

**Presidential Advisory Council on HIV/AIDS (PACHA)
64th Meeting**

Hilton Hotel
1001 E. County Line Road
Jackson, MS
July 8–9, 2019

Council Members—Present

Carl Schmid, M.B.A., Co-Chair
John Wiesman, Dr.P.H., M.P.H., Co-Chair
Wendy Holman
Marc Meachem, M.B.A.
Rafaelé R. Narváez
Michael Saag, M.D.
John Sapero
Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.)
Justin C. Smith, M.S., M.P.H.
Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC

Council Members—Absent

Gregg H. Alton, J.D.

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

Jennifer Kates, Ph.D., Vice President and Director, Global Health and HIV Policy, Kaiser Family Foundation

Staff

B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer
Caroline Talev, M.P.A., Public Health Analyst and PACHA Committee Manager

Federal Partners

CAPT Deron C. Burton, M.D., J.D., M.P.H., Associate Director for Health Equity, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention, CDC (*Day 2*)
Laura Cheever, M.D., Sc.M., Associate Administrator, Chief Medical Officer, HIV/AIDS Bureau, HRSA, U.S. Department of Health and Human Services (HHS)
Thomas Clark, Ph.D., Director, National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration (SAMHSA), HHS
Maureen M. Goodenow, Ph.D., Director, Office of AIDS Research, National Institutes of Health (NIH), HHS
Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, CDC, HHS

Sharon L. Ricks, M.A., Regional Health Administrator, Region IV, HHS
Judith Steinberg, M.D., M.P.H., Chief Medical Officer, Bureau of Primary Health Care, HRSA

Presenters

Daniel Ball, Faith and Outreach Organizer, Human Rights Campaign Mississippi
Tammy R. Beckham, D.V.M., Ph.D., Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP), and Acting Director, National Vaccine Program Office, HHS
Hope Crenshaw, Ph.D., Executive Director, Teen Health Mississippi
Thomas E. Dobbs III, M.D., M.P.H., State Health Officer, Mississippi State Department of Health
June Gipson, Ph.D., Ed.S., Chief Executive Officer/President, My Brother's Keeper, Inc., and Open Arms Healthcare Center
ADM Brett P. Giroir, M.D., U.S. Public Health Service (USPHS), Assistant Secretary for Health (ASH), HHS
Matthew Golden, M.D., M.P.H., Professor, Medicine, Allergy and Infectious Disease, Adjunct Professor, Epidemiology, School of Public Health, University of Washington
Kendra L. Johnson, M.P.H., Director, STD/HIV Office, Mississippi State Department of Health
Safiya R. Omari, Ph.D., Chief of Staff, City of Jackson, Mississippi
Marlene McNeese, Assistant Director, Division of Disease Prevention and Control, Center for Community Health Services, Houston (TX) Health Department
Leandro Mena, M.D., M.P.H., Professor, The University of Mississippi
Michael Mugavero, M.D., M.H.Sc., Professor of Medicine, The University of Alabama at Birmingham (UAB), Co-Director, UAB Center for AIDS Research
Amy Nunn, Sc.D., M.S., Founder, Mississippi Faith in Action; Associate Professor of Behavioral and Social Sciences, Brown University School of Public Health
Linda Dixon Rigsby, J.D., Health Law Director, Mississippi Center for Justice
Cedric Sturdevant, Outreach Specialist, AIDS Services Coalition

Day 1

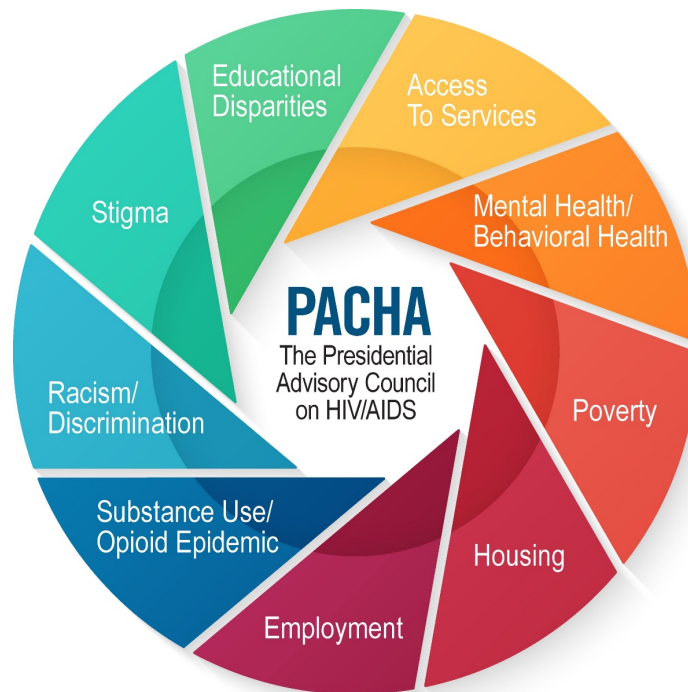
Welcome and Remarks from the Co-Chairs

Carl Schmid, M.B.A., PACHA Co-Chair, called the meeting to order at 1:07 p.m. (This meeting was broadcast live online; the recorded broadcast is available [online](#).) He noted that PACHA is meeting outside of Washington, D.C., for the second time. The Council appreciates the opportunity to visit one of the areas hardest hit by HIV and to learn about obstacles, challenges, and successes here. Before the meeting, PACHA members toured Jackson's My Brother's Keeper and the Open Arms Healthcare Center, which together provide prevention, support, and treatment for people with HIV (PWH) and people at risk for HIV infection.

Mr. Schmid outlined the agenda for the day. He expressed confidence that bipartisan support exists in Congress for the administration's *Ending the HIV Epidemic: A Plan for America*.

John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, said the morning tour demonstrated how much community-based organizations (CBOs) can do. *Ending the HIV Epidemic: A Plan for*

America seeks to provide Federal resources that leverage local assets and solutions, with communities leading the effort to use resources in ways that respond to their unique needs. Dr. Wiesman described the PACHA subcommittees, which meet monthly to address issues identified by the Council. *Ending the HIV Epidemic: A Plan for America* relies on a biomedical approach to prevention and treatment, but PACHA and others recognize that many social factors affect the epidemic (see figure):



Finally, Dr. Wiesman emphasized that the participation of PWH in the Plan is vital to fulfilling PACHA’s mantra, “Nothing for us without us.”

Roll Call

PACHA Executive Director B. Kaye Hayes, M.P.A., called the roll.

Welcome

ADM Brett P. Giroir, M.D., USPHS, ASH, HHS

Dr. Giroir said community input is critical to the success of *Ending the HIV Epidemic: A Plan for America*, which recognizes that the South is disproportionately affected by HIV. The negative trends around HIV represent an opportunity for Federal partners to learn from communities how they are addressing HIV locally. Dr. Giroir emphasized the importance of collaboration.

In his February 2019 State of the Union address, the President announced *Ending the HIV Epidemic: A Plan for America*. The President’s proposed budget requested an additional \$291 million in fiscal year (FY) 2020 to begin work on the initiative. The Plan aims to decrease new infections by 75 percent in the next 5 years and by 90 percent in the next 10 years by focusing resources on communities with the greatest burden of disease and highest proportions

of new diagnoses—specifically the District of Columbia; San Juan, Puerto Rico; 48 counties across the country; and seven southern States with a high burden of disease in rural areas. It focuses on populations disproportionately affected by HIV, including African American and Latino gay and bisexual men, transgender people, women of color, and people living in the southern United States. Dr. Giroir said the Plan has the full support of the President and HHS Secretary Alex Azar II.

Ending the HIV Epidemic: A Plan for America efforts would be futile without the engagement of local partners that have been fighting HIV for decades, said Dr. Giroir. He was inspired by the people, professionalism, and atmosphere of My Brother's Keeper and Open Arms Healthcare Center; these organizations are models of what can be accomplished if the Federal government provides resources and gets out of the way of great CBOs.

Dr. Giroir designated \$30 million from the Minority HIV/AIDS Fund (MHAF) to support preliminary work so that communities can begin work as soon as Congress approves FY 2020 funding for the Plan. The MHAF dollars will be awarded in FY 2019 to community coalitions to develop implementation plans for using FY 2020 funds. Also in FY 2019, HHS is funding pilot projects that focus on developing an HIV workforce of, by, and for the communities they serve. Another pilot supports the Cherokee Nation, in conjunction with the Indian Health Service, to accelerate progress on eliminating the epidemic in Tribal lands.

Dr. Giroir announced that he is establishing a team of USPHS Commissioned Corps officers to support *Ending the HIV Epidemic: A Plan for America* in Atlanta, Dallas, and Los Angeles as part of the Prevention through Active Community Engagement (PACE) program. These officers will work with local leaders to implement actions in the communities they represent. The PACE program is part of a larger effort, Operation Change the Map, led by Principal Deputy ASH, RADM Sylvia Trent-Adams. Operation Change the Map refers to the Office of the ASH (OASH) plan to target ZIP codes inordinately affected by certain health conditions (including HIV, hepatitis C, human papillomavirus [HPV], hypertension, and diabetes) to transform their health outcomes by increasing access, diagnosis, treatment, and awareness.

In May, Sec. Azar announced that the pharmaceutical company Gilead Sciences will donate pre-exposure prophylaxis (PrEP) medication for up to 200,000 individuals each year for up to 11 years for uninsured people at risk for HIV. Dr. Giroir said HHS is moving quickly to begin distribution of the PrEP medication within the next few months.

PACHA reached out to OASH to discuss the new rule Protecting Statutory Conscience Rights in Health Care, which was finalized in May 2019 by the HHS Office of Civil Rights; it was to go into effect in July 2019 but has been postponed. In addition, [HHS has proposed revising Section 1557](#) of the Patient Protection and Affordable Care Act (ACA), which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Dr. Giroir said HHS is fully committed to enforcing all antidiscrimination laws, including those related to civil rights and personal conscience. Dr. Giroir said any change to the ACA will not affect HHS' commitment to ensuring that PWH and those at risk for HIV have equal access to health care. He said the HHS Office of Civil Rights will speak with PACHA

members about the conscience rule and Section 1557. Dr. Giroir encouraged the public to [provide comments on the proposed rule by August 13, 2019](#).

Dr. Giroir said CDC leadership is visiting communities around the country to assist with developing local plans to address HIV. HHS also is revising the National HIV/AIDS Strategy (NHAS) and writing the first national plan to combat sexually transmitted infections (STIs). Dr. Giroir thanked the PACHA members for their commitment to fight HIV.

Questions and Answers

Asked how community organizations can submit ideas to OASH, Dr. Giroir said PACHA is the primary mechanism for gathering public feedback. OASH also is holding listening sessions around the country. CDC representatives working within communities and HHS Regional Health Officers also collect insights. As HHS makes awards to local communities for planning to implement *Ending the HIV Epidemic: A Plan for America*, it is important that all local stakeholders be involved in planning. Dr. Giroir welcomed new ideas on how to bring stakeholders together to address HIV at the local level, adding that the goal of the Plan is not to establish a large, federally operated program but to provide Federal assistance, with guardrails, to communities.

It was noted that a large influx of dollars can disrupt the ecosystem of a community and hamper interactions among organizations. Before any money is awarded for implementation, communities should have benchmarks and mechanisms for accountability in place. Dr. Giroir agreed, noting that the planning grants and pilot projects will help communities work through such issues. The Centers for AIDS Research (CFARs) will monitor ongoing efforts and provide feedback on what works, so that communities can adjust their approaches as they go. HHS will identify key metrics that all communities must track and develop an online dashboard to provide a broad sense of progress. Dr. Giroir hoped there would be opportunities for all the jurisdictions targeted by *Ending the HIV Epidemic: A Plan for America* to meet and discuss best practices and lessons learned.

PACHA Subcommittee Reports

Ending the HIV Epidemic: A Plan for America and the Updated NHAS

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

In its first meeting, the Subcommittee discussed the role of PACHA, which includes providing formal and informal opportunities to engage the community and get feedback on the Plan and NHAS. PACHA also can bolster communication about the Plan. The Subcommittee observed that some Federal partners, such as the Department of Housing and Urban Development (HUD), are missing from the discussion.

Stigma and Disparities

Rafaelé Roberto Narváez and Justin Smith, M.P.H., Co-Chairs

The Subcommittee has met twice to discuss aspects of discrimination. A lot of conversation has reflected concerns raised by community partners about, for example, discrimination against the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community and against non-English speakers. The Subcommittee appreciated that the HHS Office of Civil Rights is open to dialogue

about the issues of stigma, disparities, and social determinants of health (SDH). Addressing stigma and disparities is essential to the success of *Ending the HIV Epidemic: A Plan for America*.

Global

Robert Schwartz, M.D., M.P.H., D.Sc. (Hon.), Chair

The Subcommittee seeks to gather lessons from international experiences that can be applied to the United States. For example, Dr. Schwartz met with a professor in Warsaw, Poland, to discuss the HIV response there.

HIV Epidemic in the South: What Do the Data Say?

Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, CDC, HHS

The United States saw more than 38,000 new HIV diagnoses in 2017. Of those, 52 percent were in the South (an area encompassing 16 States and the District of Columbia). About one fifth of those diagnosed were women (mostly African Americans), and 67 percent were men who had sex with men (MSM). The South accounted for about half of all diagnoses, and 53 percent of those were among African Americans. It is estimated that the United States has 1.1 million PWH; about 14 percent are unaware they have HIV. The South accounts for half of all the undiagnosed PWH. Mississippi has a slightly smaller percentage of undiagnosed PWH than other States (12.5 percent).

Dr. McCray provided 2016 data about each stage of the health care continuum at the national, regional, and State levels. Deaths from HIV remain higher in the South than other regions, but they have been decreasing over the past decade in all regions, primarily because of increased diagnosis and treatment. PWH in the South are more likely to die from HIV. In summary, in 2016, the South accounted for 38 percent of the U.S. population but 51 percent of annual HIV infections, 45 percent of PWH, and 50 percent of undiagnosed HIV infections.

Discussion

Dr. McCray acknowledged that the current metrics for retention are not ideal because some healthy PWH do not have frequent visits to assess their viral load. However, continuous engagement is key to viral suppression. CDC is working to provide data every 6 months, and in some cases faster. For *Ending the HIV Epidemic: A Plan for America*, the CDC is considering leading indicators that can be reported every 3–4 months, at least at the national level.

Dr. McCray explained that CDC might not have granular data at the jurisdictional level.

In response to a comment from Mr. Sapero, Dr. Giroir explained that the proposed budget for *Ending the HIV Epidemic: A Plan for America* includes the cost of provider visits and laboratory tests required for PrEP, and it assumes no changes in the insurance market or Medicaid access. HHS recognizes that jurisdictions need money to treat PWH before the rates go down, so it is a matter of ensuring the budget support. Mr. Sapero further noted that PWH might be linked to care but encounter delays or barriers to seeing a provider. Laura Cheever, M.D., Sc.M., pointed out that HRSA has a rapid eligibility policy in the Ryan White HIV/AIDS Program that enables presumptive treatment for PWH who have been newly diagnosed or re-engaged in care, but more flexibility in funding is needed to allow communities to address other PWH. Mr. Narváez said

more funding to provide STI testing, as well as HIV testing and PrEP, can help link people to care. He added that CBOs that offer testing do not receive any funding for laboratory tests.

Ending the HIV Epidemic: A Plan for America in the South: Local and State Efforts

Facilitator: Michael Saag, M.D.

Presenters: Thomas E. Dobbs III, M.D., M.P.H., State Health Officer, Mississippi State Department of Health; Kendra L. Johnson, M.P.H., Director, STD/HIV Office, Mississippi State Department of Health; and Safiya R. Omari, Ph.D., Chief of Staff, City of Jackson, Mississippi

Dr. Saag posed a series of questions to the panelists about how their organizations address HIV, conduct surveillance, and work with partners, among other topics. The following key points of interest arose:

- Jackson's mayor has committed to using available resources to address HIV in particular. The city employs public and private funds to address housing, case management, transportation, and other barriers to ensure access to resources.
- Ms. Johnson explained that Mississippi is encouraging providers to frame HIV testing as a normal part of routine health screenings to bring undiagnosed PWH into care. The State aims to increase testing through mobile health providers and in local health departments.
- Dr. Dobbs stressed that county health departments continue to fulfill a service need. He noted that many people avoid HIV testing because of stigma.
- Dr. Omari noted that Jackson could model outreach about HIV on existing financial literacy education programs for city workers.
- Dr. Dobbs commented that the State is beginning to work with providers, including nurse practitioners, to develop the capacity for HIV testing and initiating PrEP. He suggested that PrEP be disseminated through local health departments and family planning clinics.
- Ms. Johnson added that Mississippi is building capacity to conduct molecular surveillance and increase health departments' abilities to use such data to increase services.
- Ms. Johnson emphasized that many people lack basic education about STIs and do not know they are candidates for PrEP.
- Dr. Dobbs described the lack of providers in rural areas as a significant barrier to care. The State is working with university partners and others to advance telemedicine.

Discussion

Ms. Johnson acknowledged that the declining workforce has been a barrier to improving HIV care. This year, the State supplemented Federal funding for more health department staff to increase capacity to care for PWH and people with syphilis, a competing priority. Dr. Dobbs called for more flexibility in the rules governing disease intervention specialists.

Although public health often is seen as being in the purview of counties and States, Dr. Omari commented that cities can be more involved in addressing SDH through outreach. In Jackson, the only source for HIV services for low-income people is the Ryan White HIV/AIDS Program. Because Jackson is a predominately African American city, health care providers have

tremendous trust issues to overcome. The city is partnering with the State to ensure that all of its workers receive accurate information. Dr. Omari added that the city could strengthen relationships with local CBOs.

Dr. Dobbs said the State has had some success working with faith-based organizations, CBOs, community leaders, and some political representatives on messaging around stigma. He added that internalized stigma prevents people from getting tested. The State is considering creating an Office of HIV Equity and Disparity to raise awareness about stigma.

Leandro Mena, M.D., M.P.H., of the University of Mississippi, said providers are getting better at offering HIV testing routinely. Marketing is key, but messaging must motivate people while not inadvertently stigmatizing the target audience, which requires consultation with the local community. Dr. Mena added that Southerners are very concerned about privacy, so consideration must be given to how to provide confidential HIV testing and treatment.

Ms. Johnson noted that Jackson effectively encourages data exchange among providers and CBOs, but challenges persist in rural communities. She noted that the State is in the planning stages for molecular surveillance, but it is still working to get buy-in from all those involved. Dr. Dobbs pointed out that the State receives money to improve its infrastructure but lacks a strong foundation in addressing SDH. The State needs funding and capacity to foster new CBOs and partnerships to expand its reach at the local level. Dr. Wiesman commented that infrastructure needs go beyond HIV, and he welcomed ideas for building capacity from the local level up to create and improve information-sharing systems. Dr. Saag added that neighboring States could work together, using inexpensive real-time tracking software, to retain PWH in care.

Lessons Learned from a CBO

June Gipson, Ph.D., Ed.S., CEO/President, My Brother's Keeper, Inc., and Open Arms Healthcare Center

My Brother's Keeper is a nonprofit CBO that serves minority and marginalized populations through leadership in public and community health. Services include capacity building; curriculum development; and training on HIV, other STIs, and primary prevention. My Brother's Keeper created the Open Arms Healthcare Center to provide holistic clinical services for the LGBTQ population but is open to all.

Through its Becoming a Healthier U program, Open Arms established links to mental health, transportation, and food services. This fall, it will debut pharmacy and dental services. With its mobile clinic, it reaches many people across the State who do not have easy access to a health care provider. The mobile unit offers screenings and connects users to local clinics for follow-up care. Open Arms functions like a Federally Qualified Health Center and has Ryan White, STI, and family planning designations. It offers opportunities for clinical and behavioral research.

The lack of sex education in Mississippi is a substantial barrier to health, explained Dr. June Gipson. Another challenge is the paperwork associated with achieving and maintaining Federal designations that allow access to Federal dollars—and the fact that none of the designations acknowledge or facilitate the work that CBOs do. The expansion from community leadership development to providing clinical services was challenging for staff. My Brother's Keeper and

Open Arms have had to adopt business principles to sustain their efforts, including investing in staff training. Dr. Gipson emphasized the range of partnerships that both organizations maintain, which allows them to pursue novel opportunities. If partnerships required support for CBOs, My Brother's Keeper and Open Arms would not be anomalies but models, she concluded.

Discussion

Dr. Gipson stated that State and local health departments undervalue CBOs and fail to see what they offer. For example, the State health department did not want to give My Brother's Keeper data because it did not think the organization could understand it. Having champions within the State and local health departments is key to mending relationships with CBOs. A vital step in the evolution to providing health services was obtaining Section 340B funding, which required the organization to partner with a local health department. Federal designations provide not only dollars but also access to other partners. Dr. Gipson stressed the importance of being willing to take necessary risks and to persist for the long term.

Dr. Gipson pointed out that the mobile health unit was staffed primarily by Black men so that other Black men would feel comfortable there. Dressing staff in scrubs shifted how community members felt about testing. At first, the mobile unit was unprepared for the number of users who lacked literacy, but it added staff to help users complete paperwork. Another challenge was determining what services different communities wanted and encouraging users to opt in to a broad range of screening. The mobile clinic has had the most impact of all of Open Arms' services.

Open Arms has integrated mental health screening, treatment, and referrals into the Ryan White HIV/AIDS Program and other programs. Dr. Gipson hopes to see mental health screening become as routine as reviewing a patient's medications.

Ending the HIV Epidemic: A Plan for America: Addressing Challenges Specific to the Rural South

Facilitator: Justin Smith, M.P.H., Co-Chair, Stigma and Disparities Subcommittee

Understanding Challenges of the Rural South

Leandro Mena, M.D., M.P.H., Professor, University of Mississippi

Dr. Mena noted that better tools and systems are needed for collecting and assessing data. Poor infrastructure in rural areas limits the use of effective tools, such as telemedicine and online education. Other issues of particular concern in the rural South are lack of trust in the health care system (fueled, for example, by anti-immigration policies), the spread of HIV related to incarceration, stigma, and aggressive homophobia.

Research can shed light on barriers, thus helping to identify the solutions. Dr. Mena gave several examples that underscored the need to better understand where people in rural areas want to receive care and how, such as placing pharmacies onsite in health care centers so patients can get prescriptions right away, with follow-up testing shortly afterward. To increase access, he recommended recruiting retired doctors to provide care, relying on pharmacists and pharmacies as entry points to care, and using mobile clinics. Through active engagement, the community—

and PWH specifically—can identify and prioritize the solutions that meet their needs. Engagement must reach beyond the health care community and its traditional partners.

Surveillance mechanisms should be strengthened, and quality assessment measures should address SDH. Expanding Medicaid in Mississippi would increase access to health care and would decrease the burden on programs like the Ryan White HIV/AIDS Program, which could then focus on providing the wraparound services that promote health.

HIV Criminalization

Linda Dixon Rigsby, J.D., Health Law Director, Mississippi Center for Justice

Ms. Rigsby explained that stigma against PWH comes in many forms, including criminalization of behavior that is not otherwise punishable. Stigma discourages people from getting tested, fuels discriminatory behavior, and promotes misinformation. PWH who internalize stigma might see themselves as unworthy and unloved, which creates yet another barrier to care.

In Mississippi, it is a felony if a person attempts to cause or knowingly causes a corrections employee, a visitor to a correctional facility, or another prisoner or offender to come into contact with blood, seminal fluid, urine, feces, or saliva, if the person knows that he or she is infected with HIV. The same exposure by a person without HIV is a misdemeanor. Dr. Rigsby stressed that there is no scientific basis for this law because HIV cannot be spread through saliva, urine, or feces. The Mississippi Center for Justice is advocating for reform and educating legislators and others. It also is forging partnerships with clinicians, social workers, academicians, and others to provide legal education to PWH, as well as training on stigma, specifically internalized stigma.

In addition to refusing to expand Medicaid, Mississippi requires personal caretakers who receive Medicaid to work or volunteer 20 hours per week. Ms. Rigsby noted that many of these caretakers live in rural areas with limited job opportunities and transportation. In addition, working 20 hours at minimum wage would put them over the income threshold for receiving Medicaid. Ms. Rigsby concluded that stigma, discrimination, criminalization, lack of access to care, lack of transportation, and unstable nutrition and housing are a recipe for hopelessness for PWH in Mississippi; nonetheless, the desire to end the HIV epidemic remains.

Increasing the HIV Workforce

Cedric Sturdevant, Outreach Specialist, AIDS Services Coalition (ASC)

The Mississippi Delta is remote and hard to reach, so its residents miss out on a lot of the HIV programs, funding, education, and resources available elsewhere. Clinics are difficult to reach. There is a persistent perception that building resources in the delta is not feasible. Homophobia remains strong in rural areas. Mr. Sturdevant said that to end the HIV epidemic, PWH must be included and involved in their own health and advocacy—and they need jobs. He proposed creating programs to hire PWH for meaningful professional positions in the HIV community.

Mr. Sturdevant pointed out that after he was diagnosed with HIV, he returned to his home in Mississippi and was unable to work for 2 years. He then went to work at My Brother's Keeper, which provided training and inspired him to start speaking out. He is now working with the leadership of ASC to develop a CBO serving rural Mississippi.

Discussion

Both Ms. Rigsby and Dr. Gipson pointed to the links between illiteracy, incarceration, and HIV. Dr. Gipson noted that poor, Black communities have poor educational systems, and the results are spilling over into health.

The Stigma and Disparities Subcommittee should look more closely at HIV criminalization. The Sero Project is an advocacy organization with resources on this issue. Ms. Rigsby stressed the need to address how stigma and fear of criminalization prevent people from getting tested. Dr. McCray said CDC has information on State HIV criminalization laws and a toolkit for educating decision makers and legislators about the impact of such laws.

Asked how Federal funding could help address HIV in the South, Mr. Sturdevant recommended HIV programs for everyone, not just targeting MSM; job creation for PWH; and sex education in schools that normalizes sex and addresses sexual health generally. Dr. Mena hoped to direct new money to create new health care delivery systems for PWH who are not in care and more links to enable people at risk to get preventive care.

Closing Remarks from the PACHA Co-Chairs for Day One

Mr. Schmid appreciated the passion and commitment of the presenters and participants, saying he felt more optimistic than before he came about what can be accomplished through collaboration. Dr. Wiesman encouraged PACHA members to (1) write down their takeaways from today's meeting, (2) think about topics the PACHA subcommittees should address, and (3) consider whether they can apply something learned from today's discussion to the work they do on a daily basis. He encouraged public participants to provide comments, particularly specific actionable suggestions, when possible. The Council concluded for the day at 4:56 p.m.

Day Two

Welcome and Remarks from the Co-Chairs

Dr. Wiesman called the meeting to order at 9:00 a.m. He welcomed the participants and invited them to submit in writing issues, ideas, and recommendations on the following topics:

- Stigma and disparities
- Access to PrEP and HIV treatment
- Ensuring community engagement
- Capacity for and barriers to implementing *Ending the HIV Epidemic: A Plan for America*

Roll Call

Ms. Hayes called the roll.

OIDP Update

Tammy R. Beckham, D.V.M., Ph.D., Director, OIDP

Dr. Beckham described the reorganization of OASH, which combined the National Vaccine Program Office and the Office of HIV/AIDS and Infectious Disease Policy to establish the OIDP. As a result, OIDP has a broad portfolio and capacity to use resources more efficiently.

Regarding *Ending the HIV Epidemic: A Plan for America*, Dr. Beckham said HHS recognizes the importance of addressing housing, SDH, stigma, discrimination, and other barriers to care. Listening sessions around the country are intended to gather input and insights from communities. Dr. Beckham reiterated that funding is available for communities to create implementation plans. In October, agencies and stakeholders will gather to discuss how the CFARs can contribute to and integrate with other components of the Plan. HHS plans to build a dashboard so that data are transparent, timely, and useful. Jurisdictions should have data to inform decision making and support accountability. HHS will identify some critical indicators to assess progress, but communities might want to track additional metrics. The dashboard will be accompanied by education on how to use the data.

Dr. Beckham emphasized that community plans should (1) represent the unique perspectives of their stakeholders and (2) propose interventions that communities believe will work for them. She encouraged individuals to contact her by [email](#) to give input on what plans should include.

OIDP is updating the NHAS, which takes a long-range, strategic approach to ending HIV. The Federal interagency working groups addressing *Ending the HIV Epidemic: A Plan for America* also are informing the NHAS subcommittees with their work. Both groups have representatives from other Federal departments, such as HUD. The Plan and NHAS share the same long-term goals. The National Viral Hepatitis Action Plan also is being updated, and it draws on subcommittees, listening sessions, and community engagement efforts parallel to the NHAS effort. With STIs on the rise, HHS is taking a similar approach to creating the first Federal action plan on STIs, which will be ready by 2020.

HHS is working on a plan to distribute the PrEP medication donated by Gilead Sciences. Dr. Beckham welcomed suggestions on how to reach more people and overcome barriers to uptake.

Role of the Faith Community

Facilitator: Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, PACHA Member

The Faith Community and LGBTQ Oppression

Daniel Ball, Faith and Outreach Organizer, Human Rights Campaign Mississippi

Mr. Ball explained that he works with faith-based organizations to help them stand up for PWH, but he noted that it is foolish to avoid discussing the ways the faith community has contributed to the epidemic by isolating and abandoning the LGBTQ community. It is impossible to create ways for faith-based communities to serve PWH without acknowledging the harm caused in the name of faith. Being ostracized can lead LGBTQ people to seek alternative forms of spiritual healing or engage in self-destructive behavior.

Mississippi and other States do not have comprehensive sex education because religious organizations oppose it. Data show that areas offering such education have lower rates of HIV and other STIs and fewer health disparities. Mr. Ball said the faith community is silencing and killing congregants by limiting resources to the LGBTQ community because of a flawed ideology about who matters. He called for open discussion about taboo topics. The faith community has a strong influence; throughout the South, LGBTQ people can legally be evicted, fired, or denied service because of others' religious convictions. Faith leaders must be accountable for the rhetoric and ideology that tells LGBTQ people they do not matter and they do not belong. Mr. Ball stated that religion has been weaponized against LGBTQ people, resulting in oppression. He recommended educating faith communities about how their actions have affected LGBTQ people and added to the health disparities they now aim to alleviate.

Activating Faith Leaders Against HIV

Amy Nunn, M.S., Sc.D., Founder, Mississippi Faith in Action, Associate Professor of Behavioral and Social Sciences, Brown University School of Public Health

Dr. Nunn said that involving churches in the fight against HIV/AIDS is challenging because of the important barriers described by Mr. Ball, but faith organizations can reach people in ways that public health providers cannot. Through one-on-one conversations with high-profile pastors in areas hard hit by HIV, Dr. Nunn and her colleagues convinced faith leaders to partner with them to help PWH in their communities and congregations. To communicate effectively, Dr. Nunn recommended starting conversations with such issues as normalizing HIV screening and the social justice and human rights aspects of health care access and equity. Beginning the conversation by focusing on sexuality is not effective. Dr. Nunn found leaders who were willing to be part of social marketing campaigns against stigma. She and her colleagues created public health messages that were affirming and elevated the voices of prominent community leaders.

Working with focus groups, Dr. Nunn and colleagues developed messages that resonate with church members for use in church bulletins. They organized a press conference with influential clergy who were tested for HIV on World AIDS Day. Some clergy have publicly asked for

forgiveness for their congregations' silence on HIV. Giving clergy leaders data demonstrating how HIV affects their community is critical. Faith communities and their leaders need education about the HIV care continuum, how biomedical interventions work, and the fact that an undetectable viral load means the virus cannot be transmitted (undetectable = untransmittable, or U=U). And they need this information in plain language, not jargon.

Dr. Nunn said stigma must be addressed, but the conversation can be refocused to emphasize spiritual resilience. He added that pastors in rural areas can be engaged to promote routine screening for HIV as part of normal health care—an approach that worked well with a large rural community health center (CHC). With information about how biomedical interventions mesh with social considerations, faith leaders can advocate for consistent PrEP use and retention in care for PWH. Dr. Nunn praised *Ending the HIV Epidemic: A Plan for America*, especially the “whole-of-society” approach that includes faith communities. She hoped it would support links between congregations and CHCs and create the foundation for novel research around behavior and implementation of science. Dr. Nunn concluded that a major Federal investment is needed to support such work.

Discussion

Mr. Ball felt that the faith community does not understand the impact it has had on health care. Dr. Nunn countered that many clergy counsel individuals, including PWH, and do some outreach. Mr. Ball said progress around HIV requires safe and inclusive places of worship and resources for LGBTQ people to address mental and spiritual health. He added that to leverage the influence of faith leaders in fighting HIV, efforts must go beyond evangelical Christians and embrace other religions and alternative forms of spiritual healing.

Dr. Nunn said working with faith leaders involves moving past intractable views on homosexuality or human sexuality. In her work, she does not avoid frank discussions about sexuality and sexual health, but the key is starting the conversation from a less controversial perspective. Mr. Ball observed that faith leaders engage differently with a cisgender, White, heterosexual woman like Dr. Nunn than with him, a gay Black man.

Dr. Nunn said she has had success working with influential pastors, and other, more risk-averse leaders have followed suit. Mr. Ball noted that in some cases, pastors are willing to expand their ministry to include the LGBTQ community but fear the backlash of the congregation if they publicly express support for LGBTQ issues.

Teen Health Mississippi

Hope Crenshaw, Ph.D., Executive Director, Teen Health Mississippi

Teen Health Mississippi advocates for medically accurate, evidence-based, age-appropriate sex education and youth-friendly health services. Teens are partners in conceiving and creating the initiatives and services offered. Dr. Crenshaw stressed that teens are individuals with unique needs and desires, but too many have been told their opinions do not matter. Teen Health Mississippi seeks to ensure safe spaces and youth-friendly clinics that can counter unhealthy messages about relationships and sex. In clinics, young people want confidentiality, but that is not always granted, said Dr. Crenshaw.

Dr. Crenshaw wondered how different the lives of some LGBTQ people would be if they had received comprehensive sex education in schools—beyond abstinence. Like everyone else, teens want to know what kinds of birth control methods work, how STIs are transmitted, how to talk about consent, and how to talk about sex. Dr. Crenshaw hoped that PACHA and others would look closely at how to foster open, honest conversations with youth about sexual health.

Teen Health Mississippi has two youth representatives as voting members of its board of directors. Its staff is diverse in age, race, and gender. Building trust is a central part of the organization's brand. Informal conversations among staff bring to light issues and perspectives that feed into the organization's work.

Discussion

Dr. Cheever noted that education is always a local issue, so community plans will determine how sex education fits into implementation of *Ending the HIV Epidemic: A Plan for America*. The Ryan White HIV/AIDS Program takes a holistic approach to care for PWH, as do many CHCs. Dr. Cheever added that with PrEP, a positive approach is key. Dr. McCray commented that adolescent education should go beyond sexual health to include drug use and behavioral health. CDC has identified programs for targeted populations that focus on a healthy environment, and it hopes those programs will be incorporated in community plans. CDC's Division of Adolescent and School Health also has many relevant programs for teen health.

Dr. Crenshaw cautioned that Federal agencies currently are promoting the risk avoidance approach (essentially abstinence only) for school-based sex education. Allowing communities to choose the educational approach, however, does not serve the best interests of youth. To protect themselves, young people need medically accurate, evidence-based, age-appropriate sex education. Teen Health Mississippi provides some access to information through social media, and it is seeking to build capacity in communities to further its reach. Unlike other organizations that provide education directly, Dr. Crenshaw's group equips parents and community members with the skills to have conversations with teens about sexual health.

Dr. Crenshaw noted that no major social movements in Mississippi have succeeded without support from the faith community. But much work is needed to address the important concerns raised by Mr. Ball, especially in small, rural communities. Dr. Nunn advocated for more Federal resources for faith communities through *Ending the HIV Epidemic: A Plan for America*, as long as the faith communities ground their responses in evidence. Mr. Ball hoped for assurances that any such funding would reach the most vulnerable people.

Ending the HIV Epidemic: Lessons Learned and Thoughts from Jurisdictions with End AIDS Plans

Facilitator: John Sapero, Co-Chair, Ending the HIV Epidemic: A Plan for America and Updated NHAS Subcommittee

End AIDS Plans in Washington State and King County

Matthew Golden, M.D., M.P.H., Professor, Medicine–Allergy and Infectious Disease, Adjunct Professor, Epidemiology, School of Public Health, University of Washington

To develop End AIDS Washington 2020, an existing State-level planning group convened a smaller steering committee to focus on the effort and hired a coordinator to organize and facilitate the work. Dr. Golden said that having a small group of people dedicated to the job and, in particular, having a dedicated coordinator who acted as a mediator when needed were vital to completing the task. The plan had explicit goals, steps, and monitoring mechanisms, but Dr. Golden explained there might have been too many steps without clear prioritization. The State achieved some of the goals, but the plan did not adequately account for the lack of funding and capacity to achieve all of the goals. It is not clear that the plan accelerated progress toward the goals. Most notably, King County experienced an unanticipated 300-percent spike in the number of people using injection drugs from 2017 to 2018, which highlights the importance of flexibility within plans to adjust to a changing situation, Dr. Golden observed.

To achieve the goals of *Ending the HIV Epidemic: A Plan for America*, jurisdictions must create the clinical infrastructure to provide testing, PrEP, and HIV treatment and retain patients in care. Dr. Golden stressed the need to distinguish “access to care” from “access to care that works.” Across the United States, the general health care system is supplemented by STI clinics, population-focused clinics, and systems to serve marginalized people. Every jurisdiction will have to expand access to care that meets the needs of MSM and transgender people—as Open Arms Healthcare Clinic has done for Jackson and surrounding areas. STI clinics play a critical role in HIV and form a link between public health outreach and medical care, but they have varying rates of success reaching MSM, so jurisdictions should consider how to leverage their services.

Dr. Golden concluded that ending HIV and meeting the needs of PWH and people at risk will require changing how the health care system works. People need easier access to care (e.g., walk-in care sites), more support services, and small incentives (e.g., food) to stay in care.

End HIV Planning in Harris County, Houston, TX

Marlene McNeese, Assistant Director, Division of Disease Prevention and Control, Center for Community Health Services, Houston Health Department

As in most places, Houston has a patchwork of HIV services supported by various sources, overseen by different agencies, and addressing different populations and areas. Its End HIV planning process was driven by community advocates. Ms. McNeese said that starting with dedicated staff to conceive, write, and evaluate the plan would have been a better approach. The plan included metrics that mirrored those in existing frameworks. Houston built a public-facing dashboard to promote transparency. The planning group set aspirational goals that forced

members to brainstorm about what ending HIV would take, which ultimately yielded strong recommendations for policy changes that had not been part of earlier plans.

Echoing Dr. Golden's assessment, Ms. McNeese stated that ending HIV will require an overhaul of the health care system. The South is missing the systems needed to address equity, because existing systems were built on racism, so it will need different interventions than other areas. Ms. McNeese said planners should be prepared for difficult discussions about race, equity, and language. Some input indicated that "ending HIV" sounds like a call to eliminate PWH, and "getting to zero" would be a less hurtful slogan. The planning process requires time for those involved to deliberate in a thoughtful way.

Planning in Progress in Alabama

Michael Mugavero, M.D., M.H.Sc., Professor of Medicine, UAB, Co-Director, UAB Center for AIDS Research

Alabama is basing planning on earlier proposals and collaborations. For example, Birmingham Unified Network to Integrate Testing and Engagement (UNITE) was a collaborative proposal to create mechanisms for various clinical and service providers to share information, but it was not funded. The Ending AIDS in Alabama initiative fostered a dialogue in 2013 among stakeholders across the continuum of care that resulted in a coalition that continues to meet monthly despite having no funding or mandate. The coalition seeks to go beyond HIV to address overall health, SDH, social justice, parity, inclusion, representation, and long-term sustainability. The coalition has moved the discussion beyond blame for the past by focusing on the future. Dr. Mugavero emphasized the power of shared space—that is, the impact of bringing people face to face to talk.

The coalition led to two high-impact CDC projects involving CBOs. The areas where those projects took place have seen reductions in new HIV diagnoses, which have increased in the rest of the State. From these efforts emerged Alabama UNITE, a coalition that facilitates collaboration among CBOs and AIDS service organizations to improve health; enables data sharing across Ryan White HIV/AIDS Program clinics, through the Alabama Quality Measures Group; and leverages CDC funding to share best practices.

Dr. Mugavero said that the plans and goals of *Ending the HIV Epidemic: A Plan for America* are ambitious. Most of Alabama's HIV cases occur in its cities; the rural epidemic must be addressed, but the absolute numbers in rural areas are small, which makes resource allocation challenging. Alabama will center its plan on the HIV continuum of care. Dr. Mugavero hopes to connect data systems in an effort to capture metrics that measure progress that go beyond typical epidemiologic measures.

Discussion

Dr. Golden observed that existing CBOs and service providers can partner with clinical care providers to expand access in many ways, and Open Arms Healthcare Center is one model. Dr. Cheever noted that HRSA and *Ending the HIV Epidemic: A Plan for America* recognize the need to balance HIV treatment for rural and urban communities.

Dr. Mugavero said data can help reveal the barriers to successfully linking PWH to care and ensuring that people who would benefit from PrEP receive it. By evaluating geographic

differences through census data and interviews and looking at SDH, researchers can identify and accelerate effective approaches at the macro and micro levels. However, current data are inadequate to explain the gaps between testing, PrEP prescription, and PrEP uptake, noted Dr. Mugavero. Ms. McNeese observed that STI clinics are underresourced; with the Gilead donation, STI clinics should be able to offer same-day PrEP access. Organizations that provide comprehensive services and care are effective. Ms. McNeese added that it is time to acknowledge that incentives and support are needed to retain people in care. Dr. Mugavero called for more research on what works and how, so that success can be translated.

Dr. Golden said policy decisions can support better care; for example, health departments can rely on disease intervention specialists to connect patients quickly and keep cases open until it is clear that the link has been made. He asked who would pay for the laboratory tests required for PrEP prescription; Dr. Beckham replied that testing and wraparound services will be incorporated into the budget for implementing the Gilead donation. Dr. Beckham also agreed that STI clinics should be able to offer same-day PrEP.

Asked about the availability of clinic services during weekends and evening hours, Ms. McNeese replied that mobile services on nights and weekends are in very high demand in Houston. Dr. Mugavero suggested thinking about “access” more broadly. Dr. Golden said urgent care centers are well positioned to provide PrEP and are open at night. However, not all of the available options feel welcoming or safe for the LGBTQ community or teens, noted Wendy Holman. Telehealth might be a good option where distance is the primary barrier to care, said Dr. Golden, but some patients need more intensive support and relationships with their medical providers. He noted that the goal is to develop a system that meets people where they are. There was enthusiasm among panel members and audience participants for incorporating HPV vaccination into STI and HIV prevention efforts.

Public Comments

Kandis Backus, Pharm.D., instructor of population health science and clinical pharmacist at the School of Medicine at the University of Mississippi Medical Center, said she serves the State’s largest Ryan White HIV/AIDS Program clinic. Dr. Backus asked that when talking about those working on the front lines, PACHA and others keep pharmacists in mind. She said she spends a lot of time assisting clients with getting medications. The people who face the most problems are not the uninsured but the insured, who must fill their prescriptions through pharmacies but cannot afford them and do not have access to public programs. Faced with such patients—especially after hours, when physicians’ offices are closed and nurses and nurse practitioners have gone home—pharmacists must try to figure out what to do for the patient. “Include us in this fight,” Dr. Backus urged. She concluded that access means nothing if you cannot get the drug.

Kathryn Garner, executive director of ASC, thanked PACHA for visiting the area to see what is happening here. ASC opened in 2002 and began as part of an Episcopal church ministry seeking to help people evicted based on their HIV status. ASC is “a gap-filler” that offers facility-based housing, assistance with Federal housing programs, emergency services, HIV testing, and links to care. Ms. Garner said ASC wants to see investments in people, organizations, innovation, and technology. ASC supports incubation, such as the CBO that

Mr. Sturdevant is creating. If she is ever going to retire, Ms. Garner said, more organizations must be in place to serve PWH, especially in rural communities. That vision is incumbent on having seasoned people in place who can create linkages to care and on agencies that will help. Quoting children's book author Dr. Seuss, Ms. Garner concluded, "Unless someone like you cares a whole awful lot, nothing is going to get better, it's not."

Tonya Green, director of social services and Ryan White HIV/AIDS Program coordinator for the Hattiesburg Family Health Center, reminded PACHA that Jackson's services cannot be recreated in southern Mississippi. She does not want to see a cookie-cutter plan, but rather plans that are unique to each geographic area of the State.

Murray Penner, executive director of the Prevention Access Campaign for North America, said his organization founded the U=U campaign in 2016. The movement has grown; nearly 900 organizations in 100 countries have endorsed the U=U consensus statement. Mr. Penner said the U=U message transformed his life and helped him shed the stigma of HIV. People around the world have described how the U=U campaign has helped them. Yet, still there are people who are not learning or benefitting from treatment. *Ending the HIV Epidemic: A Plan for America* is an incredible opportunity to motivate people to get tested, get treatment, and stay in treatment, thereby improving results across the continuum of care.

Mr. Penner urged PACHA to adopt a resolution requesting that the U.S. Government sign on to the U=U consensus statement and include it as a foundational part of *Ending the HIV Epidemic: A Plan for America*. Organizations on the ground need definitive direction from Federal agencies to use this foundational message for their local initiatives. Mr. Penner expressed pride that many Federal partners are boldly and definitively stating that U=U. He thanked HHS and its agencies for working to achieve common language from which all Federal agencies can speak, but it is past time to move forward with more definitive language and be crystal clear that U=U. Mr. Penner urged PACHA to lead with U=U. People's lives and ending HIV stigma depend on it.

Sharon Brown of the AIDS Healthcare Foundation described how she learned in 1989 that her father had HIV as a result of a blood test required for a health insurance application. The insurer denied the request for coverage and directed her father to the local health department for care. Ms. Sharon Brown said that as an African American heterosexual man with HIV in 1989, there were few services for her father—or for the caregivers of PWH, who also need support networks. Ms. Sharon Brown asked that funding be allowed to reach other organizations to provide better support services, better transportation services, and infrastructure, so that there can be a holistic approach to HIV, as there was in the early response to the epidemic. She said the current movement is missing the love and instead is mired in fighting and bickering.

Valerie Brown of the AIDS Healthcare Foundation (sister of Sharon Brown) said she hoped and prayed that PACHA members would put themselves in the situation that Jackson and other areas face and ask themselves what services they would want to receive if they were in the same position. She asked members to consider where you would go if you had just been diagnosed with HIV, in a rural area or even a city, where everyone knows you—what would you think, what would you want someone to say? To those who sit in high places and want to help,

Ms. Valerie Brown asked for the kinds of services that are available in big cities, because small cities and towns have the same problems.

Timmy Kimber of Jackson Medical Mall Foundation's CARE4ME Youth Services

described work underway in the delta through the Safe Places Over Time (SPOT) program. SPOT is an innovative testing program established in 2017 in Jackson that now has two offices, one in Jackson and one in Belzoni, where Mr. Kimber serves as program coordinator. SPOT was tailored for young men of color ages 13–29 years old but is open to all. All of its work focuses on wellness, empowerment, and leadership. SPOT offers an onsite barbershop, learning laboratory, meditation room, recreation space, art gallery, parlor designed exclusively for SPOT's Men in the Mirror intervention, and state-of-the-art testing space. Referrals are made for all additional services. All services are made available throughout the delta via the Test to Know mobile unit.

Taryn Couture, associate director of government relations for the National Coalition of STD Directors, thanked PACHA for convening in Jackson. She was thrilled by Dr. Beckham's announcement of a Federal STI plan. She said her organization is excited to work with HHS on getting funding to STI clinics through CDC. Ms. Couture said she enjoyed the conversations on how STI clinics and disease intervention specialists can play a role in *Ending the HIV Epidemic: A Plan for America*, and her organization supports such an approach. She called for increasing condom availability and outreach and for better data sharing between STI and HIV clinics, especially to address hotspots. With adequate resources, STI clinics can be very useful. It has been helpful to hear from presenters how other jurisdictions address STIs in their plans to end HIV/AIDS, said Ms. Couture. She hoped PACHA and others in the room would encourage jurisdictional plans to include STIs. Many STI clinics are not asked to engage in HIV planning because it is assumed that HIV is not their problem. Ms. Couture also recommended that PACHA include a member who represents the STI field.

Antoniuss Minniefield disclosed that he was diagnosed with HIV at age 14 in Eudora, Alaska. He said that, in terms of barriers to care, the city takes too long to get money for housing to the agencies that need it. Because of those delays, people get evicted, and they fail to maintain viral suppression. Mr. Minniefield said that if he had had comprehensive sex education, he would not have HIV today. He posed a number of questions about the logistics of services that reveal common barriers to getting and continuing care:

- Why does it take so long to get medical release forms to get care?
- Regarding AIDS Drug Assistance Programs and the Ryan White HIV/AIDS Program, for example, why do so many agencies have so many different requirements for care?
- With so many referrals, why is there no point person so people can get a firm referral rather than being sent off?
- To address linkages for approval of residence, why can't service providers write letters on behalf of homeless people?
- Why do clients have to go to other offices to get income verification forms?
- Why are people disqualified from case management on the basis of a screening tool rather than one-on-one interviews, in which they are asked about their situation in ways they understand?

Marcus McPherson spoke on behalf of PWH in Mississippi. He challenged PACHA to be accountable to the CBOs, AIDS service organizations, and PWH in the South. Everything discussed during this meeting should turn into action, and not just go away. He also called for holding CBOs and AIDS service organizations accountable to PWH—not just their funders. Some organizations tick the boxes for funding purposes but do not always keep their promises to the community, Mr. McPherson said. Community engagement can be ensured by seeing PWH not as numbers, but as people who are part of families and communities.

Additional written comments appear in **Appendix A**.

Council Discussion of HIV in the Rural South

Dr. Wiesman invited PACHA members and Federal partners to describe key takeaways from this meeting, thoughts about how the meeting's content might affect how they approach their daily work, and themes gathered from written comments provided by the participants during the meeting. Highlights of the discussion are as follows:

Access

- Equity and meaningful access must be improved; community plans should include novel approaches to access (e.g., mobile clinics, weekend hours, youth services) and metrics to assess progress.
- Organizations should ensure there are places where LGBTQ people feel safe seeking care and providers who are well equipped to respond.
- To reduce stigma and increase access, more CHCs should provide primary and HIV care together.

Funding

- Funding should support new and innovative activities in different places and to different populations, not just business as usual. Developing plans at the community level should identify what works and what gaps must be filled.
- Funding should funnel down to the communities.
- Federal agencies should acknowledge that some jurisdictions will require more funding to address barriers (e.g., the number of uninsured and structural racism).
- HHS should train project officers across agencies so they understand the parallel funding streams and can help communities streamline their efforts on the ground.
- Funding announcements can clarify expectations for collaboration and accountability.

Planning

- Communities must have specific, feasible plans for spending the money from *Ending the HIV Epidemic: A Plan for America*.
- Jurisdictions should hire coordinators dedicated to the planning process.
- Communities should bring together a broad range of stakeholders, including PWH served by CBOs and people who are not usually represented at the table, recognizing the power of lived experience. They should take advantage of the power and passion of ordinary citizens.

- Jurisdictions should engage artists as partners to communicate messages to the community.
- Communities could tap into the faith community to identify religious leaders who can serve as champions for PWH, especially in the South, but they also should grapple with the role that religious organizations have played in the epidemic.
- Jurisdictions should incorporate rapid-start regimens for PrEP and antiretroviral treatment into planning.
- Plans should include measures of success.
- Communities should identify the political barriers they face to providing effective, comprehensive HIV care and prevention so Federal partners, PACHA, and others can discuss how to overcome the barriers.

Capacity

- Programs must build capacity and seek new ways to bring hundreds of thousands of people into care.
- To build the workforce, health care providers must be comfortable treating PWH and prescribing PrEP.
- PWH should be hired to perform meaningful roles in CBOs and other organizations that serve PWH.
- Significant workforce investment is needed.
- Jurisdictions should engage pharmacists, oral health practitioners, and family practitioners, as well as nontraditional health care providers. For example, retail pharmacies can assist with messaging and disseminating information to the community.
- Organizations should hire staff from the communities they serve and provide adequate training so they can meet community needs.

Other Topics

- Regarding HIV criminalization, PACHA should shed light on the disconnect between public health efforts and State laws.
- Consideration must be given to the disruption in care that occurs when people move, especially to other States. The ability to transfer medical records has been discussed but still is not feasible.
- It might be necessary to rethink the CDC's recommendations for PrEP that require clients to come back after 30 days. PACHA should look closely at rapid-start regimens for PrEP and antiretroviral treatment, which is feasible but will require new workflows and new collaborations among health care providers and pharmacists, among others. It is possible that some services can be de-linked from medical requirements.
- PACHA members should be part of the solution.
- Federal agencies should offer guidance to State Medicaid programs on engaging with HIV programs.
- PACHA should weigh in on how the conscience rule and changes to Section 1557 will have a negative impact on PWH and people at risk. It is incongruent to permit discrimination on the basis of sexual orientation or gender identification on the one hand, while calling for ending HIV and treating everyone on the other.

- PACHA can work with national organizations (e.g., the Association of State and Territorial Health Officials, the National Association of City and County Health Officials, the Big Cities Health Coalition, and the National Alliance of State and Territorial AIDS Directors) on establishing partnerships with communities to overcome the status quo. The private sector, such as retail pharmacies and pharmaceutical companies, also should be engaged.

Mr. Schmid asked Federal partners for insights on how communities can accomplish the goals of *Ending the HIV Epidemic: A Plan for America*:

- **NIH** will take advantage of the opportunity to design novel studies and fill gaps in knowledge so that it not only disseminates findings to the field but also gathers information to advance research. NIH recognizes that it must seek new mechanisms to facilitate much more rapid data collection, analysis, and translation than in the past.
- **HRSA** recognizes the need to create new partnerships and bolster connections between CBOs and clinical providers.
- **HRSA's CHCs** can reduce stigma by doing more to frame HIV screening and prevention as a normal part of routine primary care. CHCs also can enhance collaborations with CBOs and local health departments and seek to provide care in more innovative ways.
- **SAMHSA** will incorporate the input from this meeting and from PACHA members into its thinking about how to promote evidence-based practices in digestible ways to communities and how communities can adapt those practices to meet their unique needs.
- **CDC** recognizes that political will is crucial to achieving the goals of *Ending the HIV Epidemic: A Plan for America*. It must be willing to evaluate programs rigorously and to change or eliminate those that do not work. It should emphasize that a central role of public health is collecting and reporting data to support evaluation and accountability.

Using a flip chart, Dr. Wiesman captured themes that PACHA and its subcommittees will explore. Audience members proposed additional ideas. A condensed version appears in **Appendix B**.

Next Steps and Closing Remarks

Mr. Schmid thanked the members, staff, and Federal partners for their contributions. He thanked the audience members for their passion, commitment, and work and for welcoming PACHA to Jackson. He also recognized the audiovisual team and staff who support PACHA's public meetings. Mr. Schmid committed to ensuring that the community's voice is heard as *Ending the HIV Epidemic: A Plan for America* goes forward. Dr. Wiesman appreciated all those who helped make PACHA members' stay in Jackson comfortable and the PWH who shared their stories. He praised HHS leadership for developing *Ending the HIV Epidemic: A Plan for America* and serving as champions for it. The meeting adjourned at 2:53 p.m.

Appendix A: Written Public Comments for the Presidential Advisory Council on HIV/AIDS

Hello, I'm the CEO of Healthvana, the largest technology company working in HIV/PrEP/STDs. Our team works with clinics in 17 states, representing over 250,000 patients who are HIV+ or at high-risk of getting HIV. We see a large gap in states, counties and clinics in using modern technology (not Windows 95 looking systems) to digitize clinics, to deliver real-time data, and to communicate with patients on their mobile phones. Technology has been used to improve many industries - how does the committee view the use of technology to help reach its goals?

If anyone wants to follow-up with me, please feel free to have them email me or call me at 310-925-6220.

PS - Here is a one minute video of our work on PrEP --
> <https://www.youtube.com/watch?v=hQbhurnrC20&feature=youtu.be>

Ramin Bastani (pronouns: he/him)
Chief Executive Officer
Healthvana, Inc.
mobile: 310.925.6220

Thank you for the opportunity to provide input. My name is Murray Penner, with the Prevention Access Campaign, which founded the Undetectable equals Untransmittable, or U=U, movement in 2016 in response to undeniable evidence from studies demonstrating that people living with HIV who are on treatment and achieve an undetectable viral load DO NOT sexually transmit HIV to their partners. The U=U movement has grown rapidly with nearly 900 organizations in almost 100 countries endorsing the U=U consensus statement, which affirms the tremendous benefits of treatment, both for the individual and to prevent new infections.

We all know about HIV stigma. The U=U message is life-changing and can erase the stigma of HIV. As a person living with HIV, I know first-hand how U=U has transformed my life and helped me shed HIV stigma. People all over the world who have assimilated U=U into their lives tell us every day how much it has helped them.

But sadly, not enough people know about U=U nor are they benefitting from treatment. We have a tremendous opportunity with the President's *Ending the HIV Epidemic* Initiative. U=U has incredible potential to motivate people to test for HIV, and to encourage HIV-positive people to both get on treatment AND stay on it, improving results along EVERY step of the continuum. Modeling shows us that achieving viral suppression has the greatest potential to dramatically reduce new infections.

It's why I urge PACHA today to take action and adopt a resolution requesting that the U.S. government sign on to the U=U consensus statement and include U=U as a foundational part of

the President's initiative. Organizations on the ground need definitive direction from Federal agencies to use this foundational message as part of their local initiatives.

We are proud that our Federal colleagues have worked closely with us and embraced U=U. And that many of them, including leaders at the NIH, are boldly and definitively stating that U=U. We thank HHS and its agencies for working to achieve common language from which all Federal agencies can speak, but it is past time to move forward with more definitive language and be crystal clear that U=U.

I urge PACHA to lead with U=U. People's lives and ending HIV stigma depend on this.

July 9, 2019

Public Comments

Meeting of the Presidential Advisory Council on HIV/AIDS

My name is Taryn Couture. I am the Associate Director of Government Relations at the National Coalition of STD Directors (NCSD), located in Washington, DC.

On behalf of NCSD, I want to thank the Council for convening this meeting and for the important work you are doing and in such an exciting time for the field.

Collaboration at the National Level

The National Coalition of STD Directors is thrilled to see the Administration's new initiative to End the HIV Epidemic (EtHE) quickly taking shape. We believe that, with adequate resources, STD programs will play an important role in reducing new infections by 90 percent in ten years. The syndemic nature of HIV and STDs makes STD programs and providers essential partners in the EtHE plan. STD programs and clinics already serve populations at high risk for HIV infection and play a significant role in HIV testing and linkage to care. Building on existing infrastructure at the national, state, and local levels, STD programs will be of enormous value to the Administration's efforts to end the epidemic.

It is NCSD's position that the STD field could be mobilized and leveraged to support this initiative in innovative ways including: expanding HIV counseling, testing, and linkage to care as well as PrEP services in STD clinics and other sites providing STD clinical services, expanding and improve the disease intervention specialists workforce for HIV testing and linkage to care, assuring condom availability and educational outreach, supporting jurisdiction's efforts to improve data sharing across STD and HIV surveillance systems.

State engagement of STDs in the Planning Process

In an effort to better understand how States with current end AIDS plans have included and engaged STDs in innovative ways NCSD reviewed 16 available plans from the 48 counties, seven states, Washington DC, and San Juan Puerto Rico. This analysis included Washington State and Alabama, whom we have heard from today.

In general, we found that 15 of the 16 plans touched on STDs, with:

- 14 touching on the importance of increasing STD testing

- 8 touching on condom distribution and best practices for HIV prevention
- 7 touching on the use of STD and HIV data
- 6 touching on STD clinics, PrEP, nPEP, and HIV testing
- 4 touching on the use of DIS for HIV prevention

Overall the best examples from these plans around actions STD programs can take to support ending the HIV epidemic included:

- Testing for HIV in STD clinics
- Testing for HIV when testing for STDs
- Using Disease Intervention Specialists and/or partner services to test individuals for HIV
- Connecting individuals testing positive for an STD to PrEP services, PEP and rapid-start ARVs
- Expand and improve or implement condom distribution best practices
- Educate about HIV services when testing and treating for STDs
- Identify overlaps in STD and HIV data to identify geographic clustering of STD and HIV cases

NCSD encourages that as jurisdictional plans are developed STD programs be involved to further ensure that innovative approaches to HIV and STD prevention are represented. Furthermore, we ask that PACHA and Federal partners encourage jurisdictions to include STD programs in the development of ending the HIV epidemic plans.

STD Representation

On a similar note, we would like to see STD representation on PACHA. As mentioned above there is a clear connection between HIV and STDs, in-fact in many states HIV and STD prevention are administered by either the same team or share staff and resources within the health department, there has also been numerous research showing the connection between STDs and increased risk of HIV transmission. Therefore, we strongly believe that the STD field should be represented on the Council.

We appreciate the opportunity to share our comments and recommendations with you today.

I am a member of the Mississippi HIV Planning Council. I am planning on attending the PACA meeting in Jackson but I understand seating is limited. I could also have a last minute conflict develop. I have the following questions and concerns.

I attended the CDC Prevention Conference earlier this year in Atlanta GA. A re occurring theme I heard in the break-out sessions was the need to meet people where they are. What plans are in place or being developed for agencies such as the CDC to have a stronger physical presence in the seven identified southern states. This would include the opening of satellite offices in cities including Jackson and rural areas such as the Mississippi Delta.

It was also announced at the conference that an IV drug user has a 3.5 times greater chance of entering recovery if participating in a Sterile Syringe Program. The chance of recovery is 5 times greater if participating in a SSP. What plans are in place to promote the change in legislation

needed to allow SSP in states where they are currently illegal.

We so often hear discussions of the influence of the African American Church Community and its involvement or lack of involvement in the fight against HIV / AIDS and related stigma. It appears that attempts to influence church leadership is often from the bottom up. What plans are in place for the education and inclusion of national church leadership. Leaders such as Bishop Charles Edward Blake, Presiding Bishop of the Church Of God In Christ, Memphis Tennessee and Dr. Jerry Young President of the National Baptist Convention, USA, Inc and Pastor of New Hope Baptist Church, Jackson Mississippi

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Appendix B: Themes for Future PACHA Discussion

- Community engagement and planning
 - Leverage the passion and power of people affected.
 - PWH must be at the table.
 - Integrate PWH into jobs in the field.
 - Promote use and adaptation of evidence-based practices in ways that respond to consumer needs and are digestible.
 - Address care services for people who move from different States.
 - Engage artists and cultural communities.
 - Seek input from formal and informal community engagement.
 - Recruit staff from the community; train and develop them.
 - Build capacity.
- New models of care
 - Community health centers: normalize HIV screening.
 - Medical partnership with community-based organizations.
 - Funding services that increase access.
 - Include rapid-start regimens in planning.
- Workforce issues
 - Increase the number of providers.
 - Increase the number and type of providers who prescribe pre-exposure prophylaxis.
 - Promote human papillomavirus vaccination.
 - Increase provider engagement through oral health providers, pharmacists, and family physicians.
- Southern States need increased funding (because they have less infrastructure).
- All policy is local.
 - Planning jobs should be funded.
 - Role of faith community, clergy as champions.
- Role of Federal government
 - Grow/increase agencies to expand reach.
 - Enhance coordination across agencies.
 - Link gaps back to the National Institutes of Health for further research.
 - Clarify the public health role in data and surveillance.
- Role of the private sector
 - Pharmacies, laboratories.
 - Companies that know how to disseminate information.
- Stigma reduction
 - Language matters.
- Freedom from/freedom of religion

- Flexibility is crucial.
- Political will and policy environments
 - Know the strategies and stop using methods that are not working.
 - Identify gaps and fill them.
 - Criminalization.
 - 1557 regulations and implications.
- Other target populations
 - Incarcerated people; care linkages to those recently released.
 - Homeless people; housing needs.
 - Tribal communities.