topic, costs, discrimination, lack of cultural competence by providers, health system barriers, and socioeconomic barriers. Last year, HHS enacted policy changes to prevent discrimination on the basis of gender or sex under the Patient Protection and Affordable Care Act and encouraged providers in the Ryan White HIV/AIDS Program to mobilize their infrastructure to support gender-affirming services. More recently, HHS released guidance clarifying that State child welfare agencies should use their child welfare systems to advance safety and support for lesbian, gay, bisexual, transgender, queer or questioning, intersex, and other (LGBTQI+) youth, which can include access to gender-affirming care. HHS published guidance clarifying that health care providers (HCPs) cannot be required to disclose private patient information about gender-affirming care—despite threats from the State of Texas—and making clear that denying health care based on gender identity is illegal, as is restricting HCPs from providing care on the basis of a patient's gender identity.

HHS Secretary Xavier Becerra has called on all of HHS to explore every option possible to protect children, their parents, caretakers, and families. HHS will ensure that families and HCPs in Texas are aware of all of the resources available to them if they face discrimination as a result of the State's discriminatory gubernatorial order. Other States have also attempted to limit access to evidence-based standards of care for transgender and gender-diverse youth. These actions are politically motivated, and they are egregious. It is critical that transgender and gender-diverse youth and their families have the right to access this medically necessary treatment. ADM Levine noted that President Biden supports equality and will work to ensure that everyone is represented so that they have a voice and a chance to effect change and can help people understand the diverse needs of this nation. In closing, ADM Levine again thanked the Council members for their daily work to end the HIV epidemic.

Implementing the NHAS

Harold J. Phillips, M.R.P., Director, ONAP

Mr. Phillips highlighted the role of various Federal departments and agencies in devising implementation plans for the NHAS, most notably the Department of the Interior, which is taking unprecedented steps to address the social determinants of health (SDOH) and outcomes for Native Americans and tribal communities. He noted that ONAP created a Quality of Life Indicator Work Group as part of the NHAS. It will assess existing data for measuring quality of life among people with HIV, gather community input, develop indicators, and make recommendations for Federal agency actions to improve the quality of life for people with HIV.

ONAP is collaborating with the White House Office of National Drug Control Policy on its National Drug Control Strategy, Methamphetamines and Stimulants Strategy, and harm reduction approaches. ONAP is ensuring that people with HIV are addressed in new White House strategies around LGBTQI+ people and aging, mental health, and national security.

Federal agencies must submit their plans for implementing the NHAS to ONAP by early April, and ONAP aims to finalize a coordinated implementation plan in June. A key element of the final Federal implementation plan will be the definition, specification, data source(s), and target for the developmental indicator on quality of life among people with HIV. The EHE initiative complements the NHAS by focusing on geographic areas that need additional help to meet the national goals. CDC published an optimization model that gives more insight into the EHE initiative.

The Federal implementation plan will increase health equity by expanding access to HIV testing and preexposure prophylaxis (PrEP); combating stigma and discrimination, including HIV criminalization; and raising awareness about access to care, in part by engaging the private sector. Eliminating disparities is likely to remain a key part of the President's proposed 2023 budget. Aligning existing Federal programs with the NHAS also enhances health equity. For example, the Substance Abuse and Mental Health Services Administration has announced three new funding opportunities that advance the goals of the NHAS and recognize the work under way by EHE initiative jurisdictions. Mr. Phillips encouraged State and local organizations to consider how their programs and services could better align with the NHAS. In conclusion, he noted that three of the four items that make up the Unity Agenda outlined by President Biden in his State of the Union address—addressing the opioid epidemic, improving mental health services, and supporting veterans—are especially important for people with HIV and link to the goals of the NHAS.

PACHA Subcommittee Reports

EHE and the Updated National HIV Strategy

Carl Schmid, M.B.A., and John Saperro, Co-Chairs

Mr. Saperro reported that the Subcommittee provided input for the updated NHAS and is pleased with the strategy's attention to a number of issues raised by PACHA, such as health disparities, concerns of aging PWH, and workforce shortages. He pointed out that continued community input is important for NHAS implementation. Mr. Schmid said that ending HIV will take funding, and the 2022 budget, despite some increases, falls substantially short of the amounts originally budgeted for a number of efforts, including the EHE initiative. At the previous PACHA meeting, the Subcommittee presented and PACHA approved a letter to Secretary Becerra on the need to enhance private-sector involvement in the NHAS. Such involvement is especially important given the shortfalls in funding, said Mr. Schmid. He added that the Subcommittee played an integral role in developing two agenda items for this PACHA meeting (Strengthening the HIV Workforce and Providing PrEP for the Nation) and drafted a letter to the Secretary for PACHA consideration on increasing PrEP uptake nationally.

Stigma and Disparities

Justin C. Smith, M.S., M.P.H., Co-Chair

Mr. Smith said that the Stigma and Disparities Subcommittee created a subgroup on molecular HIV cluster detection and response (MHCDR) following a robust conversation at the previous PACHA meeting. This Subcommittee plans to convene a meeting of Federal representatives, academics, policymakers, and others to discuss emerging technologies for molecular HIV surveillance and how, when, and whether such surveillance should be deployed. The Subcommittee also contributed to this PACHA meeting's agenda item on providing PrEP for the nation, which is a cornerstone of the EHE initiative but has yet to be leveraged for maximum benefit. Mr. Smith said that the Subcommittee continues to bring community voices forward, centering the experience of people with HIV and communities affected by HIV.

The Global Agenda

Jen Kates, Ph.D., Co-Chair

Dr. Kates explained that the Subcommittee has committed to ensuring that global issues are integrated into the agenda at every PACHA meeting. Opportunities exist to incorporate the lessons of PEPFAR into the domestic response and vice versa. President Biden nominated John N. Nkengasong, Ph.D., to be the PEPFAR Ambassador-at-Large and U.S. Global AIDS Coordinator a year ago, and that nomination hearing begins today. Dr. Kates thanked the Acting U.S. Global AIDS Coordinator, Angeli Achrekar, Ph.D., for her leadership, noting that PEPFAR, like other agencies, has been challenged with maintaining its programs during the COVID-19 pandemic and with leveraging PEPFAR service sites to provide COVID-19 vaccinations. PEPFAR is also developing a new 5-year strategy and seeking Congressional reauthorization. PEPFAR's annual guidance to participating countries will be the focus of discussion on Day 2 of this meeting. The Global Agenda Subcommittee assisted with coordinating the PACHA agenda item on women and Girls, engaging a participant of the PEPFAR Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) program for girls and women.

PACHA to the People

Breakout Group A: HIV Prevention in the Context of Ending the HIV Epidemic

Marlene McNeese and Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., Co-Facilitators

Dr. Wheeler summarized some of the main themes of the discussion, noting concerns that HIV services are compartmentalized to reach specific populations (e.g., LGBTQ people, aging people with HIV, or people with HIV with physical disabilities) rather than fully accessible to all. Discussion underscored the importance of integrating messaging about PrEP with awareness that a person with HIV with an undetectable viral load cannot transmit HIV (undetectable equals untransmittable, or U=U). Participants stressed the need for gender and sex education in schools, and Dr. Wheeler suggested that PACHA make a clear statement about the importance of early sex education.

The quality of service delivery is inconsistent, in part related to providers' preparedness for addressing diverse populations and their unique issues. Participants stated that the health care system is broken, and efforts must be made to advance care and treatment across the continuum, tackling the historic issues that have led to compartmentalization of services. Discussion illustrated the importance of assessing and improving quality of life for people with HIV, which

includes affordable, accessible, and quality health care, beyond a focus on indicators. There continues to be a need to address stigma and also to reframe the discussion around aging among people with HIV.

Dr. Stewart and others provided powerful ideas on how PACHA can promote an evolution from volume-based care to value-based care with better outcomes. Recommendations and initiatives should allow HCPs to deliver high-quality services that address a broad array of health and related services to optimize the quality of life of people with HIV.

Ms. McNeese added that current funding approaches perpetuate the compartmentalization of services. New and creative funding mechanisms are needed to support integrated, systemic, well-thought-out approaches to the health and well-being of people with HIV and those at risk for HIV. (A detailed summary of Breakout Group A is available in Appendix A.)

Breakout Group B: NHAS and the EHE Initiative

John Wiesman, Dr.P.H., M.P.H., and Guillermo Chacón, Co-Facilitators

For the breakout session, co-facilitators posed some questions about perceptions of the NHAS and the EHE initiative and the role of people with HIV in implementing these efforts, especially in rural communities. Participants emphasized the need to embrace U=U as an important component across all implementation steps. Discussion stressed that words matter; communication and messaging must be sensitive and use stigma-free, empowering, and inclusive language. Participants suggested breaking down messages in a way that is basic but also meaningful, recognizing that perspectives, awareness, and knowledge about HIV vary depending on the audience. It is important to seek input from a range of voices, including people with HIV, and especially for complicated topics, such as the debate over MHCDR. Some conversation focused on the need to delve deeper into stigma reduction efforts and HIV workforce issues, particularly the need for people with HIV in the HIV workforce. Efforts must reach out to young people and also address the concerns of aging people with HIV.

Participants advocated for more opportunities to provide feedback and celebrated the return of PACHA to the People. Appreciation was expressed for PACHA's efforts to include people from all the populations disproportionately affected by HIV and to recognize Native and Alaskan communities in particular. It was noted that people who are not visible in the data are essentially invisible, which has serious implications for implementation of Federal strategies. Mr. Chacón appreciated the voices of people who have lived with HIV for decades as well as people who are newly diagnosed.

Dr. Wiesman was impressed by the willingness of people to share their personal stories to illustrate what PACHA and the Federal government must address. Participants identified a need for more assistance tackling issues such as HIV criminalization at the State and local levels. That assistance includes better disseminating basic information, such as the fact that HIV cannot be transmitted by saliva. Lawmakers and policymakers need to understand the fundamentals of HIV prevention, transmission, and treatment, as do young people. Many people are unaware that HIV remains a serious chronic health condition, despite available treatment. There was general agreement that the NHAS is addressing meaningful issues, such as quality of life, aging, and

women's health, and is also a call to better integrate health care to provide a holistic approach. (A detailed summary of Breakout Group B is available in Appendix B.)

Discussion

Ms. McNeese said that participants expressed interest in how their input would carry through into next steps and concrete action. She and Dr. Wiesman committed to improving the transparency of PACHA and finding ways to report back to the community about the results of PACHA's efforts to influence policies and practices.

PACHA members thanked the participants for their engagement and for the opportunity for open, honest discussion. They appreciated the wealth of issues, ideas, and information that emerged from the discussion and highlighted some areas of particular interest, such as the following:

- Creating and disseminating broad-reaching guidance on person-first language to reduce stigma (possibly building on HRSA's work to integrate its internal guidance with that of CDC; see also the [HIV Language Guide](#) from the National Institute of Allergy and Infectious Diseases)
- Identifying resources for promoting health among people who use drugs, including PrEP access
- Assessing MHCDR
- Creating and deploying Federal resources aimed at eliminating State and local laws criminalizing HIV, such as basic education for lawmakers
- Educating providers about PrEP, especially the utility of PrEP for women, and the need for PrEP navigation services, especially for women of color
- Increasing sex-positive education, including more education about STIs, with consideration of collaborating with the National Endowment for the Arts for HIV-focused arts education
- Enabling holistic health care that account for mental health and aging, among other topics
- Expanding representation on PACHA, specifically including aging people with HIV
- Improving outreach and messaging to younger audiences at risk for HIV
- Promoting options that increase access to care (e.g., telehealth services) and acceptability of care (e.g., injectable HIV drugs)
- Prioritizing viral suppression as a key step toward ending HIV while addressing age-related conditions and other comorbidities among people with HIV
- Articulating specific, immediate, and novel steps to achieve the 2030 goals, with input from all stakeholders
- Working toward comprehensive data collection that accounts for all disproportionately affected communities
- Increasing awareness about the EHE initiative and the NHAS
- Advocating for continued leadership at the Federal level and increased resources for HIV treatment and prevention

It was suggested that PACHA subcommittees should consider the input from the breakout sessions and determine their priority issues for the next 6–12 months.

Mr. Phillips appreciated the suggestion to engage with the National Endowment for the Arts. He noted that ONAP held a community listening session to gather ideas about the Federal role in eliminating State HIV criminalization laws, and Federal agencies will digest those ideas and identify ways to support State and local efforts. Mr. Phillips anticipated that some of the implementation plans from various agencies would address some concerns of aging people with HIV, among other topics. He reminded the group that early HIV/AIDS activists stressed that knowledge is power, and many of the issues raised during the breakout sessions focused on the need to raise awareness and increase knowledge.

Timothy Harrison, Ph.D., noted that the HIV Challenge funds community-generated projects around stigma reduction, and several of the initial awardees rely on the power of art for communication. Ms. Hayes noted that ODP is finalizing a style guide for the EHE initiative that would promote more person-first language.

Closing Remarks and Recess

Ms. McNeese appreciated all of the planning and work that brought forth so much meaningful interaction. She offered special thanks to Ms. Hayes and her ODP colleagues for support and HHS Studios and Rose Li & Associates for exceptional technical support. Dr. Wiesman thanked participants for taking the time to join the meeting and provide input. He looked forward to the possibility of in-person meetings around the country to learn more about communities firsthand and to hear from people unable to participate in a virtual platform. Dr. Wiesman expressed gratitude for the Federal partners that have been so responsive to PACHA's recommendations, and particularly for doing so during the COVID-19 pandemic. He noted that lessons learned during the pandemic have made their way into the NHAS. He also noted that systems that are designed to address the needs of the most vulnerable work well for everyone. Dr. Wiesman recessed the meeting for the day at 4:26 p.m.

Day 2

Opening Remarks from the PACHA Co-Chairs

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

Ms. McNeese welcomed the participants at 10:00 a.m. She reviewed the proceedings of Day 1 and the agenda for Day 2. Dr. Wiesman reminded participants to send written comments to pacha@hiv.gov.

Roll Call

B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer; Acting Director, ODP, OASH, HHS

Ms. Hayes called the roll.

PACHA MHCDR Work Group Update

Marlene McNeese and Justin C. Smith, M.S., M.P.H., Co-Chairs

Following the November 2021 PACHA meeting, which included a panel discussion on MHCDR, the PACHA Stigma and Disparities Subcommittee established an MHCDR Work Group. It will bring together key stakeholders to define a process for developing recommendations that PACHA can put forward to the HHS Secretary and ONAP. The Work Group plans to convene a 2-day meeting on the issue. It aims to develop clear recommendations on whether, when, and how to apply MHCDR tools and, when such approaches are used, where they offer the most benefit and how to minimize harm and address concerns of people with HIV.

Update on PEPFAR Guidance to Countries for 2022

Jirair Ratevosian, Senior Advisor, Office of the Global AIDS Coordinator and Health Diplomacy, PEPFAR, Department of State

PEPFAR has enjoyed strong bipartisan support since its inception in 2003. The program has saved millions of lives and prevented millions of HIV infections. PEPFAR-funded programs provided a platform for global response to the COVID-19 pandemic. Each year, PEPFAR publishes detailed country and regional operational plan (COP/ROP) guidance for countries and regions to plan program implementation for the next fiscal year (FY). Recognizing the continued challenge of COVID-19, the guidance includes provisions for addressing COVID-19. The guidance reflects priorities of the Biden administration, such as health equity, gender equality, diversity, inclusivity, and psychosocial support. Mr. Ratevosian summarized the core policy and program priorities addressed in the guidance. PEPFAR recognizes the importance of sustaining successful approaches to drive down new infections and HIV mortality rates but acknowledges that backsliding can occur.

PEPFAR's focus on key populations includes specific new language in the guidance about increasing gender equality in HIV and other health programs; improving programs to prevent gender-based violence; and addressing the needs of adolescent girls and young women (e.g., updating the DREAMS program to include psychosocial support). The guidance spells out expectations and requirements around human rights, which includes mandatory staff training at all levels. The guidance calls on countries to scale up PrEP, improve services, and enhance data collection and monitoring for key populations, such as transgender people and incarcerated people, among others. It offers updates on testing and new PrEP products.

The guidance establishes a new minimum program requirement for FY 2023 mandating that countries

- address structural barriers to improve key populations' access to HIV services;
- mitigate harmful policies and social norms that fuel stigma, discrimination, and violence;
- strengthen the capacity of organizations representing key populations; and
- strengthen the competency of HIV service providers to address key populations.

Countries develop plans that can be implemented successfully by ensuring that all stakeholders at all levels have a voice in the planning process, including partner countries, civil society organizations, multilateral organizations, and the private sector. A number of civil society

organizations have put forth their own People's COPs to advise PEPFAR on what their countries need. COP development involves numerous meetings and discussions to reach agreement on priorities, with input from multiple stakeholders. PEPFAR relies on data for decision making and ensures that all countries have the most recent data and financial tools to achieve their goals.

Discussion

Mr. Ratevosian explained that PEPFAR promotes the message of U=U by offering guidance on how to tailor activities for a local context and providing flexibility for localities to implement U=U according to local needs. Both breakout sessions from Day 1 of the PACHA meeting highlighted the need to better disseminate the message of U=U in the United States. Mr. Ratevosian said he and Mr. Phillips agree on the need to create space for domestic programs to learn from PEPFAR successes and vice versa. PEPFAR invites stakeholders to participate in the COP process through virtual meetings, which is one opportunity for U.S. Federal agency representatives to learn more about how countries communicate U=U successfully.

Sustained funding remains a persistent concern for PEPFAR as for domestic HIV programs. PEPFAR has invested a lot in health security and pandemic preparedness but needs more funding to ensure that its pandemic response does not take away from existing HIV programs. Mr. Ratevosian noted the need to educate funders about the importance of sustaining long-term investments to maintain the gains made against HIV.

Mr. Ratevosian explained that one key to successful stakeholder engagement is requiring countries to identify and include specific types of representatives from a range of sectors before they start the planning process. Agendas should allot time for stakeholders to present their perspectives and respond to proposals. Without such intentional approaches to inclusion at the granular level, down to the composition of individual meeting agendas, broad stakeholder engagement is not prioritized.

Mr. Phillips described a number of lessons learned from PEPFAR and asked that the PACHA Global Subcommittee assist with creating a formal mechanism for continued exchange of lessons learned. Michael Saag, M.D., commented that lessons from PEPFAR led to research projects in rural communities in Alabama. He added that local plans are crucial to development of COPs.

Mr. Ratevosian observed that the COVID-19 response spurred some innovative strategies that led to policy changes. For example, countries began dispensing multiple months' worth of medication, to relieve the strain on HCPs and health care settings, especially in rural areas. South Africa created pickup locations where individuals could retrieve medications rather than go to clinics with long wait times. Telehealth services expanded. As countries increase vaccine coverage, PEPFAR is considering how to foster collaboration between HIV and COVID-19 response programs to fill in some treatment gaps, particularly in sub-Saharan Africa.

PEPFAR has long created opportunities for the private sector to engage with countries, because it recognizes the vital role of private companies in health care delivery. This approach gives companies insights into the local challenges around access, for example. Mr. Ratevosian pointed out that including the private sector requires creation of policies around conflicts of interest and other good governance. He also noted that PEPFAR seeks input from companies outside of

health care, such as food and beverage companies, which have extensive experience navigating supply chains. To launch the DREAMS program, a successful public–private partnership, PEPFAR identified the services needed, set its expectations, and relied on stakeholders to take on various components. Transparency is key to successful private-sector engagement.

Mr. Ratevosian said that efforts to increase the participation of companies outside of the health care industry should consider other motivations, such as increasing workforce productivity by improving community health. Private companies can also be asked to contribute their capacity and services instead of financial support—for example, they may have market research that can help with reaching key populations.

Mr. Ratevosian commented that some of the People’s COPs were intentionally aligned with PEPFAR indicators, which made them easy for PEPFAR to embrace. South Africa’s People’s COP is a model of accountability, with useful data that enhances the quality of the conversation and brings a realistic perspective. The People’s COPs tend to offer granular detail, and PEPFAR relies on the civil society organizations that produce them to keep PEPFAR accountable. Such efforts require funding, and civil society organizations are often supported by private funding.

PEPFAR guidance requires retraining HCPs on accountability as a structural intervention to mitigate stigma and discrimination. PEPFAR also expects communities to identify what they need to break down barriers to care and recognizes that communities need funding to perform and sustain efforts.

Asked how to ignite a sense of urgency around HIV response in the United States, Mr. Ratevosian responded that high-level leadership is crucial for setting the tone and cadence for collaboration. There was agreement that the question merits more exploration.

Laura Platero, J.D., noted that PEPFAR could be a model for sovereign Tribal governments to address HIV, although they face substantial structural barriers and lack sufficient funding. Mr. Ratevosian suggested that all stakeholders review the PEPFAR guidance for insights on a collaborative, science-based approach. He suggested that PEPFAR could seek input from ONAP before the next revision of COP guidance.

Women and Girls: Why Representation Matters

Co-Facilitators: Jen Kates, Ph.D., and Alicia Diggs, M.P.H., PACHA Members

Panelists: Jae Sevelius, Ph.D., Professor, Department of Medicine; Director, Center for AIDS Prevention Studies; Principal Investigator, Center of Excellence for Transgender Health, Division of Prevention Science, University of California, San Francisco

Lyndah Ombima Musimbi, Member, PEPFAR DREAMS Program Advisory Committee

Tiommi Lockett, National Organizer, Transgender Law Center

Eunice Mejiadeu, National Youth HIV and AIDS Awareness Day Ambassador, Advocates for Youth

Naina Khanna, Co-Executive Director, Positive Women’s Network—USA

Dr. Kates said the goal of the session was to learn from women what it means to see one's self in data, program design, and services and to learn how PACHA could better address the challenges faced by women and girls, including transgender women and girls and nonbinary people. Ms. Diggs hoped the discussion would also shed light on some positive experiences and highlight areas for more education and awareness. Dr. Kates posed questions to facilitate discussion.

How can discussions about HIV center on women with HIV rather than focus narrowly on PrEP access or those at risk for HIV?

Ms. Khanna responded that globally, about half of people with HIV are women and girls; in the United States, about one-quarter are (not counting transgender women and girls because of insufficient data). Too often, the conversation focuses solely on prevention for women and girls. The U.S. Federal response, for example, lacks attention to gender nuances. It is critical to recognize that women with HIV face entrenched systemic barriers; they are more likely to be Black, low-income, or transgender, and living at the intersection of violence and oppression. Most women with HIV live in poverty.

Ms. Khanna expressed that the prevailing narrative that people with HIV have a normal lifespan is not true for Black or transgender women with HIV. She challenged CDC to disaggregate its data to better reveal HIV morbidity and mortality rates by race and gender. The Ryan White HIV/AIDS Program and the NHAS have taken steps toward gender-affirming, holistic care and quality-of-life metrics, but even these efforts overlook sexual and reproductive health. Such shortcomings result from inadequate representation of women with HIV in program design, data collection, or monitoring.

Ms. Khanna emphasized the importance of creating enabling, affirming environments for people with HIV that support their human rights. Across the country, State legislatures are pushing laws to overturn abortion rights and target transgender people. PACHA and its Federal partners should use every tool available to overturn laws criminalizing HIV, said Ms. Khanna.

In some cases, Federal and State priorities around HIV do not align. What are the implications of that misalignment?

Ms. Luckett noted the legislation in Texas that aims to prosecute parents of transgender children who seek transition-related services and the HCPs that provide them. She said she had to fight to be recognized as a transgender woman in her home State (Arkansas). Once she was diagnosed with HIV, she was required to disclose her status to her partner before engaging in sex and to her provider in order to be eligible for Ryan White HIV/AIDS Program services. In Arkansas, failing to disclose HIV status to a partner is felony, and failing to disclose to a provider is a misdemeanor—so Ms. Luckett believed her freedom was threatened from the moment she was diagnosed. She faced housing and mental health issues, and she and her partner lived in secrecy because of the stigma of HIV. As a Black, transgender woman, Ms. Luckett said government bodies attack and criminalize her very existence. She continues to live in Arkansas because she knows her work as an advocate and the personal experience she brings to it are vital to her community, and she refuses to be driven out.

Ms. Mejiadeu said she was born HIV-positive, so she brings a different perspective. She has lost some relationships within her conservative, Cameroonian family as a result of her HIV status. Dating is difficult, because her status brings automatic judgements and assumptions about her sexual behavior. Even in areas where advocacy has succeeded in providing protections to people with HIV, the lack of education about HIV leads to continued bias, particularly among law enforcement officers. As an 18-year-old woman with HIV, Ms. Mejiadeu said she had to research questions such as whether she could be jailed for failing to disclose her status. She believes she has to hide a large part of her identity because others do not understand or have no experience with HIV.

What moved you to become an advocate for people with HIV?

Ms. Musimbi said she needed money to support herself and her family and to pay school fees. When jobs and government loans proved insufficient, she considered sex work. She met a representative from the PEPFAR DREAMS program who helped her understand how to better manage her money. Ms. Musimbi learned how to start her own business and ran a delivery service; now she works in a leading credit institution and supports her family, including paying her brother's school fees. The DREAMS program provided access to HIV testing, PrEP, and free contraceptives. In addition, it offered a safe space to interact with others and build confidence. Ms. Musimbi said DREAMS unlocked her potential, and now she trains mentors in the DREAMS program. Opportunities to become involved and lead are built in to the program. Participants have offered innovative ideas, such as packaging PrEP differently than antiretroviral drugs, to avoid stigma and increase uptake of PrEP. Ms. Musimbi said that DREAMS is scaling up projects to reach more girls and women with information, services, and opportunities so that they will not have to resort to sex work. She hoped she could transform others' lives the way hers was transformed.

Dr. Sevelius said they identify as a nonbinary person. Their perspective is a limitation and a strength in their work as a social scientist. Representation of women and girls—and specifically transgender and gender-diverse people—in the HIV response is important. The more the diversity of gender identity is recognized and acknowledged in health care, the more evident it becomes that gender-affirming care benefits everyone. In practice, such care includes social affirmation, such as using a person's preferred pronouns, and vetting referrals to ensure that transgender people receive the care they need. Structurally, it means creating environments that support gender-affirming care, such as having accessible bathrooms and data systems that allow for accurate identification by gender identity. Medically, it involves access to hormone therapy, for example. Dr. Sevelius' research has demonstrated the benefits of gender-affirming care in all types of health care services.

Dr. Sevelius described the We Are All Women project, which emerged in response to research on the barriers to integrating transgender women into sexual health services for cisgender women. It was revealed that providers need education on how to support and welcome transgender women.

Dr. Sevelius called for Federal-level attention to HIV status-neutral programming. In their research with transgender people, the community did not segregate according to HIV status. Funding that focuses solely on HIV prevention or treatment or on HIV services creates that

segregation and reinforces stigma. Communities want to support each other and be together. Dr. Sevelius cited an example of a status-neutral peer support group in which members worked together around testing, services, and health strategies.

Ms. Mejiadeu noted that disclosing her HIV status to a new provider who was not an HIV specialist was awkward, leading her to question what the provider thought a person with HIV should look like, and that experience prompted her to consider advocacy. Ms. Mejiadeu added that her own insecurities compelled her to distinguish herself from other women with HIV, particularly transgender women, by emphasizing that she was born with HIV. She realized that making that distinction was tantamount to advocating for herself but not for others. All women and girls with HIV travel a similar path in terms of care and services, so the distinctions around transmission or gender identity are not helpful.

Ms. Luckett noted that participating in a 2014 PACHA meeting was the catalyst for her involvement in advocacy. She shared her experience broadly in high-profile settings such as the U.S. Conference on AIDS. She learned that not everyone was willing to accept her, but her authenticity touched people—just as Ms. Mejiadeu’s authenticity does. Ms. Luckett noted that all women and girls face attacks on their bodily autonomy, such as restrictions on abortion access or gender-affirming surgery. In her advocacy, Ms. Luckett seeks to highlight similarities rather than differences. She added that the Positive Women’s Network offers trainings on cultural sensitivity to educate about transgender issues. Providers need more education about how to treat transgender people so that they can help patients make informed decisions about care.

What steps can PACHA take to advance the agenda around women and girls with HIV?

Ms. Khanna said that this conversation underscores why representation matters. She called for structured forums to include the voices from the populations most affected by HIV to deepen the conversation and strengthen the involvement of civil society organizations in the HIV response. Ms. Khanna suggested that members of people with HIV networks that represent communities most affected by HIV should have designated seats on PACHA and other bodies that advise on development, monitoring, and evaluation of the NHAS and the EHE initiative.

Ms. Khanna proposed that PACHA recommend incorporating focused, gender-neutral responses into the NHAS, the EHE initiative, and other programs. The HIV community has an opportunity to counter the longstanding policies of policing the bodies of women, transgender people, and people of color by uplifting bodily autonomy.

Everyone has a shared interest in creating destigmatizing environments of care for people of all genders and races, Ms. Khanna noted. In an effort to promote HIV status-neutral services, PACHA and its Federal partners should ensure that the quality and quantity of services for people with HIV are maintained. Doing so requires attention to monitoring, evaluation, and assessment. Ms. Khanna added that addressing the needs of all women with HIV would require a systemic change but would benefit everyone.

Strengthening the HIV Workforce

Focused Strategies for Reimagining the HIV Workforce and Achieving the Goals of the EHE Initiative

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

Dr. Guillamo-Ramos explained that the number of people with HIV receiving treatment is growing, as is the proportion of people with HIV over age 50, while the HIV workforce is decreasing. The pace of progress over the past 10 years toward decreasing new HIV infections is not rapid enough to reach 2030 goals. HIV transmission clusters identified by molecular HIV surveillance demonstrate that current HIV systems have gaps and failures. The COVID-19 pandemic has decreased the available HIV workforce, exposed chronic inequities in health care, and disrupted HIV care. For all these reasons, Dr. Guillamo-Ramos proposed a new approach to HIV workforce development according to five strategies.

- **Broaden definitions of the HIV workforce:** Encourage a diverse cohort of qualified HCPs who do not necessarily specialize in HIV treatment to provide comprehensive health and social services for people with HIV and recruit other potential providers, such as community health workers, dentists, and pharmacists.
- **Adopt multidisciplinary team-based models of care:** The Ryan White HIV/AIDS Program demonstrates that use of multidisciplinary care teams results in better patient outcomes than does traditional delivery methods.
- **Enable practice to the highest level of licensure and training:** Each State dictates the scope of practice for providers such as nurse practitioners, physician assistants, and pharmacists. No data support such restrictions for the purpose of safety. Allowing nurse practitioners to practice according to their full capacity would decrease the shortage of primary care providers by 70 percent; enabling physician assistants and pharmacists to do so would further mitigate the workforce shortage.
- **Adopt decentralized and differentiated models for service delivery:** Rather than requiring people to receive care in a central facility, services should also be provided through telehealth, in homes, in pharmacies, and through community-based organizations (CBOs). Ideally, assessment will determine what care is needed, at what frequency and intensity, who should provide it, and where.
- **Increase the capacity to mitigate SDOH:** Despite increasing recognition of the role of SDOH, more work is needed to identify the mechanisms that mitigate the drivers of SDOH. Research should explore the contributors to resilience and thriving.

Dr. Guillamo-Ramos offered the following recommendations:

- Remove regulatory barriers that place restrictions on practicing at the highest level of training and licensure.
- Ensure CMS reimburses for decentralized, differentiated, team-based, whole-person HIV prevention and care services.

- Support a shift toward education and training that emphasizes key competencies needed for team-based, whole-person HIV care and increase funding for specialized HIV training.
- Invest in infrastructure development for delivery of decentralized, differentiated HIV prevention and care services.
- Allocate funding to HIV-specific demonstration projects designed to mitigate the specific mechanisms of SDOH and foster multilevel resilience.

Supporting Education and Training for the HIV Workforce

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

Dr. Armstrong illustrated the insufficiency of the HIV workforce with data from 14 States (primarily in the Southeast) that do not have any clinicians with HIV experience serving people with HIV who are covered by Medicaid. More HCPs with experience in HIV are needed because of the complexity of HIV treatment, particularly for people who are aging or have comorbidities or both. Providers must be comfortable addressing sexual health and, ideally, committed to a holistic, team approach that addresses SDOH. Dr. Armstrong offered several ideas for expanding the number of HCPs who can care for people with HIV.

HCPs can gain HIV expertise through residencies and fellowships. However, HIV specialists are paid less than other types of care providers, regardless of training type. The Bolstering Infectious Outbreaks Pandemic Workforce Act proposed in Congress would offer student loan repayments for HCPs who work in medically underserved communities and could help expand the diversity as well as the size of the workforce. Every HCP training program should include basic HIV care and prevention so that all HCPs have some comfort treating people with HIV. Mechanisms that provide primary care providers with easy access to a regional network of HIV experts for consultation by phone or online are effective ways to address the needs of people with HIV in underserved areas. HCPs would also benefit from access to decision-support tools that help with selection of antiretroviral therapy for uncomplicated cases.

The COVID-19 pandemic demonstrated the power of telehealth services, particularly for those in rural areas. People must have safe and comfortable ways to use telehealth services, which requires addressing the digital divide and limited broadband access. Dr. Armstrong echoed Dr. Guillamo-Ramos' suggestion to expand the capacity for differentiated service delivery so that people have options to receive care in ways that make sense for them.

Dr. Armstrong supported all of Dr. Guillamo-Ramos' recommendations but added that investment in training should also consider individuals who are not pursuing HIV specialization. In addition, she recommended that infrastructure be developed to support the non-HIV-expert workforce in addressing the needs of people with HIV.

Discussion

Dr. Guillamo-Ramos acknowledged shortages across the entire health care workforce over the past 2 years as a result of the COVID-19 pandemic. Data indicate that many nurses choose to work outside of hospitals and migrate to areas where they can practice according to the full

extent of their training. Nursing schools are experiencing a shortage of faculty, which leads them to turn away student applicants. Many students need financial support for education and training because the compensation is inadequate, a persistent problem in a field dominated by women. Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, emphasized that undercompensation must be addressed, particularly in rural areas.

Mr. Chacón strongly supported Dr. Guillermo-Ramos' recommendations. He noted that efforts must be made to provide health services on weekends to meet community needs and to eliminate stigma and bias within the HIV workforce.

Dr. Guillermo-Ramos said that a decentralized model would move the locus of care into the community, which would increase community engagement and broaden the workforce that addresses the needs of people with HIV. He explained how limitations on scope of practice prevent health delivery systems from getting the most out of trained HCPs (see also the [American Association of Nurse Practitioners assessment of practice environments by State](#)).

Raniyah Copeland, M.P.H., suggested that Dr. Guillermo-Ramos' proposed recommendations include relevant members of the nonclinical HIV workforce, who are important to ending the HIV epidemic. She noted that HRSA is piloting a program to recruit HIV workforce members from Historically Black Colleges and Universities to enhance cultural competence. Ms. Copeland advocated for student loan forgiveness programs for clinical and nonclinical staff, which can enhance the diversity of the workforce. She noted that facilities need technical assistance on how to ensure effective interactions among HIV workforce of different generations.

Dr. Armstrong observed that it is critical for HCPs to collaborate with CBOs to improve the quality of care and access to services for people with HIV. She noted that HIV has led the way in integrating clinical and nonclinical care, and the Ryan White HIV/AIDS Program pioneered the concept of a medical home. Some efforts have been made to provide holistic care outside of Federally funded programs, which could be a model for the future.

Dr. Saag commented that the nature of HIV care has changed over time. Now, infectious disease specialists can act as consultants to primary care providers who can meet many of the needs of people with HIV. Dr. Saag said that he will work with other PACHA members to translate Dr. Guillermo-Ramos' recommendations into a resolution for PACHA consideration.

Providing PrEP for the Nation

Justin C. Smith, M.S., M.P.H., and Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, PACHA Members, Co-Facilitators

Mr. Smith said access to PrEP and related services required for continuous use is key to ending the HIV epidemic, yet only about one-quarter of the 1.2 million people eligible have been prescribed PrEP. Dr. Stewart added that guidance recommends that all HCPs talk to their sexually active adolescent and adult patients about PrEP and prescribe PrEP to anyone who requests it. Current programs are not reaching people who would benefit the most.

Driving Demand, Creating Access for All

Kenyon Farrow, Managing Director, Advocacy & Organizing, PrEP4All

Mr. Farrow outlined the racial and ethnic disparities in PrEP uptake. Underuse of PrEP is tied to the lag time between approval and HCP guidance on PrEP use, the high cost of the drugs, the lack of coverage of required laboratory testing, and low awareness about PrEP. To overcome these barriers, Mr. Farrow advocated for a national PrEP access program that covers the full scope of care needed for PrEP initiation and ongoing use.

Mr. Farrow suggested methods to increase demand for PrEP, such as combating misinformation around PrEP and providing people on the front lines with better tools to understand and address patients' reluctance to begin PrEP. More and better messaging is needed to reach people who would benefit from PrEP. The number of HCPs who can prescribe PrEP should be increased. Screening could be conducted with a single question about current or intended sexual activity, followed by HIV and hepatitis B testing. A national education campaign should be launched to increase awareness of PrEP and U=U.

To improve access to PrEP, Mr. Farrow recommended engineering systems to serve the most vulnerable people, then adding services as needed to help people who are less vulnerable. Systems should allow for maximum flexibility, without administrative hurdles or economic means testing. Organizations should be offered financial incentives to provide PrEP and to retain patients in care. A modest, universal PrEP program could lower overall patient care costs. Federal entities should identify those insurers that are inappropriately charging their beneficiaries for PrEP.

A New Ending, Not Just a New Chapter: The Need for a National PrEP Program

Amy Killelea, J.D., Killelea Consulting

Ms. Killelea described the drug pricing and access problems that make PrEP unaffordable despite the availability of low-cost generic options. Neither tweaking the broken and fragmented health care system nor pumping more Federal grant money into it will help. Instead, Ms. Killelea and her colleagues at Johns Hopkins Bloomberg School of Public Health put forth a [detailed proposal for a national PrEP program](#). She summarized the three key components of the plan:

- A bulk purchasing program that allows the Federal government to negotiate fair prices for PrEP drugs and laboratory testing for Medicaid beneficiaries and the uninsured. Negotiations would start with safe, effective, oral PrEP medications and anticipate new products to come. The ability to negotiate drug prices was vital to the success of HRSA's AIDS Drug Assistance Program.
- Options for clinical settings to dispense PrEP on site and to offer laboratory services to those without insurance coverage.
- A national network of nontraditional community sites that offer PrEP, supported by telehealth. This network can reach people who do not regularly access clinical health services and would complement existing services.

The proposal underscores the need for Federal funding to take the pressure off of clinics to rely on the 340B drug pricing program, which is not always a sustainable or ethical way to fund PrEP. Ms. Killelea said progress toward ending HIV requires a plan, not just more money.

Federal Steps to Increase PrEP Access

Carl Baloney, Jr., Vice President and Chief Advocacy Officer, AIDS United

Mr. Baloney said that to ensure that PrEP is available to everyone who would benefit, health insurance plans would have to prioritize people of color, people of transgender experience, people who use drugs, and people who engage in sex work. Among the steps the Federal government could take to improve PrEP uptake are simplifying PrEP protocols and providing access to simpler tools. All HCPs need better education about PrEP and how to talk about sexual health with their patients. Opt-out HIV screening should be implemented wherever possible, including emergency departments, urgent care settings, and annual wellness screenings, so that people have access to HIV testing wherever they enter the health care system. As with COVID-19 tests, the Federal government should make HIV rapid testing kits free and available by mail or even in pharmacies, libraries, and post offices to ensure access for everyone. Pharmacists should be able to prescribe PrEP, and PrEP should be considered a preventive medicine.

Medicare is effective at covering PrEP and related laboratory and medical visit costs, but people who are uninsured cannot afford these ancillary costs even if they have access to the medication. The 340B drug pricing program plays a role in access, and recent changes undermine the ability of clinics to work toward HIV prevention goals. The Federal government should seek to protect the 340B program's original intent of stretching scarce Federal dollars for safety net systems. The Ready, Set, PrEP program was flawed from the start because it did not account for the costs of HIV testing and prescribing. Organizations that participated in Ready, Set, PrEP faced a net loss in revenue as a result.

Mr. Baloney encouraged PACHA to support an ambitious program to increase PrEP access and uptake by recognizing that HIV remains an epidemic; emphasizing the tools available to eliminate HIV; capitalizing on the momentum and lessons learned from the COVID-19 pandemic around education, testing, and prevention; destigmatizing HIV; and eliminating State laws that criminalize HIV.

Policies and Programs Needed to Ensure PrEP Access Nationwide

Carl Schmid, Executive Director, HIV+Hepatitis Policy Institute

Mr. Schmid reiterated some of the reasons for low PrEP uptake, adding that CDC only recently began allowing grantees to use Federal funds to pay for ancillary services required for PrEP. No mechanisms are in place yet for grantee accountability. Other barriers relate to stigma and a daily pill regimen plus follow-up visits. Mr. Schmid agreed with the other presenters on the need for a national PrEP program that covers current products and anticipates future developments, such as long-acting PrEP. CDC should allow grantees to spend more on PrEP and ancillary services. HRSA-funded community health centers in EHE jurisdictions have demonstrated great success in initiating PrEP, and funding should be expanded to support all 1,400 community health centers in providing PrEP.

Mr. Schmid called for more data to better understand where PrEP is being provided. Current regulations should be enforced, so that private insurance beneficiaries have access to PrEP via the drug formulary with no cost sharing. Newly approved drugs should be evaluated quickly and guidance updated accordingly. Medicaid's approach to PrEP has been successful, but many States have not expanded Medicaid to include all low-income people. Medicare Part D covers PrEP but requires beneficiaries to share the costs.

Two proposals have been put forth in Congress to establish a national PrEP grant program. The PrEP Assistance Program Act would provide funding for community and provider outreach as well as PrEP and associated services for uninsured and underinsured people. The PrEP Access and Coverage Act takes a similar approach but also stipulates an HHS-led education campaign program and privacy protections for PrEP users who have a family insurance plan. Alternatively, Mr. Schmid said, a program could be established through Congressional appropriations by building on existing grant programs. Numerous HIV and LGBTQ+ organizations jointly signed a letter to President Biden advocating for \$400 million for a national PrEP grant program for FY 2023 that builds on existing programs and mechanisms.

Discussion

Mr. Schmid acknowledged that successful PrEP adherence requires wraparound services similar to those provided by the Ryan White HIV/AIDS Program. He noted that Federal legislation is needed to ensure that injectable PrEP formulations are available through all insurance formularies without cost sharing in all States.

Ms. Copeland pointed out the lack of concrete data on the cost of addressing the social drivers that limit PrEP uptake in certain populations. For example, there are no data on the costs of a national outreach campaign. Ms. Copeland urged advocates to put a price tag on the proposed solutions. Mr. Farrow said CDC should have data on the costs of its education campaigns.

Mr. Sapero noted that HIV.gov offered some good [materials to raise awareness about PrEP](#).

PACHA Letter to the HHS Secretary on Scaling Up PrEP

Mr. Schmid introduced a letter to Secretary Becerra drafted by the EHE and HIV Strategy Subcommittee on increasing PrEP uptake nationally, which was circulated to PACHA members in advance. It outlines the need to prioritize racial, ethnic, and other inequities in access and uptake of PrEP and to maximize the role of existing systems in paying for PrEP drugs and ancillary services. The letter also calls for creation and funding of a national PrEP grant program that would support community and provider outreach and pay for PrEP and associated services for uninsured and underinsured people. In response to Ms. Copeland, the draft was amended to include the need to estimate the resources needed to achieve the PrEP goals identified in the NHAS as a preliminary step toward creating a national PrEP grant program. In the list of potential recipients of national PrEP grant funding, Dr. Weisman suggested that public health departments at all levels be included, and Ms. Platero recommended adding Indian Health Service and Tribal health programs. Marc Meachem, M.B.A., and Gregg Alton, Ph.D., recused themselves from the vote.

Vote

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

See Appendix C for the final letter.

Public Comments

Mark Misrok said that the National Working Positive Coalition addresses the long-ignored employment needs of people living with or at greater vulnerability for HIV as well as the physical, mental, and economic health and well-being of people with HIV. In 2022, including through the devastating impact of the COVID-19 pandemic, the importance of employment and employment services to the health, well-being, and quality of life of people with HIV has yet to be acknowledged with a meaningful response. CDC's most recent surveillance data indicate that 41 percent of people with HIV were unemployed in 2019, reflecting the lack of access to employment-related information, services, and resources within HIV supportive services, which has continued unchanged throughout the HIV epidemic. Communities more vulnerable to HIV and most impacted by it are also communities with long histories of unequal access to quality education and to employment and economic opportunities. Meanwhile, HRSA's HIV/AIDS Bureau has kept directives in place since the 1990s that ban the use of supportive services dollars by Ryan White HIV/AIDS Program grantees to provide employment or job readiness services, suppressing growth of responses to the employment needs of people with HIV that could grow organically in community-based programs that are most trusted and often most committed to communities not prioritized in mainstream workforce development or vocational rehabilitation initiatives. Mr. Misrok urged PACHA to exercise leadership in ending the abdication of responsibility in HIV care and prevention for addressing employment needs of communities confronting these severe inequities.

Miguel Rosa-Rubio of Family Services Network of New York, Inc., appreciated the efforts to address HIV around the country, including during the COVID-19 pandemic. He highlighted the need to develop more capacity among HCPs and increase involvement at the community level by including key populations, such as people who are sexually active and older people with HIV. Those communities could be involved in other related variants or other related social demographic descriptions or key populations. Mr. Rosa-Rubio said that efforts should not just highlight people of color but also address many realities in the community to approach HIV prevention and care. Many challenges, such as language barriers and others faced by key populations, are not highlighted in the NHAS. Many people do not have insurance and do not have access to the right information to approach PrEP and care. There is a high demand among people who are migrating to major cities from other States that lack certain services that, for example, New York provides at the community level. In addition, people migrate from other countries just to have appropriate access to HIV treatment. Mr. Rosa-Rubio said he was happy to hear about the involvement of the community.

Deondre Moore of the Prevention Access Campaign said that U=U is a missed opportunity in the United States, which has a lot to learn from PEPFAR. The new guidance clearly shows that U=U is more than a message. Accumulating evidence shows it is an underutilized way to positively impact prevention and care outcomes. A recent study showed that men who received

tailored, peer-delivered U=U messaging had an 89 percent greater likelihood of accepting an HIV test compared with men who did not. A study of people with HIV in 25 countries, including the United States, found that people with HIV who discussed U=U with their HCPs were 41 percent less likely than those who did not to have poor adherence, more than twice as likely to report viral suppression, 48 percent more likely to report optimal sexual health, and three times more likely to report always sharing their status.

Positive outcomes result from the confident, clear, and consistent messaging that is the hallmark of U=U campaigns. Therefore, this call to action is not about the broader concept of treatment as prevention but specifically about U=U. The field recognizes the potential of U=U. Providers, CBOs, and State and local health departments across the country are seeking resources and technical assistance. They are using U=U in prevention, stigma reduction, disease intervention, care linkage, and core medical support services, but they need support. PACHA should recommend and advocate for the following changes:

- Include U=U in technical assistance, capacity building, and the work of AIDS Training and Education Centers
- Fund U=U as part of future research and Special Projects of National Significance
- Include U=U in funding announcements and work plans

As discussed in Day 1 breakout sessions, U=U should be a required component of prevention. It positively impacts health outcomes, so the role of U=U across the continuum of care should be explicitly named and supported. PEPFAR got it right, and so can the domestic HIV response. Mr. Moore sought consistency in global and domestic efforts. He urged PACHA to recommend and advocate for the changes described and for meaningful inclusion of U=U in the NHAS and the EHE initiative. He asked that PACHA recommend that the White House officially endorse U=U so that the United States can join Canada, Vietnam, and other countries across the globe in choosing science over stigma. With PACHA's leadership and support, the impact of U=U can be measured, optimized, and scaled up to improve the health and well-being of people with HIV and also prevent new transmission. Embracing U=U will be a win for everyone, Mr. Moore concluded.

Ace Robinson of the COVID Clinic and the Federal AIDS Partnership said that, as the President of the United States and CDC have rightfully noted, racism is a public health threat that must be addressed with direct action and intentionality. First and foremost, for people with vaginas who are most impacted by HIV and who identify as Black people assigned female at birth, the decision by the U.S. Food and Drug Administration not to review and ultimately allow access to the dapivirine vaginal ring to avert HIV is absolutely unacceptable. People with vaginas who live abroad have more options for HIV prevention than those who live in the United States, which is unacceptable. Mr. Robinson called on PACHA and the Biden administration to support a full review of this prevention option and equitable access to it. In addition, as noted by Mr. Baloney of AIDS United, racism in clinical settings must be acknowledged and addressed to accomplish the work described by previous speakers related to U=U and PrEP. By far, LGBTQ+ people are the most impacted by scope and scale. There have been 40 years of failed attempts to support those communities most impacted by HIV because programs have been created and implemented predominantly by White health officials and funded through predominantly White

organizations. Expanding access to PrEP and treatment must be culturally responsive, tailored, and timely. That change is possible through an intentional, community-centered approach, and that change must happen now. No focus group is needed to realize that an integrated approach is needed to address public health and the systemic racism therein.

Reginald Brown of Vocal-NY.org explained that in 1986, he was living and performing in Athens, Greece, when he flew to Kansas City to visit his parents and got a physical examination. The doctor performed an HIV test without Mr. Brown's knowledge and informed him that he had 2 years to live. He was told to "be careful" around his nieces, who were toddlers, but given no information on what that meant. At that time, an HIV diagnosis was considered almost-certain death, and Mr. Brown said his universe stopped at that moment. He was numb, confused, and scared in Kansas City. But he returned to Athens to dance, sing, act, teach dance, choreograph, and model because he still had the successful, rewarding career of his dreams. Then, he felt a spiritual call to look at his blessings. First, he no longer had to worry about getting HIV. Second, he recognized the absolute necessity of prioritizing his time. Mr. Brown decided that whether he had 2 days or 2 years, he would live until he died. That was more than 35 years ago. Mr. Brown said he is still living his best life. He has been unable to transmit HIV since 2003 and has had no AIDS-related illnesses. Mr. Brown said that somebody who looks like him needs to see him and hear his story. He thanked PACHA for the opportunity to be seen, heard, and appreciated.

Thalia Santos of the Alliance for Positive Change in New York City said that with a grant from the New York State Department of Health, the Visiting Nurse Service of New York Choice Select Health Special Needs Plan and the Alliance for Positive Change have targeted people with HIV who are virally unsuppressed, lost to follow-up with their primary HIV care providers, untreated, or underserved and often living with advanced HIV disease in some of the most socioeconomically underresourced areas of New York City. Together, the organizations have deployed the Alliance's peer community health worker model for people with HIV who are not in care, combining their resources as a CBO and a managed care organization to bring members back into care and treatment and work toward viral suppression. The organizations developed a low-cost, high-impact, and reproduceable model led by individuals who come from and look like the communities that are disproportionately affected in New York City—primarily communities of color. Ms. Santos emphasized that peers alone, designated AIDS centers alone, and medical care organizations alone cannot do what is needed to get these most challenged members engaged and virally suppressed. She requested support for her organization's efforts and designated funding for the creation of more collaborative models.

Ciarra Covin of The Well Project said that breastfeeding/chestfeeding, while a complex issue, is considered both the healthiest option for infant feeding for the general population and a standard of care for women and other birthing parents living in HIV resource-limited settings globally. Limited research on breastfeeding and HIV in high-resource settings has resulted in a lack of education and clinical standards for providers in these areas to support women living with HIV in making informed infant feeding decisions. Speaking as a woman living with HIV who is currently breastfeeding her child and as a representative of The Well Project, Ms. Covin suggested that PACHA advocate for the following:

- Efforts to ensure that parents living with HIV have access to the information, support, and tools necessary to make informed infant feeding decisions
- Provider education and tools that address the complex realities facing parents living with HIV and their infant feeding decisions and that affirm their rights to make informed decisions about the best course of care and treatment for their children
- Research to understand existing data on HIV and infant feeding and to identify and address remaining knowledge gaps
- Policy reform to make guidelines in Federal strategies, including the EHE initiative and the NHAS, more relevant to the lived experiences of women and other birthing parents with HIV

Updated policies must center on sexual and reproductive health and rights, intersectional lived experiences, and bodily autonomy of women and other birthing parents living with HIV. These policies must reflect the rights of women and other birthing parents living with HIV to make the best infant feeding decisions for themselves and their babies and to receive support from their health care teams. They must also address the harm of criminalizing women living with HIV, including those who breastfeed.

Lucy Slater of the National Association of County and City Health Officials thanked PACHA for its recommendations in support of a national PrEP grant program. She asked that PACHA also consider recommending a national PrEP program. Local health departments are key partners in HIV prevention, treatment, detection, and response, and they play an important role in implementing PrEP. A recent study found that one-half of all local health departments engage in PrEP implementation, but more than one-third of respondents did not have any specific funding to do the work. As the nation's patchwork of PrEP financing mechanisms stands, many local health departments across the United States depend on cost savings from using brand-name forms of PrEP, which is an entirely unsustainable system for putting effective and affordable HIV prevention in the hands of communities who need it. Unsurprisingly, local health departments reported significant challenges related to funding, staffing, and resources needed to navigate complex payment systems and to ensure PrEP availability for uninsured clients. Therefore, while increased funding for local HIV prevention activities remains needed, grant funding is only a Band-Aid in this unsustainable system. A national PrEP infrastructure would scale up generic PrEP as a cost-effective option and create a platform to deploy new forms of PrEP as they are developed. It would ensure access to PrEP and all associated costs for the uninsured and individuals on Medicaid, allow for streamlined financing and delivery, and promote the uptake of status-neutral models by local providers. The National Association of County and City Health Officials joins the call for a simplified, equitable, accessible PrEP program that would allow local public health providers to focus on reaching communities that need PrEP the most.

See Appendix D for all written public comments submitted.

Next Steps and Closing Remarks from the PACHA Co-Chairs

Ms. McNeese thanked all those involved in creating such a rich agenda and all the presenters and participants for their ideas and input. She again offered special thanks to Ms. Hayes and her

OIDP colleagues for their work and HHS Studios and Rose Li & Associates for exceptional technical support.

Dr. Wiesman indicated that PACHA takes all of the materials, presentations, and discussions into consideration as it prioritizes its next steps. He appreciated the contributions of all participants. PACHA has already addressed some suggestions through resolutions, and Dr. Wiesman recognized the need for PACHA to follow up on the status of its recommendations. As noted earlier, he and Ms. McNeese are committed to increasing transparency about the results of PACHA's recommendations. Dr. Wiesman adjourned the meeting at 4:30 p.m.

Appendix A: Summary of Breakout Group A: HIV Prevention in the Context of Ending the HIV Epidemic

Introduction

Marlene McNeese, Co-Chair of the Presidential Advisory Council on HIV/AIDS (PACHA), and Darrell Wheeler, Ph.D., M.P.H., M.S.W., PACHA member, hosted an open discussion about HIV prevention in the context of ending the HIV epidemic. Before the breakout session, PACHA expressed interest in hearing feedback about prevention in specific populations (women and adolescent girls, people age 55 and over, people living with substance use and mental health disorders, and people who are lesbian, gay, bisexual, transgender, queer, and others [LGBTQ+]) and on preexposure prophylaxis (PrEP) assistance programs. Dr. Wheeler encouraged participants to suggest recommendations that PACHA could make to influence Federal policies. Highlights and key points of discussion follow.

PrEP Access

Even as recently as 2020, women were not included in clinical trials of PrEP, limiting their access to PrEP. Clinical trial designs and budgets should include investment in community engagement and participation, such as funding for transportation. To improve diversity, trial designs should consider the cultural humility and cultural competency needed to engage underrepresented populations, such as transgender people. Investigators must recognize and work to repair mistrust in the health care system and clinical research, especially among people of color (POC), that resulted from unethical and disparate research.

Health care providers (HCPs) lack education about PrEP and demonstrate bias in prescribing PrEP for POC, despite Centers for Disease Control and Prevention and U.S. Preventive Services Task Force recommendations and guidance. PACHA should recommend more HCP education on PrEP access. Access to PrEP must extend to all, regardless of insurance status.

Funding must be increased to ensure access to PrEP and ancillary services such as laboratory testing (see Johns Hopkins Bloomberg School of Public Health: [“New Policy Proposal Seeks to Improve Access to Medications that Prevent HIV Infection”](#)). PACHA should support proposed legislation in Congress to fund a national PrEP program. Once funding is available, there should be a strategic plan for comprehensive PrEP access that stretches the dollars as far as possible. Relying on cost-savings from the 340B drug pricing program is not a sustainable approach for health departments and clinics.

Systemic Barriers and Compartmentalization

Services and programs are targeted to specific populations, without concern for overlap or holistic care. More consideration should be given to combining services—for example, by allowing localities to link senior services with Ryan White HIV/AIDS Program services.

The fragmented U.S. health care system prevents a coordinated approach to ending HIV. Acknowledging the failures of the current patchwork of care is a first step toward advocating for a better system of care and payment that prioritizes value over volume and supports effective, patient-centered care. Variations in HIV care among States contributes to stigma and disparities

in care. The stigma implicit in the system and the biases that create barriers to care must be addressed.

Long-term survivors of HIV should be seen as partners in health care who have insights and skills to offer. HCPs should take a broader view of their patients' overall health, but the current reimbursement system prevents them from doing so. More investment must be made within *Ending the HIV Epidemic: A Plan for America* to recognize that people with HIV have expertise that should be incorporated into research development and implementation.

PACHA could recommend that Federal funding be tied to equitable access to health care. For example, States receiving funding should certify that they do not have laws or policies that discriminate on the basis of sexual orientation, gender identity, or disability status.

Significant racial and ethnic disparities persist around perinatal HIV transmission, compounded by the fragmented health system. Guidance is needed for pregnant people and parents of infants on how to navigate various systems of care and payment mechanisms. Better data collection and data sharing are needed to improve understanding of potential perinatal HIV transmission. Many jurisdictions have seen increases in perinatal transmission during the COVID-19 pandemic.

Providers should continue to offer telehealth services when appropriate to ensure access, but should recognize the needs of people without Internet access. Note, for example, that access to self-testing for HIV and sexually transmitted infections (STIs) with follow-up linkage to care via telehealth has been useful for rural Alaskans.

Education and Awareness

The fact that a person with HIV with an undetectable viral load cannot transmit HIV (undetectable equals untransmittable, or U=U) is rarely included in prevention messaging, despite consensus on the data. Government funding should require incorporation of U=U into messaging. U=U merits the same level of financial support and promotion as PrEP.

HIV prevention education and awareness efforts do not adequately address cisgender or transgender women, leaving them vulnerable. Mandatory sex education in schools is an important method for teaching girls about HIV prevention. Prevention messaging should shift away from individual risk for HIV and instead be integrated with reproductive health and wellness so that it is normalized—thereby reducing stigma.

A national sexual health literacy campaign is needed to improve individuals' and HCPs' understanding of sexual health, including HIV testing and the continuum of sexual orientation and gender identity, so that HCPs can have meaningful conversations with patients, particularly POC and LGBTQ+ people. So-called "don't say gay" bills and other legislation that targets queer identity are related to a lack of sexual health literacy.

A sexual health literacy campaign should promote understanding and access to care for people, especially youth, in custodial settings (e.g., detention and foster care facilities), for whom there is a legal obligation to provide essential care. PACHA could recommend that the Department of

Justice assess whether custodial facilities provide sufficient access to care. It should be recognized that the lack of sexual health literacy contributes to violence against queer people.

PACHA could recommend a framework for funding sexual health and prevention education through community organizations that represent and have access to communities with a high prevalence of HIV.

PACHA should propose creation of a toolkit for providers that includes the following:

- Guidance for primary care providers on recommending PrEP and condom use for any woman or adolescent girl with an STI. (Note that California mandates that providers discuss PrEP with any person seeking an STI test.)
- Guidance for obstetrician-gynecologists and others who care for pregnant patients to address HIV acquired during pregnancy.

The toolkit could also be used to train community leaders and school-level educators to promote HIV prevention in schools. A participant described existing materials that focus on Native American and Alaska Native youth that center their voices and promote cultural understanding, communicating in a sex-positive, gender-informed, and trauma-informed manner. (See Project Red Talon National Network handout on p. 31.) Such materials could be included in toolkits and adapted for other populations. The American Academy of HIV Medicine is developing a comprehensive sexual education curriculum for providers. PACHA should compile public resources and make them available to providers.

Updated guidance is needed on breastfeeding/chestfeeding among people with HIV, who continue to be targeted by child protective services and law enforcement.

People with Physical Disabilities

People with HIV who have physical disabilities—and particularly those with mobility constraints—are not specifically mentioned in PACHA’s agenda. High-level leadership and national guidance are needed to bring attention to the barriers faced by people using wheelchairs or who have other mobility issues. More work must be done to streamline the bureaucratic processes, such as the paperwork that leaves people waiting months for wheelchair repair with no alternative means of mobility because insurance plans do not cover backup wheelchairs. Health equity must include people with disabilities. The South lacks effective disability rights laws, so Federal protections are needed to address physical and other barriers. National guidance is needed to help case managers and others navigate the procedures for getting benefits. The Americans with Disabilities Act falls short in protecting people with HIV with physical disabilities. Challenges faced by this population must be addressed in implementation plans.

Older People

The Older Americans Act may offer a vehicle for improving services for aging people with HIV. PACHA has not paid sufficient attention to this population. Older people with HIV lack representation on PACHA, and their concerns are not adequately reflected in efforts by the Department of Health and Human Services or the White House Office of National AIDS Policy.

The Ryan White HIV/AIDS Program does not meet the needs of older people with HIV and needs to be revamped.

Mental Health Services

African American people face health disparities across the board, particularly in access to mental health services. Few mental health care providers are POC, and those that are tend not to be included in health insurance companies' covered networks of providers.

Adverse childhood experiences affect health later in life. PACHA should recommend that providers assess for adverse childhood experiences and consider the potential implications for patients' health. PACHA should recommend that providers track referrals to ensure that patients receive recommended care.

Other Issues to Consider

- Harm reduction services are needed to prevent HIV among substance users (e.g., syringe exchange services).
- Workforce challenges persist, especially because many HIV prevention staff have been recruited into COVID-19 work for the past 2 years.
- PACHA should advocate for a comprehensive set of quality-of-life measures in Federal programs and services for people with HIV.
- Insurance companies should be regulated to ensure that patients receive needed care. Current insurance reimbursement is inadequate for providers to supply sufficient care.
- Long-term survivors include people who were infected perinatally; focused interventions are needed for individuals transitioning from pediatric to adult care.
- HIV education should be integrated into training for primary care HCPs.
- Language remains a barrier to health and education resources for non-English speakers.
- People starting PrEP regimens, particularly young women, need support, similar to those starting HIV treatment. Such support includes adherence strategies and attention to mental health as well as general health concerns.
- Advocacy groups bring the perspectives and ideas of subpopulations to the table.

Project Red Talon National Network

Healthy Native Youth Educator Resources

Project Red Talon National Network

Ending the HIV Epidemic in the U.S.

Projects of the Northwest Portland Area Indian Health Board (NPAIHB) & Northwest Tribal Epidemiology Center

NPAIHB Sexual Health Collaboration Programs



[Healthy Native Youth](#)

Educators, parents, and caring adults

[HNY Implementation Toolbox](#)

A step by step guide to choosing and implementing an evidence-based health curriculum with community support and engagement

[Paths \(Re\)Membered Project](#)

Two Spirit and LGBTQ+ community

[Celebrating Our Magic Toolkit](#)

A free Two Spirit and LGBTQ+ Pride toolkit for community and clinical spaces



WERNATIVE

FOR NATIVE YOUTH BY NATIVE YOUTH...

[We R Native](#)

For Native youth, by Native youth

[Ask Your Relative Program](#)

Advice for Native youth, from Native youth. Topics range from identity and culture to gender and sexuality

[Indian Country ECHO](#)

Clinicians, health programs, and peer recovery programs

[ECHO Programs](#)

Interactive online learning environments for clinicians and staff to work with clinical experts from across Indian Country



[NPAIHB HIV/AIDS](#)

Prevention | Treatment | Healing

[Youth Support and Resources](#)

Resources and helplines specifically for AI/AN youth



Project Red Talon Network, continued

Healthy Native Youth Educator Resources

Project Red Talon National Network (2021-2022)

The Project Red Talon National Network, coordinated by Healthy Native Youth at NPAIHB, includes collaborative partners who provide outreach, education, and technical assistance in their regions and nationally to disseminate best practices for long standing and critically emerging issues for improved HIV prevention and care for high-risk AI/AN (including MSM, young adults, IDUs, and transgender individuals).

Alaska Native Tribal Health Consortium

I Know Mine
<https://www.iknowmine.org/>



Inter-tribal Council of Arizona

ITCA healthy native youth program
<https://itcaonline.com/programs/health-services/healthy-native-youth/>



University of Texas at Houston – School of Public Health

Native It's Your Game 2.0
<https://hnynativeiyg.sph.uth.tmc.edu/>

Full curriculum
<https://www.healthynativeyouth.org/curricula/native-its-your-game/>



Johns Hopkins University Center for American Indian Health

Respecting the Circle of Life
<https://caih.jhu.edu/programs/rci-camp>

Full curriculum
<https://www.healthynativeyouth.org/curricula/respecting-the-circle-of-life/>



Southern Plains Tribal Health Board

Native TEST program
<https://www.spthb.org/programs/our-grants/native-test/>



Standalone Lessons

Two Spirit, LGBTQ and Sexual Identity (Ages: Middle School, High School, Young Adults):
[Indigenizing Love Toolkit](#)

Reducing Risky Sexual Behaviors (Ages: Middle School, High School, Young Adults):
[Native STAND 2.0 – Safe Snagging](#)

STIs (Ages: Middle School, High School, Young Adults):
[Native It's Your Game 2.0 STIs Handout](#)

HIV/AIDS (Ages: Middle School, High School, Young Adults):
[Native STAND 2.0 - HIV/AIDS](#)

Funding Credit: This Project is funded by the Indian Health Service HIV and Behavioral Health programs. This work is also supported with funds from the Secretary of DHHS Minority AIDS Initiative Fund.

Appendix B: Summary of Breakout Group B: National HIV/AIDS Strategy (NHAS) and Ending the HIV Epidemic: A Plan for America (EHE Initiative)

Introduction

John Wiesman, Dr.P.H., M.P.H., Co-Chair of the Presidential Advisory Council on HIV/AIDS (PACHA), and Guillermo Chacón, PACHA member, hosted an open discussion about the NHAS and the EHE initiative. They expressed interest in learning about participants' knowledge and perceptions of the NHAS and the EHE initiative; how the programs can be implemented, particularly in rural communities; and how to better engage people with HIV or at risk for HIV in implementation efforts. Dr. Wiesman encouraged participants to suggest topics that PACHA should explore more deeply and where it can make recommendations to influence Federal policies. Dr. Wiesman provided an overview of the EHE initiative, and Harold J. Phillips, M.R.P., Director of the White House Office of National AIDS Policy (ONAP), outlined the NHAS. Highlights and key points of discussion follow.

Perceptions of the NHAS and EHE Initiative

The NHAS and the EHE initiative have missed the opportunity to promote the message that a person with HIV with an undetectable viral load cannot transmit HIV (undetectable equals untransmittable, or U=U). The hallmark of U=U campaigns is clear, confident language that emphasizes the potential to improve the quality of life for people with HIV, in contrast to the treatment as prevention approach. (See [New York City's U=U web page](#).) The President's Emergency Plan for AIDS Relief offers a good model for incorporating U=U into messaging and interventions across the continuum of care. U=U should be included in work plans and funding opportunities, research opportunities, AIDS Education and Training Centers content, and Special Projects of National Significance.

Community-based organizations (CBOs), health care providers (HCPs), and State and local health departments across the country are seeking technical assistance and funding for capacity building. Federal investment could optimize how U=U is integrated, scaled up, and tailored to different populations. A strong Federal endorsement of the data supporting U=U could spur broader adoption across the country.

The NHAS and EHE initiative are put forth as connected programs, but they were not developed together. Strong Federal guidance is needed to better integrate the NHAS, the EHE initiative, and the Ryan White HIV/AIDS Program. When the EHE initiative was released in 2017, women were addressed primarily in the context of HIV prevention, and women with HIV were underrepresented. The NHAS does a better job addressing quality of life for women with HIV, but the two plans seem disconnected. It is not clear how the NHAS is intended to influence the work of the EHE jurisdictions on the ground.

The NHAS does not go far enough to integrate the sexual and reproductive health needs of women with HIV into efforts to advance the well-being of women. Federal guidance around perinatal HIV issues should be incorporated into the NHAS and other Federal strategies. Federal

strategies should address the harm caused by criminalizing women with HIV who are pregnant, seeking to become pregnant, or breastfeeding/chestfeeding.

The country is not prepared to address the financial, housing, and other needs of the large and growing cohort of older people with HIV, which is crucial to ending HIV. The AIDS Clinical Trials Group has failed to fund intervention studies on aging people with HIV, who make up the majority of people with HIV. The calls to action in the NHAS and the EHE initiative should be translated into funding, mandates, and research and implementation projects to address the pressing issues facing older people with HIV.

Resources are needed to facilitate engagement by people with HIV in implementation as well as outreach and education. People with HIV are often not compensated for their time and expertise.

State departments of health should better coordinate with Federal efforts to address HIV and sexually transmitted infections (STIs).

In the South in particular, it seems that only people who work in the HIV field are aware of the NHAS or the EHE initiative. More work is needed to communicate beyond the public health community.

More effort should be made to seek input from and engage a wider pool of people in developing and implementing plans and policies, so that new voices and perspectives come to the forefront. At present, the same small group of people seem to serve on all the State and local advisory groups and planning councils year after year.

Improving HIV Education and Awareness

Young people lack education about HIV. Even high school students are not aware that HIV, although manageable, is a lifelong chronic condition. According to the [Guttmacher Institute's report on sex education](#), only 19 States require sex education programs to include information on condoms, yet 37 States and the District of Columbia require information on abstinence.

No high-profile public figures are reaching out to youth about HIV. Many people—young and old—believe that HIV is no longer a problem. This perception is partly driven by media reports that many people with HIV now have a normal lifespan. Advances in longevity for people with HIV have largely benefited White, cisgender people who have access to care and resources. People of color (POC) with HIV, particularly women, have made little progress toward a normal lifespan.

The perception that HIV is no longer a concern also pervades State legislatures. At the same time, laws persist that criminalize HIV, reflecting a lack of understanding about HIV. A basic education campaign should address simple concepts, such as how HIV is and is not transmitted. PACHA could help advance basic education about HIV for a wide range of audiences. Such training requires funding.

Training resources (e.g., from [The Sero Project](#), as described by Kamaria Laffrey) for public health providers, case managers, and others could be tailored to legislators. The [Center for HIV](#)

[Law and Policy](#) conducts HIV and infectious disease trainings for law enforcement officers, prosecutors, and other professionals and is working with the Association of Prosecuting Attorneys on a fact sheet on HIV and infectious diseases for law enforcement personnel.

No Federal body is leading a coordinated effort to work with schools or communities to ensure that they have access to evidence-based curricula and best practices around HIV. ONAP and Federal partners could convene a working group to provide guidance to educators in schools and communities. Tribal communities have a good record of educating young people but sometimes clash with Federal partners or project officers over what content is appropriate to include.

Some States and legislatures have or are promoting policies that regulate what schools can teach in relation to issues of particular concern for lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) people, which limits sex education and creates a roadblock to ending HIV. ONAP would like more information about specific regulations on language or curricula that limit discussions of LGBTQ+ issues. To respond to restrictive school policies, an education curriculum should be developed that focuses on the biology of viruses, such as HIV, COVID-19, and hepatitis, to increase understanding of how viruses spread and how vaccines work.

States need incentives to change harmful policies. Information alone is not enough.

Person-first language is important to reduce HIV stigma. All meetings and presentations should begin with a recognition of preferred pronouns. See examples of stigma-free language from the [Positive Women's Network](#) and [The Well Project](#).

A status-neutral approach must flow from the Federal level down and be fully integrated, rather than the current, outdated system in which the Health Resources and Services Administration addresses care and the Centers for Disease Control and Prevention (CDC) addresses prevention. New York City developed the [New York City HIV Status Neutral Prevention and Treatment Cycle](#), which outlines the steps that can lead to an undetectable viral load and to effective HIV prevention. It emphasizes that HIV care does not end with the first undetectable viral load.

There is a strong need to address sexual health literacy, HIV misinformation, puritanical policies around sex and deployment, and HIV criminalization in the Department of Defense in particular.

The following education resources were shared:

- [CDC HIV Information and Youth web page](#)
- CDC [Let's Stop HIV Together](#) campaign
- [Healthy Native Youth](#) compendium of curricula
- [Mid-Atlantic AIDS Education and Training Center](#)
- The Well Project: [What Are HIV & AIDS?](#)

The following resources on HIV criminalization were shared:

- The Williams Institute at the University of California, Los Angeles, report, [HIV Criminalization in California](#)
- HIV.gov: [ONAP Listening Session on HIV Criminalization](#)
- The Well Project: [HIV Criminalization and Women](#)

Improving the Quality of HIV Care

Outside of HIV care clinics, most HCPs lack awareness about preexposure prophylaxis (PrEP) and U=U, so they miss opportunities to treat or refer patients for care that could prevent HIV. Emergency department HCPs in particular would benefit from increased awareness.

HCPs need better education on the sexual and reproductive health needs of women living with HIV. Most women with HIV (cisgender and transgender) experience stigma from HCPs and the medical system.

In 2019, the U.S. Preventive Services Task Force made a Grade A recommendation for use of PrEP by drug users, yet that recommendation is rarely highlighted. HCPs and social workers would benefit from more information about PrEP for drug users. Such information should be included in the NHAS and the EHE initiative.

The fragmented health care system is difficult to navigate. Behavioral health care should be integrated with biomedical care to address the needs of people with HIV. Interdisciplinary teams of providers are needed to care for people across their lifespan. Lack of continuity of care affects outcomes. A clear need exists for more trauma-informed care and wraparound services. Attention is needed to ensure that people with HIV are retained in care, which includes addressing related needs, such as transportation and housing.

Contingency management (rewarding healthy behavior) for HIV care should be explored as a way to reduce individual and structural barriers to care. CDC endorsed an evidence-based intervention using high-magnitude financial incentives, but there is no funding or structure for these interventions. Contingency management has been shown to be effective in addressing HIV, substance use, mental health, and many more conditions.

Data Issues

HIV data exist for American Indians and Alaska Natives, but those data are often left out of presentations. The Indian Health Service and Tribal epidemiology centers are working to expand, improve, analyze, and correct existing data sources. Efforts are also under way to tailor the NHAS for implementation in Indigenous communities.

Participants appreciated the work to develop an indicator to assess quality of life for people with HIV, because it is demoralizing when programs and providers focus solely on viral load.

State and Federal reporting requirements should be coordinated to decrease the burden on CBOs and improve the quality of data.

Molecular HIV surveillance data are being gathered and used without consent. Individuals should be informed about how test results are reported and shared. Given the amount of misinformation about HIV and its transmission, it is clear that molecular HIV surveillance data can be used in dangerous ways. The issue has been raised with PACHA and Federal partners many times, yet no progress has been made.

Overcoming Access Barriers

Telehealth services are one mechanism for improving access to care. A novel approach could be the establishment of intervention stations—places where a person can access health services remotely. People in rural areas in particular need access to stigma-free telehealth services.

States vary in services provided for immigrants with HIV. There should be national policies for health care and prevention services for immigrants.

Other Issues to Consider

- More funding for HIV prevention and treatment should be directed to Historically Black Colleges and Universities.
- The Housing Opportunities for Persons with AIDS program needs better oversight and accountability. The results of confidential annual surveys should not be used as a tool against long-term HIV survivors.
- HIV workforce challenges persist. Organizations should be encouraged to hire more people with HIV, who have insights and perspectives that can improve services and care provided.
- PACHA should consider establishing a youth caucus and an elders' circle.

Appendix C: PACHA Letter to the HHS Secretary



March 15, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Recommendations to Scale-Up Uptake of PrEP Nationwide

Dear Secretary Becerra:

As you and the Biden administration proceed with implementing the National HIV/AIDS Strategy (NHAS) for the U.S. 2022–2025 and the *Ending the HIV Epidemic in the U.S.* (EHE) initiative, we urge you to support the creation of a national PrEP program to ensure there is a concerted scale up of PrEP so that all those who need it can access and afford PrEP along with any associated services.

As part of this effort, we recommend that the following components be included:

- 1) **Addressing Racial, Ethnic and Other Inequities Must be Prioritized.** Only 23 percent of the approximately 1.2 million people indicated for PrEP are receiving it. In 2019, only 8 percent of Black/African Americans and 14 percent of Hispanic/Latino persons who were eligible for PrEP were prescribed it, compared to 63 percent of white persons. In order to ensure PrEP uptake is increased among certain populations and communities, all PrEP programs and efforts must first prioritize those communities and areas of the country that are most in need of PrEP and currently not utilizing it. Expanding PrEP into minoritized racial/ethnic communities is critical in addressing the ongoing and widening disparities in PrEP access and uptake. In order to increase PrEP uptake among American Indian/Alaska Native (AI/AN) communities PrEP must be on the Indian Health Service (IHS) National Core Formulary and made available without cost-sharing as part of trust and treaty obligations to Tribal Nations.
- 2) **Utilize and maximize existing payer systems including private insurance, Medicaid and Medicare.** Thanks to your efforts and the Biden administration more people have health care coverage than ever before. We urge you to ensure that all payers cover PrEP and associated services to the fullest extent possible under the law. This includes zero cost sharing for those with private insurance under the Affordable Care Act. We urge you to ensure insurers are in compliance with the [guidance](#) CCHIO issued on July 19, 2021, and that new PrEP drugs, such as the long-acting injectable, be covered as quickly as legally possible. We also urge that similar guidance be issued for Medicaid and Medicare programs.

PACHA Letter to the HHS Secretary, continued

- 3) **Create and fund a national PrEP Grant Program for Community and Provider outreach and pay for PrEP and associated services for those who are uninsured and underinsured.** The *Ending the HIV Epidemic* initiative already includes the provision of PrEP for community health centers. Some elements needed to implement PrEP currently exist in CDC's HIV and STD prevention programs and among their grantees. Each of these efforts should be dramatically scaled up with additional resources. In order to broaden the reach to more areas of the country and more people who need PrEP, particularly for the uninsured and underinsured, we urge you to estimate the resources needed to achieve the PrEP goals identified in the NHAS and support the creation of and fund a national PrEP grant program. This program should provide funding to public health departments, Indian tribal communities/IHS/tribal health programs, rural health clinics, community health centers, Ryan White Program grantees, sexual health and family-planning clinics, community-based organizations providing HIV prevention services, and others to ensure that PrEP reaches the communities most in need. The program should be designed to allow for the lower cost purchase of PrEP medications via the 340B drug pricing program, the utilization of generic PrEP, and free PrEP medication programs, PrEP peer navigation programs, PrEP marketing campaigns, and other culturally-relevant programs as appropriate. Funding of innovative strategies that effectively decrease PrEP usage disparities will be critical to close the widening racial and gender disparities of PrEP usage. This should include examining opportunities for clinics that are solely funded by the Ryan White Program to provide both PrEP and post-exposure prophylaxis (PEP). Reducing stigma and discrimination against potential PrEP users must be a central element of the provider outreach efforts.

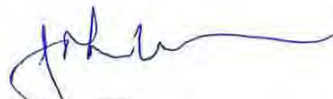
Establishing a national PrEP program will allow communities across the country to help meet the goal in the Strategic Plan to increase PrEP coverage to 50 percent by 2025. It will also help address ongoing racial and ethnic disparities and decrease new HIV infections.

This letter was unanimously adopted by PACHA at its meeting, conducted virtually, on March 15, 2022. We look forward to your response and working with you and your Department on implementing our recommendations. Thank you very much.

Sincerely,



Marlene McNeese
Co-Chair



John Wiesman
Co-Chair

cc: Admiral Rachel L. Levine, MD, Assistant Secretary for Health, Admiral, U.S. Public Health Service, U.S. Department of Health and Human Services (HHS)
B. Kaye Hayes, MPH, Acting Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP) and Executive Director of PACHA, OASH, HHS
Harold Phillips, MRP, Director, White House Office of National AIDS Policy

Appendix D: Written Public Comments

Mark Misrok, Executive Director, National Working Positive Coalition and Member, Steering Committee, U.S. People Living with HIV Caucus

Comments to the Presidential Advisory Council on HIV/AIDS

Mark Misrok, Executive Director, National Working Positive Coalition and Member, Steering Committee, U.S. People Living with HIV Caucus
March 15, 2022

I'm Mark Misrok, Executive Director for the National Working Positive Coalition. I'm a person living and aging with HIV, and a member of the Steering Committee for the U.S. People Living with HIV Caucus.

The work of the National Working Positive Coalition is focused, in alignment with HIV care and prevention, to strengthen responses to the long-ignored employment needs of people living with or at greater vulnerability to HIV. Our work is also in alignment with the U.S. People Living with HIV Caucus in prioritizing physical, mental, and economic health and wellbeing of people living with HIV in a framework of justice and human rights, and with a particular emphasis on bringing back to the U.S. HIV response a true, meaningful, and substantial commitment to the quality of life of people living with HIV, as so powerfully articulated in "Demanding Better: An HIV Federal Policy Agenda by People Living with HIV," which I urge you all to read.

In 2022, including through the devastating impacts of the COVID pandemic, we have yet to acknowledge the importance of employment and employment services to the health, wellbeing, and quality of life of people living with HIV with a meaningful response. Perhaps it's no surprise that [the CDC's own most recently released MMP, or Medical Monitoring Project, surveillance data, reflects 41% of people living with HIV as unemployed for the pre-pandemic year 2019](#). I believe this extraordinarily high percentage reflects the lack of access to employment-related information, services, and resources within HIV supportive services that has continued unchanged across all eras of the epidemic.

We know that communities most vulnerable to HIV, and most impacted by it, are also communities with long histories of unequal access to quality education and to employment and economic opportunities.

Meanwhile, the HIV/AIDS Bureau has kept directives in place since the '90's that ban use of supportive services dollars by Ryan White HIV/AIDS Program grantees to provide employment or job readiness services, suppressing growth of responses to the employment needs of people living with HIV that could grow organically in community-based programs most trusted and often most committed to communities not prioritized in mainstream workforce development or vocational rehabilitation initiatives. I urge PACHA to exercise leadership in ending the abdication of responsibility in HIV care and prevention for addressing employment needs of communities confronting these severe inequities.

Rosa-Rubio

March 16, 2022

New York, New York; United States

US Presidential Advisory Council on HIV/AIDS(PACHA)

Public comment letter:

Thanks for the opportunity to participate in public comments on the 73rd Presidential Advisory Council on HIV/AIDS (PACHA) full council meeting scheduled on Monday, March 14, and Tuesday, March 15, 2022. I felt honored and delighted with interesting presentations and panel discussions

It is important to highlight the idea of reframing programmatic indicators, strategies, interventions, and languages to improve prevention and care through more comprehensive involvement of the community in different levels, open society, key populations, general community-based organizations, and medical/mental health services.

There is high evidence to develop innovative capacity-building strategies at different levels that should include the visibility of key populations on demand for better comprehensible integrated HIV prevention and care services.

It is relevant to emphasize the lesson learned through the last 30 years, to evaluate the good Practices that could be used nowadays, integrate innovative experiences articulated and incremented during the COVID-19 pandemic, such as amplified access to Telehealth and virtual training for providers and people from the community.

Capacity-building should include an educational curriculum in medical, mental health, and other community levels, creating human resources as part of a comprehensive package of services free of stigma and discrimination. This level of the capacity building should expand the knowledge and understanding of ETE strategy, U=U, Prep and Pep, and Status Neutral approach

There's still a gap related to the proper characterization of populations historically classified in high risk (LGTBQ, Black Community, Hispanic/ Latino, Youth, Immigrants, women elderly PLWH, and other sexually active populations); There's an emerging need to implement more baseline studies, community surveys, and research to know the new dimensions of these key populations.

Reframing the risks and languages could determine the impact of ongoing challenges evidenced in different levels. Own of the main issues identified in the community are the challenges of language barriers (urban language or barriers to speaking and understanding English). There's still a barrier to developing better programmatic indicators based on a general overview from the community level.

To finalize, it's relevant to continue including civil society, community-based organizations, and health providers in monitoring and evaluation strategies, including midterms general evaluation meetings that could measure goals achievements and identify rapid solutions and improvement that contributes to End the Epidemic.

Quote: Humanizing data can save lives

Looking forward to participating in future meetings

Miguel A. Rosa Rubio

MD, MPH CHC

Family Services Network of New York Inc.

Billy Fields

Hello, my name is Billy Fields. Thank you for this opportunity to share my concerns. I am a healthcare advocate and speak on behalf of People With HIV who have Physical Disabilities. Far too long, this population has been overlooked and underrepresented. People With HIV and Physical Disabilities who use “Power Wheelchairs” have had to endure many barriers that interrupt their access to care and services, and jeopardize their independence.

Consequently, they feel cut off and trapped at home because of the inability to use their legs (or power chairs) and are forced to wait on paperwork that take months to process. Managed Long Term Care services and contracted repair companies are woefully nonresponsive and do not prioritize needed repairs. As a result, clients are plagued with frustration, isolation, anxiety, and despair that often impact their livelihoods, quality of care, and mental health. These inequities and ineffective protocols need immediate action.

I further elucidate that it is critical to devise more efficient processes to be expedited that focus on our needs. One need of which is decreasing the turnaround time for completion of wheelchair repairs. Yes, electric-powered nondurable equipment, often breaks down. Personally, I have experienced disruptions for periods of up to 4 months waiting on repairs and maintenance. Currently, the necessity for backup chairs has increased due to high demand and limited availability.

To keep people retained in the care as well as optimize their quality of care, we must address the concerns of this population. This is only one issue of many that People With HIV who have Physical Disabilities have to confront. In this case, thoughtful execution of the ADA falls short when addressing this population’s issues and vulnerability. If we are to overcome the challenges of the EHE (Ending the HIV Epidemic) for all people, the plight of People With HIV and Physical Disabilities must be included in the Blueprint. Thank you!

Reginald Thomas Brown, M.Ed., VOCAL-NY

This is Reginald Thomas Brown, M. Ed. from VOCAL-NY.

Greetings everyone,

My name is Reginald Thomas Brown. My pronouns are they/them. I grew up in Kansas City, KS, and currently live on 42nd Street in the Theatre district of New York City, and I am 70 years old.

In 1986 I was living and performing in Athens, Greece and took a flight back to KC KS to visit my parents whom I had not seen since 1977. While there, I went to my mother's doctor for a physical because I had not seen my doctor in NYC since 1978.

Unbeknownst to me the doctor did an HIV test. They called me and asked me to come to their office. Their words were, “Get your affairs in order because you will be dead in 2 years.” The most upsetting words were, “Be careful around your 1 and 2 year old nieces.” I had NO idea

what that meant. Do I touch them? Am I allowed to be in the same room with them? My diagnosis was HIV+. At that time an HIV+ diagnosis was almost certain death.

My universe stopped at that moment. I was numb, confused and scared in Kansas City, KS!! But, I returned to Athens to dance, sing, act, teach dance, choreograph and model because I still had a successful rewarding career of my own dreams!!!

Then, my spirit spoke to me and said, look at the blessings in this message. #1. I don't have to worry about getting HIV anymore. #2. It showed me the absolute necessity of prioritizing my time. THIS is important and THAT isn't and my choices are non-negotiable. The most important blessing, #3 is my decision to live whether I have 2 days or 2 hours, UNTIL I die. That was 35+ years ago. I am living my best life, have been unable to transmit HIV since 2003, and have had NO AIDS-related illnesses. Somebody who looks like me needs to see me and hear my story. Thank you for allowing me to be seen, heard and appreciated!! God bless you.

Jules Levin, Executive Director, NATAP

Hello

Here are my succinct comments for PACHA.

1. **Aging & HIV** is a very serious problem for PLWH. It is under recognized & underestimated. By 2030 its expected that 75% will be over 50 & 40% over 60. Right now 30% in NY & SF are right now over 60. These PLWH are unable to get the care they require to meet their needs. The HIV healthcare system is broken, despite a RWCA of \$1 billion dedicated to address the needs of PLWH. we need to reboot & redise the RW Care system to meet the needs of aging & elderly PLWH. We need to integrate geriatric care elements into HIV clinics on site, not at remote sites. HIV doctors need to have the time needed to provide the care elderly & aging PLWH require. We need a new HIV healthcare system because its broken now. As it is now older, aging & most particularly elderly PLWH who suffer from multiple comorbidities & polypharmacy are unable to get their care needs met. The prime culprit is the insurance companies bth public & private have ruined our HIV healthcare system because they have so limited & restricted reimbursement that clinics & large hospital based clinics are now limiting doctor-patient visits to 20 minus. In addition visits with specialists like a cardiologist or a nephrologist are also limited to 20 minutes. There is not enough time that clinicians have to provide the time & attention elderly & aging that aging & elderly PLWH need who suffer with multiple comorbidities & complicated conditions who need more time & attention. The affects of the insurance reimbursement restrictions also results in PLWH waiting 1-3 months to see a specialists; PLWH are unable to easily & readily access mental health or psychiatric care. The end result of this is many elderly PLWH are experiencing declining health, cannot get the care they need, feel abandoned & mortality is worse - thats right, the death rates are higher & will increase for this population. The affects of social determinants of care & HIV itself both contribute to accelerated aging so we need to address the affects of the social determinants of care.

2. **Aging & HIV related research** does not get the attention. We need a fast-track funded mechanism that allows for aging related research that includes implementation research. Because

patient-friendly research that can affect clinical care is not getting implemented & the process to do this has become so difficult that it doesn't get done.

3. **Women with HIV** experience aging worse than men. They experience more inflammation, more comorbidities, worse physical & mental decline in older age. They suffer worse social determinants of care which clearly contributes to these poor outcomes. They need special care & services programs.

thanks,

Jules Levin
Exec Dir
NATAP
www.natap.org

Noah Raper, HIV Law and Policy Advocate

Hi, my name is Noah Raper, 30 years HIV+, member of Tennessee HIV Modernization Coalition, member of vumc BioVu can, Recipient of Strobel award and community action community award.

My comment is about telehealth. So many in the HIV+ community struggle just to make ends meet. Telehealth is a great tool but has become a barrier during covid. So many of us have connection to the Internet via our phone, we don't have a home office with all the works too make telehealth work. Getting people connected with home internet, a computer, will make telehealth more successful and eliminate it being a barrier.

Thank y'all for keeping us living and being the voice of all of those who are no longer here. Many survived the AIDS crisis but were taken by covid. PACHA makes me think of all my friends who aren't here. Thank y'all for this wonderful opportunity for a regular person to be a part of this.

Sincerely,

Noah Raper

HIV Law and Policy Advocate

He/Him/His
#HIVisNOTaCRIME

National Association of County and City Health Officials (NACCHO)

Public Comment Submitted By:

National Association of County and City Health Officials (NACCHO)

1201 Eye St. NW, 4th Floor

Washington, DC 20008

Comment Submitted To:

Presidential Advisory Committee on HIV/AIDS (PACHA)

Presented via Zoom on March 15, 2022

Good afternoon, my name is Lucy Slater, and I am the Senior Director for HIV, STIs, Viral Hepatitis and Harm Reduction at the National Association of County and City Health Officials, the only organization dedicated to serving all 3,000 local health departments in the U.S. We are glad to hear panelist Amy Killelea's discussion of a national PrEP program during PACHA today and as the voice for local public health, I am here on NACCHO's behalf to ask that the committee seriously consider recommending a national PrEP program.

Local health departments (LHDs) are key partners in community HIV prevention, treatment, detection, and response, and play an important role in implementing PrEP. A recent NACCHO study indicated that half of surveyed LHDs engage in PrEP implementation, however over one-third do not have any specific funding to do this work. As our nation's patchwork of PrEP financing mechanisms stands, many local health departments and clinics across the U.S. depend on cost-savings from previous brand-name forms of PrEP, an entirely unsustainable system for putting effective and affordable HIV prevention in the hands of communities who need it. Unsurprisingly, LHDs report significant challenges related to funding, staffing, and resources needed to navigate complex financing systems and payment assistance programs, and to ensure PrEP availability for uninsured clients.

While NACCHO continues to call for increased funding for local HIV prevention activities, grant funding is only a band-aid in this unsustainable system. A national PrEP infrastructure would scale up generic PrEP as a cost-effective option and create a platform to deploy new forms of PrEP as they develop. It would ensure access to PrEP and all associated costs for the uninsured and individuals on Medicaid; it would allow for streamlined financing and delivery, and promote the uptake of status-neutral models by local providers

NACCHO is joining the call for a simplified, equitable, and accessible National PrEP Program which will allow local public health providers to focus their efforts on reaching the communities that need PrEP the most.

Charmaine Graham, Co-Chair, Consumers Committee, HIV Health and Human Services, Planning Council NY, To the Advisory Council

With Paramount importance towards transformation in the HIV Communities.

I am thankful that the PACHA has taken needed time to engage and listen to the needs of PLWH. There is a difference between hindsight and mind sight, where we take a look at the input and how it can work out.

Change is always tough at first , however being persistent for the betterment of people's lives is key

Please see information below in regards to my suggestions. These are some of the things members of the Consumers Committee discuss during our meeting.

1. Increase accessibility for all people with disabilities
2. Reduce data burden ,increase direct service delivery
3. Increase accessibility to Sex Positive Workshops
4. Promote peer to peer support among Young Adults
5. Keep modifying incentives for OPLWH and YPLWH
6. Create Culturally and Linguistically Appropriate Services
7. De-escalation ,de-stigmatization and the normalization of Mental Health and Substance
8. Support the recognition and dismantling of biased and inequitable practices Planning Strategies
9. 9.Consumers knowledge of rights, Services, policies, and procedures to support advocacy and client centered care
10. Accelerates uptake of technology
11. Cultural safety
12. Sex Positivity
13. Craft programs for age 55 and older (Sewing, Netting, Art &Crafts ect.)

For all gender

Charmaine Graham
Co-Chair ,Consumers Committee
HIV Health and Human Services, Planning Council NY

Omar Martinez Gonzalez, Organization: Multicultural AIDS Coalition, Inc., LGBTQ+ Program Coordinator

To whom it may concern,

I am writing to submit a public comment for the PACHA community engagement session happening on Tuesday, March 15, 2022. Below is the requested information:

Name: Omar Martinez Gonzalez

Organization: Multicultural AIDS Coalition, Inc.

Title: LGBTQ+ Program Coordinator

Comment: Tremendous harm was done to our fight against HIV/AIDS when the previous administration targeted immigrant communities around the public charge definition for adjustment of status and naturalization. People living with and those vulnerable to HIV who were accessing publicly funded HIV/AIDS prevention services ceased accessing these vital services for fear of being locked out of immigration benefits. Any HIV elimination strategy must take into account the undocumented and immigrant communities, and ensure that these services are not only readily available to them, but that these communities are aware that they can access these services without fear of immigration penalties.

Omar Martínez González (he/him/his)

Program Coordinator

CONNECTEDBoston



March 14, 2022

Co-Chairs and Members of the Presidential Advisory Council on HIV/AIDS (PACHA):

The HIV Medicine Association (HIVMA) is pleased to provide testimony regarding two main topics highlighted for discussion during the interactive community engagement session: HIV Prevention in the Context of Ending the HIV Epidemic (EHE) initiative, and the National HIV/AIDS Strategy (NHAS) for 2022-2025. HIVMA represents nearly 6,000 physicians, researchers and other health care professionals who provide HIV prevention, care and treatment and conduct research in communities across the U.S.

HIV Prevention in the Context of Ending the HIV Epidemic: PrEP Assistance Programs

The recently updated NHAS recognizes the need for greater utilization of PrEP. However, there have been significant challenges in PrEP uptake, particularly in communities most at risk of HIV, including Black, Latinx and transgender populations. Only 23 percent of the approximately 1.2 million people who would benefit from PrEP have been prescribed PrEP. Expanding PrEP access to historically marginalized communities and populations is critical to reducing HIV-related disparities and reducing new HIV infections. The Ryan White HIV/AIDS Program is a lifeline for HIV treatment, but there is not a comparable program to ensure access to PrEP regardless of insurance status or ability to pay.

We support the proposal by Amy Killelea and colleagues to establish a [National PrEP](#) program to increase access to PrEP, including lab testing and ancillary services. A national program should leverage public funding and the availability of effective generic PrEP options to dramatically expand PrEP access. The national program would also create a platform to rapidly expand access to novel PrEP options as they become available and extend PrEP access to individuals not connected to existing PrEP programs or health systems.

Congress has introduced two bills to increase and support PrEP access that would complement or could be the base for a national program. The PrEP Assistance Program Act ([H.R. 5605](#)) would provide grants to states, community-based organizations, community health centers and others to establish and support PrEP programs. These programs would provide PrEP and associated medical services as well as the community and provider outreach needed to carry out successful PrEP programs.

In addition, the PrEP Access and Coverage Act ([S. 3295/H.R. 6117](#)) will increase the utilization of HIV prevention drugs by ensuring these medications and any associated costs are covered by health insurance. The bill also will promote public health campaigns and expand access to HIV prevention drugs for uninsured individuals and underserved communities. Furthermore, the PrEP Access and Coverage Act prohibits discriminatory actions such as denying life insurance benefits, disability insurance and long-term care insurance for PrEP users.

Supporting the Workforce Necessary to End HIV as an Epidemic in the U.S.

Achieving the goals of NHAS and the EHE initiative will require a robust, diverse and culturally responsive HIV workforce that reflects the populations disproportionately impacted by HIV. This is particularly important given that nearly 80% of U.S. counties lack a single ID expert, and in 14 southern states, more than 80% of the counties have no experienced HIV clinicians, with the disparities greatest in rural areas.

The impact of the COVID-19 pandemic on the infectious diseases (ID) and HIV public health and clinical workforce, including administrative staff, has elevated the need for policy and programmatic interventions to reinforce, grow and diversify the HIV workforce to ensure access to quality HIV prevention and care services in communities across the country.

We urge PACHA to focus on HIV workforce challenges and opportunities across the prevention and care continuum during the next PACHA meeting to generate specific, bold and actionable recommendations for the White House, HHS and the private sector to advance the ambitious goal of ending HIV as an epidemic.

HIVMA and the Ryan White Medical Providers Coalition members developed [detailed recommendations](#) that focus on incentivizing new clinicians to enter ID and HIV care; addressing burnout; streamlining access to services and supporting innovative delivery models; enhancing HIV training pathways and opportunities; and increasing support for interdisciplinary and multidisciplinary prevention and care teams. We urge PACHA and the Administration to consider these recommendations as you engage in the development of the NHAS implementation plans.

As a top priority, to help address financial barriers to entering the field, we urge support for advancing loan repayment for ID and HIV physicians and health care professionals through the Bolstering Infectious Outbreaks (BIO) Preparedness Workforce Act ([S. 3244/H.R. 5602](#)). This legislation would establish a new loan repayment program for health care professionals who work in biopreparedness and response activities and/or provide ID and HIV care in medically underserved communities and with medically underserved populations. We urge support for the inclusion of the BIO Preparedness Workforce Act in the Senate's bipartisan PREVENT Pandemics Act legislation led by Sens. Patty Murray (D-WA) and Richard Burr (R-NC).

To make progress in improving health equity and addressing workforce challenges in the short term, we recommend HHS and other federal partners consider the following:

- Convening an HIV and ID workforce summit to bring together HHS, Health Resources and Services Administration (HRSA), CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH) and Centers for Medicare & Medicaid Services (CMS) to evaluate ID and HIV workforce needs and novel strategies and policies, including for financing health care, to address them.
- Releasing a Medicaid Bulletin that outlines and encourages states to take steps to support NHAS and EHE through their Medicaid programs by streamlining access to HIV drugs for treatment and prevention; supporting innovative service delivery, such as community health workers and street medicine; and reimbursing for telehealth and teleconsultation, including for audio-only

Marwan Haddad, continued

visits, among other policies.

- Engaging private health insurers and private practitioners through an Ending the HIV Epidemic campaign that they can commit to by:
 - Signing a public pledge to participate in the Ending the HIV Epidemic campaign;
 - Implementing core [HIV quality measures](#);
 - Disseminating the latest HIV guidelines to their provider networks;
 - Ensuring streamlined access to evidence-based HIV prevention and treatment drugs, e.g., approve coverage if recommended by the HIV clinician, 12-month authorizations for HIV drugs and automatically authorizing 90-day refills; and
 - Discontinuing co-pay accumulator programs.

Thank you for the opportunity to provide input on the topic of prevention, in particular, establishing a National PrEP program. This, along with the urgent need to support the HIV workforce, will help increase access to quality HIV care, address ongoing racial and ethnic disparities and decrease new HIV infections. Please contact HIVMA Senior Policy & Advocacy Manager Jose A. Rodriguez at JRodriguez@hivma.org to schedule a meeting to discuss our recommendations.

Sincerely,



Marwan Haddad, MD, MPH
Chair, HIVMA

Attachment: [Recommendations](#) for Strengthening & Diversifying the HIV Workforce



Recommendations for Strengthening & Diversifying the HIV Workforce

U.S. National HIV/AIDS Strategy (2022 to 2025)

Version: February 2022

Achieving the four primary goals articulated in the [National HIV/AIDS Strategy](#) and the [Ending the HIV Epidemic](#) initiative will require a robust, diverse and culturally responsive HIV workforce that reflects the populations disproportionately affected by HIV. The impact of the COVID-19 pandemic on the infectious diseases and HIV public health and clinical workforce, including administrative staff, has elevated the need for policy and programmatic interventions to reinforce, grow and diversify the HIV workforce to ensure access to quality HIV prevention and care services in communities across the country.

The following recommendations were generated during virtual forums held in August 2021 with HIVMA and RWMPC members and were reviewed and revised in February 2022.

Short Term:

- **Enhance Support for the Existing HIV and ID Clinical Workforce & Care Team:** Address the stress and burnout experienced by the HIV workforce during the last two years by:
 - Recommending increased funding for the Ryan White HIV/AIDS Program, including for Part C, to provide more competitive salaries for all members of the Ryan White HIV/AIDS care team;
 - Promoting best practices for managing clinics and community-based organizations; and
 - Engaging the Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau and the Centers for Medicare & Medicaid Services (CMS) to reduce administrative burden and to commit to supporting innovative delivery models, including reimbursement for telehealth and telemedicine, including audio-only visits.
- **Address Financial Barriers for ID and HIV Physicians and Health Care Professionals:** Support passage of the [Bolstering Infectious Outbreaks \(BIO\) Preparedness Workforce Act \(S. 3244/H.R. 5602\)](#). In addition, urge inclusion of the bill in the Prepare for and Respond to Existing Viruses, Emerging New Threats and Pandemics Act (PREVENT Pandemics Act) that is being led by Sens. Patty Murray (D-WA) and Richard Burr (R-NC) and recommend funding for the bill in the President's budget each year.
 - The BIO Preparedness Workforce Act would create a new loan repayment program for health care professionals who engage in biopreparedness activities anywhere in the U.S. or who provide ID care, including for HIV and viral hepatitis, in underserved areas or at federally funded facilities.
- **Facilitate Collaboration Across HHS to Respond to ID and HIV Workforce Shortages:** Convene an HIV and ID workforce summit to bring together the Department of Health and Human Services (HHS), HRSA, the Centers for Disease Control and Prevention (CDC), the Substance

Abuse and Mental Health Services Administration, the National Institutes of Health and CMS to evaluate HIV and ID workforce needs and novel strategies and policies, including for financing health care, to address them.

- **Address Financial Barriers for ID and HIV Physicians and Health Care Professionals:** Work across federal agencies to curate a directory of federal loan repayment opportunities that ID and HIV health care professionals may apply for to relieve their student loan debt.
- **Build Interprofessional HIV Workforce Capacity:** Recommend increased funding for HRSA's AIDS Educating and Training Centers in the President's budget to support novel approaches to supporting and growing the HIV workforce.
- **Advance Health Equity:** Commit to increased support for the availability of multilingual clinicians and the translation of HIV clinical guidelines and resources for patients, clinicians and other health care professionals.
- **Build Interprofessional HIV/ID Workforce Capacity:** Leverage pharmacists to expand access to screening and prevention services through pharmacies and pharmacists as allowable under state laws.
- **Advance Health Equity by Engaging State Medicaid Programs:** Partner with HHS to release a Medicaid Bulletin that outlines and encourages states to take steps to support the Ending the HIV Epidemic initiative through their Medicaid programs by streamlining access to HIV drugs for treatment and prevention; supporting innovative service delivery, such as community health workers and street medicine; and reimbursing for telehealth and teleconsultation, including for audio-only visits, among other policies.
- **Engage Private Health Insurers/Private Practitioners:** Engage private health insurers through an Ending the HIV Epidemic campaign that they can commit to by:
 - Signing a public pledge to participate in the Ending the HIV Epidemic campaign;
 - Implementing core [HIV quality measures](#);
 - Disseminating the latest HIV guidelines to their provider networks;
 - Ensuring evidence-based and streamlined access to HIV prevention and treatment drugs, e.g., approve coverage if recommended by the HIV clinician, 12-month authorizations for HIV drugs and automatically authorizing 90-day refills; and
 - Discontinuing co-pay accumulator programs.
- **Advance Health Equity:** Leverage investments in [community health workers and peer outreach specialists](#) in response to the COVID-19 pandemic by supporting them to also conduct HIV education and support linkages to HIV, STI and viral hepatitis screening to advance the goals of the National HIV/AIDS Strategy and the Ending the HIV Epidemic initiative.

Longer Term:

Address Stigma and Discrimination With Health Care Professionals

- Engage primary care and other health and medical profession associations in a campaign to educate providers on the stigma and discrimination experienced by people with HIV within the health care system and how it impacts their health and quality of life. See, as an example, [Your Guide to Creating a Stigma-Free Health Care Zone](#), developed by the San Antonio Alliance.
- Partner with provider organizations to incorporate and educate physician and other health care professional trainees and fellows on their role in reducing stigma and addressing health equity issues.
- Increase training and funding for gender-affirming programming with primary care and HIV providers.

Address Financial Barriers for ID and HIV Physicians and Health Care Professionals

- Urge CMS to re-evaluate reimbursement and payment methodologies for inpatient evaluation and management codes to appropriately value cognitive care and evaluate financing models to better support comprehensive, person-centered holistic care.
- Work with CMS and key stakeholders to develop and evaluate sustainable and equitable financing for innovative health care delivery models, including street medicine or mobile outreach, telehealth and [differentiated care](#).

Strengthen the Interprofessional Prevention & Care Team

- Strengthen HIV curriculum in nursing and advanced practice provider programs with a focus on programs in the South, Historically Black Colleges and Universities, Hispanic-Serving Institutions and institutions that focus on training rural health providers to develop a diverse clinician pipeline.
- Partner with the Accreditation Council for Graduate Medical Education (ACGME), Accreditation Commission for Education in Nursing (ACEN), the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Review Commission on Education for the Physician Assistant to incorporate basic HIV screening, prevention and treatment education into training curriculum.
- Increase support through CMS, HRSA, SAMHSA and CDC for interdisciplinary and interprofessional teams and team training for pharmacists, advanced practice providers, physicians, nurses, social workers and mental health and substance use treatment providers.
- Address recruitment and retention challenges for community health workers and outreach staff by developing and disseminating best practices that will support higher base salary levels and developing a pathway for professional support, job placement and advancement. Direct resources to recruiting populations heavily impacted by HIV, including Black, Indigenous and other people of color, and trans young adults.

Build HIV Care Team Capacity – Support Training Pathways for HIV Primary Care

- Identify opportunities to expand support for enhanced residency training in HIV to increase the cadre of primary care providers with expertise and experience in HIV clinical care in geographic areas of highest need. See [Human Immunodeficiency Virus Training Pathways in Residency: A National Survey of Curricula and Outcomes](#) as background. See HRSA's [Primary Care Training and Enhancement – Community Prevention and Maternal Health as a model](#).
- Support enhanced HIV training opportunities, including clinical fellowships or residency programs, for nurse practitioners, physician assistants and clinical pharmacists.

Provide Support to Clinicians Managing Care for Fewer People With HIV & Private Practitioners

- Expand support for agile, easy-to-access innovative mechanisms that offer robust support to less experienced HIV providers, such as teleconsultation, Project ECHO and peer-to-peer learning models at the systems and local level.
- Increase support for private practitioners managing fewer patients with HIV by offering funding mechanisms to support case management services and by supporting campaigns to educate private practitioners on the AIDS Education & Training Center Program, state AIDS Drug Assistance Programs and other services available through state health departments.
- Develop tools to facilitate adoption of the [federally approved practice guidelines](#) by clinician level, including pocket guides, decision-tree diagrams and other clinician-friendly tools.
- Explore the development of a [Health Care Effectiveness Data and Information Set measure](#) for HIV screening, prevention, care and treatment.



1101 14 St., NW, Suite 300
Washington, DC 20005
(202) 408-4848
www.aidsunited.org

March 22, 2022
Presidential Advisory Council on HIV/AIDS (PACHA)
330 C Street SW, Room L609A
Washington, DC 20024

Delivered via electronic mail.

Councilmembers,

AIDS United's mission is to end the HIV epidemic in the United States. Our work is always guided by the voices of people living with and communities most vulnerable to HIV. AIDS United envisions a time when all people, organizations and governments commit to ending the HIV epidemic and strengthening the health, well-being, and human rights of everyone impacted by HIV. Our Public Policy Council consists of over 50 of the nation's leading HIV organizations. We write in support of our members to provide input in regards to the importance of workforce development to the administration's important goal of ending the epidemic during the present decade.

The HIV medical workforce is in urgent need of new providers, especially those that look like the people they serve.

As the HIV epidemic enters its fifth decade, we are facing a wave of retirements of providers that have worked in the provision of HIV care and research since the early days before the development of antiretroviral drugs, challenges in recruiting new providers to the field and the lack of attention to HIV in many health professions schools. Due to that, the number of young providers that are knowledgeable about HIV and focusing on HIV care and prevention is decreasing. At the same time, due to advances in HIV clinical care leading to longer life expectancy, HIV prevalence continues to rise.

Additionally, as the epidemic disproportionately impacts people of color and individuals who are LGBTQ throughout the country, who in turn are less likely to have proper access to healthcare, it becomes essential that we have a more diverse medical workforce, as well as a larger workforce, focusing on HIV.

Part F of the Ryan White HIV/AIDS Program already provides a structure designed explicitly for workforce development that should receive increased federal investments to support its mission and end the HIV epidemic.

AIDS United, continued

The AIDS Education and Training Centers Program (www.aidsetc.org) is a network of eight regional university-based centers created under Part F of the Ryan White statute with the explicit statutory goal of training and developing the medical workforce throughout the US and its territories. Part F also funds two national centers, one of which provides real time clinical consultation, and a national online HIV curriculum (www.hiv.uw.edu). Since their inception, they have been hard at work training medical providers across all levels of the medical profession, such as physicians, mid-level practitioners, nurses, and pharmacists, as well as non-clinical providers. For more than two-and-a-half decades, the AETCs have operated under a cooperative agreement with the Health Resources Services Administration (HRSA) to serve as the health workforce training arm of the Ryan White program.

In the years between 2016 and 2019, for example, the AETCs conducted a total of 29,656 training programs, and from 2017 to 2019, 109,285 participants were trained. Two-thirds of these trainees provided services in settings where the majority of people served are people of color living with HIV.

The AETC program requires additional resources and expansion. Prior budgets have not been reflecting this.

The AIDS Education and Training Programs under Part F need the resources and funding to expand their vital mission of workforce development. However, during the decade prior to FY22, Part F was consistently flat-funded at \$33.6 million, with a small increase of \$700,000 in FY22 to a total of \$34.3 million. With the current developments in infectious disease and the greater awareness of how epidemics and pandemics can harm our society, it becomes all the more essential that this program is properly and adequately funded.

There are other already-existing resources for workforce development that should be strengthened, such as the CDC's Capacity Building Assistance (CBA) programs.

In addition to the HRSA funded AETC network that focuses primarily on clinical care, as well as biomedical prevention, the CDC funds a national network of CBA programs that focus on developing the HIV prevention workforce, particularly at state and local health departments, community based organizations (CBOs) and other clinics and organizations dedicated to HIV prevention. The CDC supports a CBA provider network in the form of the Capacity Building Assistance Provider Network (CPN), to deliver training, technical assistance and continuous quality improvement for community based organizations and CDC-funded health departments for free. They are an overall technical assistance resource for HIV prevention workers.

We recommend that the AETC and the CBA programs be strengthened and expanded rather than have new workforce development programs created, which would risk redundancy and confusion.

AIDS United, continued

Creating additional new entities dedicated to workforce development would only create redundancy with already existing programs such as the AETC program and the CBA program. We recommend that the Administration further resources, prioritize and look towards expanding the resources and funding of these existing programs so that they can scale up their efforts consistent with the level needed to achieve the Administration's goal to end the epidemic this decade.

We are available to answer any comments or concerns and are additionally available to link you with the National Alliance for HIV Education and Workforce Development (NAHEWD www.nahewd.org), which is an association of the AETCs nationwide, so that you can meet with them should you desire to do so. If you have any questions, please do not hesitate to reach out to us at policy@aidsunited.org.

Sincerely,

Carl Baloney,

Vice President and Chief Advocacy Officer