

Presidential Advisory Council on HIV/AIDS (PACHA)

67th Meeting (Virtual)

June 1–2, 2020

Council Members—Present

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

John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, Secretary of Health, Washington State Department of Health, Olympia, WA

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

Alicia Diggs, M.P.H., Medical Case Manager, Positive Wellness Alliance, Lexington, NC)

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC, AAHIVS, Professor and Director, Center for Latino Adolescent and Family Health, New York University (NYU); Pilot and Mentoring Core Director, Center for Drug Use and HIV Research, NYU; Nurse Practitioner, Adolescent AIDS Program, Montefiore Medical Center, Bronx, NY

Wendy Holman, CEO and Co-Founder, Ridgeback Biotherapeutics, Miami, FL (day 1 only)

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

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

Michael Saag, M.D., Associate Dean, Global Health, School of Medicine, and Professor of Medicine, Division of Infectious Disease, 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

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), Professor and Head, Dermatology, Rutgers New Jersey Medical School, Rutgers, The State University of New Jersey, Newark, NJ

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

Council Members—Absent

None

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., Senior 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; Principal Deputy 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., Public Health Analyst and PACHA Committee Manager, ODP, OASH, HHS

Federal Partners

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

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

Neeraj Gandotra, M.D., Chief Medical Officer, Substance Abuse and Mental Health Services Administration (SAMHSA)

ADM Brett P. Giroir, M.D., U.S. Public Health Service (USPHS), Assistant Secretary for Health (ASH), HHS

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

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

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

David Johnson, Deputy ASH, OASH, HHS

RADM Jonathan Mermin, M.D., M.P.H., USPHS, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention, CDC

Harold J. Philips, Senior HIV Advisor and Chief Operating Officer, *Ending the HIV Epidemic: A Plan for America* (EHE), OASH, HHS

Crystal Simpson, M.D., Medical Officer, Office of Medicare, Centers for Medicare and Medicaid Services (CMS), HHS

CAPT Samuel Wu, Pharm.D., Public Health Advisor, Office of Minority Health, HHS (day 2)

Presenters and Panelists

Angeli Achrekar, Dr.P.H., M.P.H., Principal Deputy, U.S. Global AIDS Coordinator, U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

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

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

Maureen M. Goodenow, Ph.D., Associate Director, AIDS Research, Director, Office of AIDS Research, NIH

Marwan Haddad, M.D., M.P.H., Medical Director, Center for Key Populations Community Health Center, Inc., Middletown, CT

Rita Harcrow, Director, Office of HIV/AIDS Housing, HUD

Kirk James, M.D., Acting Targeted Capacity Expansion-HIV Team Lead, Center for Substance Abuse Treatment, Division of Services Improvement, SAMHSA

RADM Jonathan Mermin, M.D., M.P.H., USPHS, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention, CDC

Johanne E. Morne, M.S., Director, New York State Department of Health AIDS Institute, Albany, NY

Richard Ortiz, Ryan White Case Manager and Linkage Specialist, Latinos Salud, Miami, FL

Harold J. Philips, Senior HIV Advisor and Chief Operating Officer, EHE, OASH, HHS

Larry Scott-Walker, Executive Director, THRIVE Atlanta, Atlanta, GA

Day 1

Welcome and Remarks from the Co-Chairs

Carl Schmid, M.B.A., PACHA Co-Chair, called the meeting to order at 2:02 p.m. (This meeting was broadcast live online; the recorded broadcast is available online, <https://www.youtube.com/playlist?list=PLr17E8KABz1HTHIESNLIW24ukDZ13IOvm>.)

The meeting was planned to take place in person in California, but the global pandemic of the novel coronavirus (COVID-19) required that a virtual meeting be held. Mr. Schmid called for a moment of silence to remember those who have died as a result of the pandemic and those who are sick, as well as to honor the caregivers, service employees, and public health officials working so hard during this pandemic. Mr. Schmid also recognized several activists in the field of HIV/AIDS and lesbian, gay, bisexual, transgender, and queer (LGBTQ) rights who had died recently. Mr. Schmid then acknowledged George Floyd, an unarmed Black man killed by a White police officer in Minneapolis on May 25, 2020, sparking national protests. He asked that PACHA members dedicate their work to the memory of those recently lost. John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, observed that recent deaths are a reminder of how much racism and stigma persist in the United States and remain a public health threat. Dr. Wiesman outlined the agenda for the meeting.

Welcome and Swearing-In of New PACHA Member

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

ADM Giroir expressed sadness for those who have suffered and died from COVID-19 and from HIV/AIDS. He explained that in early March he was designated to lead the COVID-19 testing response for the Federal Emergency Management Agency, and he expected to return to his post as ASH full time in mid-June.

Continuing the EHE work remains critical, said ADM Giroir. The challenge of ending HIV/AIDS was compounded by the lack of infrastructure, loss of insurance, growing substance use, and other problems exacerbated by COVID-19. In light of the COVID-19 response, ADM Giroir explained, HHS is revising the Ready, Set, PrEP program to allow participants to get up to 90-day refills of preexposure prophylaxis (PrEP) and to automatically extend the eligibility of those whose participation would have expired between June 1 and September 29—both actions through September 30.

Ready, Set, PrEP provides no-cost medication for those who qualify, but only 891 people have enrolled so far. ADM Giroir stressed that COVID-19 has impeded efforts, but HHS needs to improve the enrollment numbers, and he looked to PACHA's help and leadership to do so. Albertsons Companies has joined the other pharmacy chains that have partnered with HHS to distribute PrEP, enabling participants to get PrEP from more than 30,000 pharmacies or by mail. There is no reason that enrollment cannot be expanded tenfold or even 100-fold, emphasized ADM Giroir.

Although much work must be done, ADM Giroir noted that some bright spots have emerged from the current pandemic. For example, providers have begun using telehealth approaches to see patients and prescribe PrEP. SAMHSA approved temporary funding to grantees to support

HIV and hepatitis self-testing. Also, CDC released guidance on self-testing for its grantees, and OASH is working on similar guidance for IHS. CMS has elevated the practice of pharmacists to allow them to order tests and receive reimbursement for their time. ADM Giroir welcomed suggestions on how to enlist pharmacists to help end HIV. COVID-19 raised awareness about the significant health disparities that this country has faced for decades, and ADM Giroir affirmed that he and his colleagues are committed to erasing those disparities. He hoped that a new sense of awareness, sensitivity, and empathy will give everyone a fair opportunity to attain good health. “The more we communicate and work together, the better we will be able to emerge from this crisis and reform our health care system,” ADM Giroir noted.

ADM Giroir welcomed new PACHA member Alicia Diggs, M.P.H., and administered the oath of office. He thanked all the PACHA members and expressed confidence that their work would provide concrete steps to help end HIV/AIDS in America.

Roll Call

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

PACHA Check-In: How Has COVID-19 Impacted You and Your Work?

Dr. Wiesman, Secretary of Health for Washington State, noted that the first case of COVID-19 in the United States was diagnosed in Washington in January, and nearly all of his effort since then has been devoted to COVID-19. The urgency of the situation required rapid decision making, and no other State had yet experienced the novel virus. Leadership had to coordinate responses among staff who were spread out across the State, some working from home. Public health officials looked closely at disparities to understand who is most affected by the pandemic, such as people with HIV (PWH) and people who are immunocompromised, elderly people, and essential workers. The disproportionate impact on people of color and people of low socioeconomic status has been overwhelming, noted Dr. Wiesman. Washington issued a stay-at-home order on March 23. Dr. Wiesman determined that safe syringe exchange was among the services and programs essential to citizens. Some of those safe syringe programs allowed take-home opioid treatment.

With community-based organizations (CBOs) suspending activities, far less HIV testing has occurred, raising long-term concerns about identifying PWH and getting them into treatment. Washington is piloting home testing for HIV and other sexually transmitted infections (STIs), which could facilitate starting more people on PrEP and might be a long-term solution for some organizations. The State also increased access to telemedicine for treating PWH and prescribing PrEP and expects to continue doing so. Dr. Wiesman noted that telemedicine might not help those who do not have access to high-speed internet (e.g., in rural and poor communities) or those who need in-person support.

Many staff in local health departments (LHDs) who work on HIV outreach have been redeployed to conduct COVID-19 contact tracing, which has impeded HIV-related outreach, prevention, and data collection. The State is looking at policies to support the unemployed, such as a high-risk employees’ bill of rights. It would ensure that workers at high risk (e.g., older than age 65 or

with certain chronic health conditions) have appropriate opportunities to continue working without taking on more risk (e.g., through telework) and, if that is untenable, that they receive unemployment insurance, maintain their employer-sponsored health insurance, and be offered reinstatement when the pandemic is no longer a threat.

Mr. Schmid explained that COVID-19 shut down the formal and informal meetings that policy advocates rely on, so digital and virtual connections have become especially important. Notably, the pandemic has increased knowledge and awareness about infectious disease, screening, vaccines, the value of public health, and the critical role that HIV has played in how infectious disease is diagnosed and treated. Although in-person meetings are not possible, Mr. Schmid commented it is easier than ever to get policymakers, Federal agency staff, and members of the media on the phone. He noted that a lot of work on EHE is on hold.

Justin C. Smith, M.S., M.P.H., explained that the pandemic accelerated Positive Impact Health Centers' move toward telehealth, aided by the temporary relaxation of some Federal patient privacy regulations. Telehealth has been used successfully for PrEP prescribing and behavioral health care, such as addiction treatment and support groups, and it has helped maintain continuity of care. Stay-at-home orders have not resulted in decreased sexual activity, so prevention remains key. Positive Impact set up mail-order condom distribution on request. The organization is considering how to implement home testing. It has kept sites open to provide services, with robust procedures for protecting staff and patients. Many of the organization's partners, particularly LHDs, are overwhelmed with the COVID-19 response, so providing HIV services relieves some burden.

Michael Saag, M.D., shared that his own experience contracting COVID-19 brought to the surface lessons learned from caring for PWH for more than 30 years. In particular, he had renewed empathy for the fear that comes from having a disease for which there is no treatment and little is known. He also followed the lead of many courageous HIV activists who publicly announced their HIV status early in the epidemic. He used his experience as both a health care provider and a patient with COVID-19 to get the message out about the danger of the pandemic disease. Dr. Saag thanked all the PWH who had the courage to speak up about their infections.

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC, AAHIVS, explained that he practices mostly in the Bronx, NY, which is disproportionately burdened with HIV and COVID-19. The current pandemic required him and his colleagues to figure out how to do what they thought they could not do—and quickly. For example, they implemented remote health services, 90-day medication refills, and home deliveries of care supplies (including personal protective equipment [PPE]). They also communicated guidelines for isolating at home and established new procedures for protecting frontline staff and managing face-to-face health care visits. Dr. Guillamo-Ramos noted that efforts were made to monitor people's mental health, given the huge disruptions to daily life. He pointed out that COVID-19 testing has been suboptimal for young people, but he thinks they may play a role in transmission, so any guidance must do a better job addressing them.

Ms. Diggs commented that the Positive Wellness Alliance has halted in-person and home visits but continues to provide pantry and transportation services. Case managers are connecting with

clients to assess their physical and mental health and directing clients to services available. The organization also is providing emergency financial assistance.

John Saperro provided results from a consumer survey conducted by his organization on Ryan White HIV/AIDS Program services during the COVID-19 pandemic in New Haven, CT, and Phoenix, AZ. Medical providers, case managers, and HIV/AIDS service organizations retooled their operations, often with minimal interruption in service, to keep PWH in care and virally suppressed. Some programs transformed overnight to provide telehealth services. Programs in Arizona that already offered home-testing kits doubled the number of home tests provided since March. Notably, about 28 percent of consumer respondents reported losing their jobs since March 1, which poses particular difficulties for people who were already economically disadvantaged.

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), described the massive disruptions and huge financial consequences of shutting down universities, such as his institution, Rutgers University. Medical schools have been overwhelmed since the pandemic; Rutgers has been working with the U.S. Army's Urban Augmentation Medical Task Force to serve the New York City metropolitan area. The university has been working to quickly publish research related to the pandemic. COVID-19 has devastated the New York metropolitan area, and Dr. Schwartz commented that he was grateful for the opportunity to work with partners to address the pandemic and think about how to prepare for future outbreaks.

Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, stated that many patients in her area could not access services by video or telephone; for those who could, advocates worked hard at the local and national levels to ensure that telemedicine was reimbursed by insurers. Recognizing the inequalities brought to light by the pandemic, Cooperative Health sought ways to increase access to care for all. Staff members' hours were reduced, but they increased their contact with clients by telephone. They made sure clients had the medications they needed, delivered if necessary; allowing a 90-day supply of drugs was important for that effort.

Rafaelé Narváez explained that Florida faced unique circumstances. Many in his community are undocumented and therefore reluctant to come in for testing. Many are farmworkers and do not drive, so they could not reach places where food was being offered. Many community health clinics and CBOs were closed. Minorities, in particular, lacked access to services. The clinics that were treating patients were not offering HIV or STI tests. Latinos Salud remained open with reduced staff, exhausting its financial resources, to provide testing and link clients to care offered by larger organizations that had more resources. Telehealth is complicated for people who do not speak English, so Latinos Salud provided translation services. Case managers picked food up from food banks and delivered it to clients' homes. Even the organization's funding for Ryan White program services was cut, but staff continued to provide case management and other services. Mr. Narváez expressed that the spirit to serve persists.

Marc Meachem, M.B.A., emphasized that the digital divide poses problems for organizations, as well as individuals. He noted that some PWH were in "survival mode" and seeking support for rent and food. Service organizations are seeing many more people who need assistance with basic services.

Wendy Holman indicated that her organization is working 24/7 to develop antivirals to treat COVID-19. She said she was surprised and disappointed by the social stigma affecting people with COVID-19 and suggested more deliberation about minimizing stigma around all disease, not just HIV.

Gregg H. Alton, J.D., noted that nonprofits have had to reevaluate how to provide direct services. Those that focus on education, for example, faced challenges ensuring that children have access to computers and internet service so they can access online classes, tutoring, and counseling. The pandemic has prevented in-person fundraising by nonprofits. On the other hand, researchers have found that telemedicine works for clinical trial management and patients like it, which may have a long-term effect on medical research and care. Although clinical trials face challenges because research centers are closed, they also are finding that participants are more compliant and refill their medications more readily.

Impact of COVID-19 and the HIV Response

Facilitator: Carl Schmid, M.B.A., PACHA Co-Chair

Center for Key Populations, Community Health Center, Inc., Middletown, CT

Marwan Haddad, M.D., M.P.H., Medical Director

Dr. Haddad explained that not all clinics could scale telehealth services up quickly or successfully. Substance misuse treatment providers faced more barriers, because they found it difficult to start new patients on medications and group therapy options disappeared. HIV providers were stretched thin, and team-based care became difficult with staff working from home. Undocumented people, migrant farmworkers, and homeless people have been particularly affected. For many clients, though, telehealth services eliminated transportation, child care, and other barriers. Regulations of the AIDS Drug Assistance Program (ADAP) were relaxed to allow earlier medication refills, larger quantities, and home delivery, which improved clients' uptake.

Dr. Haddad reported that most HIV prevention efforts have been disrupted, including initiation of PrEP, screening for HIV and other STIs, and access to safe syringe exchange. The Ryan White program and related services face growing concerns around food and housing insecurity; transportation; substance use and mental health services; costs of insurance premiums, copays, and deductibles; and case management needs. Dr. Haddad emphasized that it is essential that reimbursement policies cover telehealth and pay equally for phone and video services. The streamlined ADAP processes should be maintained. Bolstering the HIV workforce requires loan forgiveness and increased reimbursement for those who provide behavioral services. Telehealth services could help address the shortage of HIV medical professionals and should be facilitated across State lines. Finally, Dr. Haddad called for investment in safety net programs that support Ryan White program, community health centers, HIV prevention, safe syringe exchange, and substance misuse prevention and treatment.

New York State Department of Health AIDS Institute, Albany, NY

Johanne E. Morne, M.S., Director

Ms. Morne highlighted that the discrimination, stigma, fear, disparities, and social determinants of health (SDH) that surround HIV are mirrored in COVID-19. The disproportionate impact of COVID-19 on people of color is tied to disparities that predate the novel virus. New York

believes that no community should be left behind in terms of public health. Efforts to contain COVID-19, such as contact tracing, go back to the HIV/AIDS response, and they can be a model for the future.

New York seeks to align its COVID-19 response with the daily work of public health. As the State reopens, the Department of Health AIDS Institute is restarting regional listening sessions to determine how to integrate new priorities into existing work. New York State expanded access to the ADAP, recognizing the increased need spurred by loss of employment.

Research on PWH who have COVID-19 is key to understanding the impact of the disease. The similarities between PWH and those most susceptible to COVID-19 underscore the need to better address health disparities and SDH. Demographics alone do not increase risk. Rather, risk is the result of lack of access to care, poverty, inequality, and geographic disadvantage. To date, telehealth services, home testing, flexibility in regulations around HIV medications and substance misuse treatment, increased funding, and safe syringe access have been effective for PWH during the pandemic and should be retained, Ms. Morne recommended.

THRIVE Atlanta, Atlanta, GA

Larry Scott-Walker, Executive Director

In response to COVID-19, THRIVE closed its in-person support (including its thrift store and food pantry) and switched to virtual support to help clients feel less isolated. As Georgia reopened (earlier than other States), THRIVE worked with national partners to spread reliable information and links to resources to ensure that its clients, Black PWH, feel safe. It is coordinating with trained professionals to provide mental health services. Notably, virtual options have increased participation in services by at least 25 percent. The organization is linking more people to services than ever before, likely because more people than ever lack the basics they need. For those for whom telehealth is insufficient, THRIVE is scheduling face-to-face appointments and providing food (so that clients can take their medicine as directed).

THRIVE has long implemented full transparency in an effort to dispel stigma. Lack of clarity and not knowing one's status can drive risky behavior around COVID-19, just as it can for HIV. Mr. Scott-Walker shared that his background and experience fuel his belief in resilience. Black people are strong and have survived slavery, the Jim Crow era in the South, HIV, and now COVID-19. THRIVE recommends that organizations ensure their clients have access to adequate support, including peers who can provide information and field questions. Efforts should be made to prioritize factual information, especially for PWH. The lack of true leadership and reliable information during the pandemic have caused anxiety, Mr. Scott-Walker concluded.

Latinos Salud, Miami, FL

Richard Ortiz, Ryan White Case Manager and Linkage Specialist

Mr. Ortiz explained that some clients faced challenges applying for Federal food assistance and getting to appointments. The inability to have laboratory work done or get test results posed a barrier to assistance from HUD's Housing Opportunities for Persons with AIDS (HOPWA) program. With no transportation, clients could not get to food banks. Latinos Salud staff reached out to clients to deliver food and help them get to their doctors' appointments. Working with

LHDs, Latinos Salud staff ensured that clients had 90-day supplies of medications delivered to their homes.

Although housing assistance was available, clients reported having to provide extensive documentation online to receive it. Mr. Ortiz and colleagues helped link clients to HOPWA emergency assistance and other resources. They also helped clients apply for or extend ADAP benefits, working directly with providers in some cases. Mr. Ortiz explained that he and his colleagues are doing the work on the ground to meet clients' needs, and those efforts have gone fairly smoothly.

Discussion

Ms. Morne explained that the flexibility around COVID-19 has enabled organizations like hers to assist clients with rent support, nutrition education, and meal programs, for example. Dr. Haddad commented that more certainty around future funding and reimbursement will allow organizations to transition to a new normal, especially as organizations strive to develop plans for the near future. Mr. Scott-Walker added that the uncertainty around future funding—and the possibility of having to repay hundreds of thousands of dollars—provokes anxiety. He emphasized that communities and organizations will not be returning to the state that existed before the pandemic.

Ms. Morne pointed out that fear—of information being shared or of immigration status being revealed, for example—is a barrier to sustaining effective services. Discussion is needed about how to communicate about safe, supportive services while mitigating the fear of potential consequences.

Asked about the regional listening tour, Ms. Morne replied that the Department of Health AIDS Institute and many other stakeholders worked with New York State to develop a blueprint for ending HIV that spanned 2015 to 2020. The approach used evidence to establish consistent goals around which all planning revolves and broke those goals down by region. About a year ago, the New York AIDS Institute started taking with leaders about addressing HIV beyond 2020 and began the regional listening tour. It is now continuing to meet virtually, which has enabled many who would not have attended in-person meetings to participate.

To speed up the ADAP approval process, the AIDS Institute prioritized making registration more efficient, aided by a policy for providing antiretroviral therapy (ART) upon diagnosis, which demonstrates the benefits of program flexibility. Since the pandemic began, the number of people who pick up their ADAP prescriptions has risen, partly because of increased awareness and partly because of community discussion about the significance of being on ART during the pandemic, Ms. Morne pointed out.

Mr. Scott-Walker explained that THRIVE is reaching out to clients and helping them test their capacity to use telehealth. A lot of clients are returning to care because they have heard that those who are virally suppressed are doing well during the pandemic. For those clients, there is some urgency to see a health care provider, so if appointments are delayed, THRIVE ensures that clients' other concerns are addressed, including mental health needs.

Dr. Haddad said that Connecticut sped up the ADAP eligibility process by eliminating the need for patient signatures. Case managers working from home have found they have more time to call clients, and clients have expressed satisfaction with their care. Some people who have been reluctant to seek care have finally begun to engage. More people are using phone and video options for behavioral health services. Medication uptake and adherence has increased, likely because of home delivery and 90-day supplies. Dr. Haddad added that increased Federal funding for infrastructure is needed to sustain some of the gains, including funding for staffing.

Neeraj Gandotra, M.D., of SAMHSA commented that there have been reports of people avoiding urgent care for behavioral health and substance use problems, then presenting later with more severe conditions. Mr. Ortiz shared that he has been linking clients to services effectively, and other panelists said they were not aware of clients avoiding needed behavioral health care.

Mr. Scott-Walker observed that the pandemic has demonstrated how services can be streamlined by, for example, not requiring individuals to get forms from multiple places. It has also exemplified the effectiveness of telehealth for medical and behavioral health. Linking clients to mental health services has been easier because mental health has been a prominent part of discussion about COVID-19, Mr. Scott-Walker pointed out. Dr. Haddad added that telehealth services for PrEP are key. Home testing is feasible and will be especially important for people in rural areas. Dr. Haddad expressed concerns that some patients, especially PWH, have been reluctant to seek medical care during the pandemic. Substance use is also a concern, given that the pandemic can trigger overuse.

Laura Cheever, M.D., Sc.M., of HRSA supported the push for self-testing and encouraged organizations to take full advantage of the flexibility being offered around Federal guidelines. Antigone Dempsey, M.Ed., of HRSA added that the pandemic has pushed HRSA and its grantees to seek novel approaches to providing services.

Ms. Morne and Dr. Haddad both thought that partnerships with LHDs have been vital to sustaining services. Both cited homeless populations as a key focus of efforts in conjunction with the health departments.

Dr. Haddad noted that not all people will want or be able to access telehealth, so a balance of services must be offered. Dr. Saag cautioned providers to be mindful about the potential unintended consequences of telehealth, such as missed diagnoses. Dr. Schwarz stated that physicians should examine patients in person when possible.

Ms. Morne commented that the pandemic has provided opportunities for the Department of Health to work more closely with other State agencies and has demonstrated the potential to broaden the department's reach. Despite the State's longstanding relationships with LHDs, Ms. Morne said, the State and LHDs are still learning about resources that each has, which will improve services in the long term. Mr. Scott-Walker noted that THRIVE has started using geomapping to link clients to services closer to their homes.

Closing Remarks

Mr. Schmid commented that the day's proceedings highlighted the HIV community's resilience. Dr. Wiesman appreciated that those who serve PWH are finding ways to reduce barriers and make services more efficient. He acknowledged that the adaptations have led to benefits and also unintended consequences, and he hoped that over time, a balance between the two would be reached. PACHA and others must consider policies that can harness the positives, Dr. Wiesman noted. The meeting recessed for the day at 4:57 p.m.

Day 2

Welcome and Roll Call

Dr. Wiesman reconvened the meeting at 2:01 p.m. and recapped the previous day's highlights. He and Mr. Schmid welcomed the participants. Ms. Hayes called the roll.

PACHA Subcommittee Reports

EHE and the Updated National HIV/AIDS Strategy (NHAS)

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

Mr. Schmid explained that the Subcommittee has been busy planning this PACHA meeting and will propose recommendations on the basis of the proceedings. In response to ADM Giroir's comments, the Subcommittee will consider why enrollment in Ready, Set, PrEP is low (although it recognizes that only a small amount of funding was disbursed to community partners to support the program, and funding only started in March.) The Subcommittee will review whether jurisdictions funded under EHE anticipate delays in meeting their targets because of the pandemic. It also is monitoring Congress' work, recognizing that EHE requires continued funding.

Mr. Saper added that the Subcommittee was impressed with the efforts at all levels to address the needs of PWH during the pandemic and hopes that innovations will continue. In recent years, PACHA has been meeting outside of Washington, DC, in an effort to engage communities and learn about work in the field. The Subcommittee is discussing how PACHA can carry that intention forward with limited face-to-face contact.

Stigma and Disparities

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

In early March, the Subcommittee met and learned about model programs using art to explore and communicate issues around stigma and disparities. Most of those efforts were canceled because of the pandemic. The Subcommittee now is discussing with NIH how research around stigma and disparities can inform solutions. NIH is preparing a presentation about research on stigma and disparities for the 2020 International AIDS Conference.

Mr. Smith emphasized that the protests underway now around excessive use of force by police stem from structural racism and violence, which produce the stigma seen against PWH and others. He stressed that PACHA must take stigma into account in everything it does and must

make that clear in its recommendations. Mr. Narváez agreed on the importance of understanding how the events happening now translate into stigma and disparities among minorities and how PACHA can address those issues.

Global

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), and Gregg H. Alton, J.D., Co-Chairs

The Subcommittee is focused on COVID-19, particularly its impact on PEPFAR clinics and programs around the world. PEPFAR may provide lessons that can be applied domestically, particularly around rolling out PrEP for women and girls in the United States. Dr. Schwartz recalled that PEPFAR leader Deborah L. Birx, M.D., presented at PACHA's February 2020 meeting. He looked forward to learning more about the challenges of addressing overlapping global epidemics.

EHE and COVID-19: The Federal Response to Prevention and Access Challenges

Facilitator: Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC, AAHIVS, PACHA Member

HRSA

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

Dr. Cheever explained that Ryan White program providers are seeking innovative ways to deliver care, as exemplified by the previous day's speakers. With funding from the Coronavirus Aid, Relief and Economic Security (CARES) Act, HRSA awarded \$90 million to Ryan White programs in April to prevent, prepare for, and respond to COVID-19, and awardees had new flexibility to apply the funds. HRSA was involved in the COVID-19 claims reimbursement portal that enabled health care providers to be reimbursed for testing uninsured people, retroactive to February 4.

HRSA deferred some activities and extended deadlines for certain applications and reports. Its annual National Ryan White Conference on HIV Care and Treatment will take place virtually in August, which will enable more attendees than ever to participate. HRSA will leverage funding from the HHS Minority HIV/AIDS Fund for three initiatives that grew out of community-based engagements last year:

- Reducing stigma at the system/client level in Ryan White-funded programs through technical assistance and training at multiple levels
- Supporting programs that have initiated Rapid ART Start to develop standard operating procedures for the approach so it can be integrated into systems of care
- As part of EHE, addressing how to better meet the needs of Black women diagnosed with HIV who are not in care

NIH

Maureen M. Goodenow, Ph.D., Associate Director, AIDS Research, Director, Office of AIDS Research

NIH suspended its intramural research programs on March 16. It is now taking steps to restart some work not directly related to COVID-19. As a result of new emergency appropriations, NIH is playing a significant role in Operation Warp Speed, a unique public-private partnership primarily focused on developing a COVID-19 vaccine. It also is supporting the Rapid Acceleration of Diagnostics program, a national technology competition, and another public-private effort, Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV). The HIV/AIDS Clinical Trials Network is among those being used to test some compounds, demonstrating the role that HIV infrastructure is playing in COVID-19 research. NIH is bringing together research across its Institutes and Centers, with attention to addressing vulnerable populations, including PWH.

The five working groups of NIH's Office of AIDS Research Advisory Council collaborated to create interim guidance on COVID-19 for PWH, which represents the first such cooperation among all five groups. The Office of AIDS Research created a task force to identify research priorities for areas in which HIV and COVID-19 interact, and the priorities will guide funding.

Dr. Goodenow explained that HIV trials that had not started are on hold, and many studies are delayed indefinitely. Notably, research on a long-acting injectable drug to prevent HIV transmission ended early with successful results, and a companion study continues. Looking ahead, NIH is evaluating the implications of stopping research midway and how to recover from the setbacks.

HUD

Rita Harcrow, Director, Office of HIV/AIDS Housing

The CARES Act allotted \$65 million for HOPWA and allowed grantees flexibility in how they offered short-term assistance—for rent or utilities, for example—and how they met administrative requirements. Beyond the typical uses for HOPWA funding, grantees provided money for hotel stays to support isolation as needed; private transportation services in the absence of public options; essential services, such as food, medicine, and PPE; food delivery services; and education and supplies for reducing risk and controlling infection.

Ms. Harcrow explained that HOPWA plans to continue providing technical assistance and is trying to increase capacity rapidly. It will continue outreach to grantees and communities to assess their needs. The agency has been holding frequent webinars to disseminate information, answer questions, and convey expectations to grantee cohorts. Among efforts to coordinate with Federal partners, HOPWA is working with the HRSA Ryan White program to provide cross-walking guidance to help communities maximize their use of the programs. The HUD website offers various resources for grantees and others.

CDC

RADM Jonathan Mermin, M.D., M.P.H., USPHS, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention

RADM Mermin acknowledged that COVID-19 has elicited fear and discrimination. Many of those who work in public health aim to fight injustice with public health tools, and he added that the coming year will test those efforts. CDC disease specialists who usually conduct contact tracing to identify PWH or those with STIs have mostly redirected their efforts to COVID-19

tracing. Fewer people are being tested for HIV, which affects surveillance data. Most HIV efforts have been scaled back, even as concerns are rising about worsening rates of HIV.

Limited data from two small studies of PWH who were infected with COVID-19 found they did not experience morbidity or mortality higher than other populations. However, SDH that increase HIV risk also increase COVID-19 risk, and the pandemic has hurt HIV programs. CDC is collaborating with hospitals and Tribal health partners to get more complete data on race and ethnicity. It received \$11 billion to support testing, tracing, and surveillance. CDC also granted a no-cost extension for EHE awardees to update their plans.

CDC published COVID-19-related guidance on safe syringe exchange programs and immunocompromised people. It provided advice on how to prescribe PrEP with limited patient contact and how to treat HIV when telehealth is unavailable. CDC is working on more self-testing and self-sample-collection mechanisms and guidance. Dr. Mermin looked forward to hearing from PACHA and others how CDC guidance could be more helpful. He appreciated that some Minority HIV/AIDS Fund dollars were used to mail HIV self-testing kits to people who are transgender or racial and ethnic minorities, as well as to others at risk, and to provide special clinical capacity for HIV treatment. Dr. Mermin concluded that HIV-focused CBOs serving communities of color are key to educating people about COVID-19, and CDC has worked to provide information they can use in those efforts.

HHS/OASH Harold J. Phillips, Senior HIV Advisor and Chief Operating Officer, EHE, OASH, HHS

Mr. Phillips emphasized that EHE remains a priority for HHS, and his office aims to support Federal and community partners as they seek solutions to providing services and establishing guidance. The website [HIV.gov/coronavirus](https://www.hiv.gov/coronavirus) has updates on EHE and other efforts and describes the flexibility of available support during the pandemic.

The pandemic has allowed EHE staff to strengthen ties and enhance communication with the three regional offices where Prevention Through Active Community Engagement (PACE) officers are deployed to assist with EHE implementation. The regional offices have provided insight on the impact of COVID-19 and have helped connect people to Federal and other resources. Efforts are underway with the PACE officers to identify and engage all the sectors and stakeholders needed to help reach the goals of EHE. Staff also are assessing the tools that stakeholders need from Federal sources to support engagement.

EHE staff continue to update the NHAS, but publication will be delayed. The final product will clarify that EHE outlines an HHS operations plan, whereas the NHAS describes a national effort involving other Federal agencies and partners. Mr. Phillips observed that the pandemic has put public health at the forefront and offers an opportunity to talk about how the private sector can play a role. The EHE dashboard is nearing release. The Minority HIV/AIDS Fund provided resources for IHS to further its EHE work, because IHS did not receive funding for those efforts in the most recent Federal budget.

Some planned outreach around Ready, Set, PrEP was modified in light of the pandemic. For example, iHeartRadio donated air time for HHS-sponsored weekly virtual Pride events in June.

Mr. Phillips added that efforts are underway to find innovative models to further the four pillars of EHE. His office worked closely with CDC and HRSA to develop guidance on self-testing for HIV, and with SAMHSA and IHS to disseminate it. Staff will focus next on linking people to care through its website.

SAMHSA

Kirk James, M.D., Acting Targeted Capacity Expansion-HIV Team Lead, Center for Substance Abuse Treatment, Division of Services Improvement

Dr. James explained that most grantees have adopted telehealth practices, but fewer people are entering substance use and mental health treatment programs. Among those receiving services, no-show rates are lower than before the pandemic, probably because transportation is no longer a barrier. Overall, SAMHSA grantee organizations are testing fewer people for HIV and hepatitis. However, SAMHSA now allows grantees to use Federal funds to pay for self-testing kits for HIV and hepatitis, which can be mailed to clients.

Dr. James anticipated that grantees would continue to become more adept at using telehealth. He hoped SAMHSA could reach more people with a combination of telehealth and in-person services when circumstances permit it. In September, SAMHSA will award 80 grants for a program that uses navigators to reach racial and ethnic minority people at high risk for substance misuse and HIV. Unrelated to HIV, SAMHSA conducted a rapid grant competition to disseminate funds to all States, Territories, and Tribes to address COVID-19 among people with substance use or mental health disorders.

Discussion

Dr. Cheever pointed out that the CARES Act allowed HRSA to fund NASTAD (National Alliance of State and Territorial AIDS Directors) to gather data quickly to assess the potential for increased enrollment in Ryan White programs. As more people lose their employer-sponsored health insurance, Dr. Cheever anticipated more demand for ADAP, but she did not know whether other aspects of Ryan White programs are likely to need more emergency funding.

RADM Mermin described immediate disruptions to routine testing and reporting capacity by CBOs and others. Health departments already are facing hiring freezes and low revenues. CDC hopes to get data where it can, but the disruptions have scientific, programmatic, and policy implications. For example, regulatory system requirements pose a challenge to approval of more self-test kits, even with emergency use authorization.

Mr. Phillips stated that HHS is considering how it can help CBOs, particularly those that are struggling economically, to further the goals of EHE. CDC's cooperative agreements this year require that a portion of health department funding go to CBOs to support STI clinics.

Dr. Cheever commented that the new HRSA funding opportunity focused on Black women can be used to support culturally responsive programs for Black transgender women. It is up to applicants to propose programs. She added that HRSA is making efforts to develop capacity among organizations to apply for funding to support transgender activities.

RADM Mermin acknowledged the disparities in the incidence and severity of COVID-19 among Native Americans. CDC's efforts include sending teams to Indian Country to assess the situation and implement prevention programs. It also is working with Tribal communities to assess STIs during the pandemic.

HIV and COVID-19: Perspectives and Lessons Learned from PEPFAR

Angeli Achrekar, Dr.P.H., M.P.H., Principal Deputy, U.S. Global AIDS Coordinator, PEPFAR

Dr. Achrekar outlined impressive progress around the world on preventing and treating HIV, facilitated by PEPFAR. The agency now is working to determine how to protect those gains in light of the pandemic. About 95 percent of PEPFAR's investment goes to African countries. PEPFAR invests nearly \$1 billion per year to support infrastructure and capacity, including laboratory facilities and staff, surveillance, public health workers, and nurses. It now is determining how to leverage that infrastructure to support COVID diagnosis and treatment while ensuring that communities affected by HIV continue to have services they need.

To reduce the potential exposure of staff and clients to COVID-19, PEPFAR has established policies to minimize client visits for nonessential services and adapted HIV service delivery models to ensure social distancing, limited contact, and suspension of any services that cannot be provided safely according to guidelines. PEPFAR is providing flexibility to programs by offering and frequently updating guidance on solutions, innovations, and lessons learned.

PEPFAR's work is driven by detailed data collection. In Africa, data come from 3,000 laboratories, including 28 national reference laboratories, which have been leveraged to assist with COVID-19. Key interventions to protect PWH during the pandemic emphasize convenient, client-centered care, such as maximizing retention in care before stay-at-home orders took effect through patient tracking and contact to establish access to virtual care. Using virtual platforms, providers communicate with PWH to encourage adherence and provide telemedicine.

As a result of COVID-19, 20 countries have adopted more inclusive multimonth drug dispensing policies, long advocated by PEPFAR. Decentralizing drug delivery by allowing home delivery by community health workers, waiving fees at community pharmacies, setting up automatic dispensing lockers, and providing alternative pickup points all have helped to ensure that PWH have adequate supplies of needed drugs. Dr. Achrekar observed that similar challenges occurred abroad as domestically, including supply chain issues.

Stigma and discrimination against PWH are exacerbated by COVID-19, Dr. Achrekar noted. Social distancing is difficult in multigenerational households and high-density communities. Gender-based and other violence, economic hardship, and food insecurity all contributed to worsen conditions for PWH during the pandemic. The response to the pandemic must prioritize a human rights approach, centered on evidence, empowerment, and community engagement, Dr. Achrekar concluded.

Discussion

Dr. Achrekar noted that countries have made extraordinary progress against HIV, but there are substantial concerns that COVID-19 will erode that progress. PEPFAR already is seeing declines and delays in services. Dr. Achrekar observed that a lot of the medications used in Africa and elsewhere come from India, and delays have occurred as a result of lockdowns there. The quality of drug delivery and other services remains a concern, as well.

Public Comments

Taryn Couture of the National Coalition of STD Directors (NCSN) said NCSN conducted a survey of its members in March, which revealed that 57 percent of disease intervention specialists (DIS's) report that they or other DIS's in their jurisdictions have been redeployed for COVID-19. Furthermore, 78 percent of DIS's reported deferred services or field visits, and only 32 percent have the capabilities to perform virtual or remote field services for contact tracing. The survey also found reduced capacity among STI clinics, which provide a vital community resource for HIV testing and linkage to PrEP. STI clinics reported that more than 75 percent of their staff have been redeployed to respond to COVID-19, and 60 percent of clinics are experiencing reduced capacity to treat STIs. This reduction in clinical capacity includes restricting patients' eligibility for appointments by requiring that they be symptomatic, need treatment, or be a current PrEP patient. Respondents reported challenges keeping up with client caseloads because of limited field visits and clinic hours, and many jurisdictions have been unable to maintain their STI and HIV caseloads. The survey showed that 62 percent of jurisdictions have not been able to maintain their HIV and syphilis caseloads. Ms. Couture submitted NCSN's recommendations to PACHA in writing.

Edric Figueroa of the ACT NOW: END AIDS Coalition asked that CDC clarify various components of the PS19-1906 Initiative: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States. Specifically, for Component A, how has capacity-building with health departments been disrupted by COVID-19? Regarding Component B, CDC provided feedback on jurisdictional plans in March 2020, but many local communities have not had access to those plans—even before the pandemic. All community partners must have access to the plans and the feedback provided; transparency is key, emphasized Mr. Figueroa.

The 2020 CARES Act brought welcome increases to Ryan White and HOPWA programs in response to COVID-19, but additional resources for prevention traditionally not funded by these programs are needed, such as increasing access to at-home HIV testing; more education; PrEP, post-exposure prophylaxis, and harm reduction services; and financial support for laboratory tests and fees required to access and adhere to these programs.

CDC should consider allowing HIV testing, prevention, and treatment activities in any forthcoming COVID-19 response funds or efforts. The pandemic provides an opportunity to increase HIV health literacy and learn from the HIV movement with regard to criminalization and the misuse of public health surveillance, which disproportionately affect Black and LGBTQ communities.

Increased funding is required to respond adequately to co-occurring epidemics at the jurisdictional level. These funds should anticipate pent up demand for services due to the

disruption from COVID-19. In 2019 the CDC announced efforts to build up State and local viral hepatitis surveillance systems, but those have been delayed because of COVID-19. Very few jurisdictions provide State or local funding for viral hepatitis surveillance. There is an urgent need to support harm reduction services that prevent HIV and hepatitis C, such as long-term, take-home methadone doses; buprenorphine initiation via telemedicine; and the removal of barriers to Federal funding for, and State and local legalization of, syringe service programs.

Lastly, racism is a public health emergency, as illuminated by the rates of COVID-19 and HIV transmission in Black and other communities of color across this country. CDC must establish strategic partnerships with people-of-color-led organizations, such as the Black AIDS Institute, that lay out clear plans on how to tackle issues of systemic racism as they pertain to HIV and other health disparities. The Black AIDS Institute's *We the People* report stated, "A plan to end the HIV epidemic without specific attention paid to structural oppression that marginalizes at-risk communities will always fail."

Collin Haynes of Development Associates LLC said his organization provides monitoring and evaluation to support the response from governments, civil society organizations, and international organizations to provide treatment, support, and prevention for PWH. Development Associates believes that many of the challenges show a great need for institutional strength, and there is a need to continue education and training. There also is a need to ensure that the field has the best and brightest people to mitigate some of the challenges faced by PWH. State-of-the-art research and technology have paved the way to transform the lives of people. Twenty or 30 years ago, people thought HIV was a death sentence. Now, people are living longer with HIV, and it is almost becoming a chronic disease, thanks to research. But there are gaps that need to be filled so that advances reach minority populations and groups. Development Associates would like to see a world where services are delivered at a higher level of quality and assurance is given. Mr. Haynes expressed solidarity with all of its partners for the work of PACHA and HHS, The Global Fund, CDC, the United Nations Programme on HIV and AIDS, and all the organizations that have joined hands together in discouraging the scourge of HIV over the years. Science and technology have created a way forward for PWH. In closing, Mr. Haynes shared that he was heartened by the words of George William Curtis, a writer, editor, and civil rights leader who said, "Happiness lies first of all in health." Development Associates wants people to continue to live happy, healthy lives.

Elizabeth Lovinger of the Treatment Action Group called for PACHA to release a statement on the importance of scaling up investment in HIV research to address COVID-19-related disruptions, concerns about rigorous and ethical SARS-CoV-2 research, and the dangers of politicizing NIH grant funding. The emergence of COVID-19 has dramatically disrupted HIV research and development (R&D) in several ways. First, basic research and preclinical trials have been interrupted unless deemed essential. If trials require in-person visits, participants must obtain special documents to permit travel, which can include extensive paperwork and significant investment. These costly disruptions threaten the future of HIV R&D. Sustained and increased public funding will be required to keep efforts on track to fulfill commitments to end HIV. The Ad Hoc Group for Medical Research has requested an additional \$31 billion in emergency supplemental funding for NIH to recover costs from COVID-19 disruptions to research.

Advisory and decision-making bodies, including NIH's ACTIV public-private collaboration, must be responsive to HIV research advocates' and other community-based advocates' demands. Some troubling events have occurred because some trial results are not being made transparent, and some emergency use authorizations have been approved in the absence of reliable efficacy and safety data. Also, dangerous compromises to ethical standards in human subject research are being considered.

Despite the need for rapid responses to COVID-19, relaxing research standards could backfire and worsen the pandemic. This can be avoided by including input from HIV research advocates and learning from past mistakes of the HIV epidemic. All publicly funded research and R&D must be safeguarded from political interference. There are echoes of the recent withdrawal of Federal funds for fetal tissue research. Numerous letters have been written to the Administration about the short-sightedness of halting ethically compliant research at a time when vulnerable communities are more at risk of dying from COVID-19. Ms. Lovinger called for unleashing the full force of science and human rights advocacy and not hindering scientific advancement, especially at a time when the Federal government is tasked with leading the development of much-needed therapeutics and vaccines. The Treatment Action Group urged PACHA to safeguard the integrity of HIV research and protect the nation's public health. It looks forward to working in partnership with PACHA to end HIV and all infectious diseases through a well-funded, ethical, and rigorous science agenda.

Lucy Slater of the National Association of County and City Health Officials said that in April, her organization surveyed 50 LHDs that offer HIV prevention and treatment tailored to community needs and priorities. The survey asked about the impact of COVID-19 on HIV, STI, and viral hepatitis programs. All of the respondents described some negative impact, such as closing or slowing down services because of social distancing and reassignment of HIV DIS's, contact tracers, and other personnel away from HIV programs to support the pandemic response. LHDs are closing clinics and reducing appointments. Many no longer take walk-in patients. Many are suspending or reducing HIV testing and harm-reduction services, particularly PrEP initiation, as well as other prevention, outreach, and education work. LHDs expressed concerns about increased high-risk behavior in their communities due to the stress of isolation and inability to access harm reduction services. Respondents were concerned about a resurgence of HIV and other STIs in their communities.

LHDs described strategies to continue offering such services as telehealth, express testing, self-testing, syringe services by phone or delivery, and increased number of syringes distributed per visit. COVID-19 is not going away, Ms. Slater added, and LHDs must adapt to address both pandemics. But all of this is happening against the background of significant budget cuts and the loss of 25 percent of staff—or nearly 50,000 jobs—in LHDs since 2008. The public health system needs additional, sustainable resources to ensure full staffing of health departments for the combined pandemic response and mitigation of social distancing.

Jose Rodriguez of the HIV Medicine Association (HIVMA) asked PACHA to consider the importance of ensuring a robust infectious disease and HIV workforce to respond to ongoing and new public health epidemics. As more people need lifelong HIV care, the number of HIV clinicians entering the field falls far short of demand, creating critical access issues. In February,

U.S. Representative John Lewis introduced the HIV Epidemic Loan-Repayment Program Act to enable new HIV health care workers to work in areas with high need that are seeing HIV outbreaks due to the epidemic of substance use disorders. In remarks to PACHA on June 1, Dr. Haddad, an HIVMA board member, described strategies to support HIV prevention and care after COVID-19 and noted the workforce challenges that have been compounded by the role that infectious disease and HIV providers are playing in responding to the pandemic.

Data on the impact of the pandemic on the infectious disease and HIV clinical workforce are not yet available, but a recent study evaluated the HIV clinical workforce capacity in 14 States in the South. The researchers found that 81 percent of the counties studied did not have an experienced HIV clinician. As noted by Dr. Haddad, to attract more clinicians to the field, the low reimbursement rate for cognitive services must be addressed, and loan repayment should be provided to clinicians in communities with an insufficient number of experienced HIV providers. The need is especially critical in communities of color, which have higher rates of HIV and AIDS-related deaths. Research has shown that PWH have better health outcomes when under the care of expert HIV clinicians.

The pandemic has highlighted the critical need for a robust HIV workforce to prevent and respond to public health crises as well. As work aims to mitigate the impact of COVID-19, HIVMA urges support for interventions to bolster the workforce, such as a loan repayment program. A well-trained HIV and infectious disease clinical workforce is needed to impact the HIV epidemic as envisioned by EHE, but with the pandemic, that need is now even greater, Mr. Rodriguez concluded.

See the appendix for additional public comments submitted.

Next Steps and Closing Remarks from the PACHA Co-Chairs

Mr. Schmid concluded that the meeting revealed the hurt the community is feeling but also how people have adapted and created new opportunities. He envisioned PACHA's considering what can be done in the near term to support work against HIV as the battle against COVID-19 continues and what should be done differently in the long term based on lessons learned. PACHA subcommittees will continue to meet, and it is likely that the full PACHA will meet virtually again in a few months.

Dr. Wiesman commented on the urgency of reenergizing efforts to address the root causes of racism and stigma. He acknowledged the challenge of doing so as resources to fight HIV are redirected against COVID-19. Sustaining the HIV response and replenishing resources must be addressed. Dr. Wiesman added that lessons must be distilled quickly so that solutions can be implemented in time for a potential second wave of COVID-19. He concluded that much work remains, but he was confident that progress could be achieved by uniting their efforts.

Mr. Schmid and Dr. Wiesman thanked the PACHA members, presenters, participants, and organizers. The meeting adjourned at 4:58 p.m.

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



Written Statement from In The Meantime Men's Group, Inc.

Written Statement:

As things continue to unfold relative to the Corona Virus Pandemic, and our HIV Community Based Service Providers retool & modify service delivery protocols in an effort to End AIDS; It is our hope that PACHA put forth recommendations to provide Federal support to the local county health jurisdictions to ramp up robust combined HIV testing, STI Screening, and Corona Virus Testing.

In The Meantime Men's Group, Inc.

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Considerations about the U.S. Preventive Services Task Force (USPSTF) 'A' grade recommendation for PrEP

The U.S. Preventive Services Task Force (USPSTF; <https://www.uspreventiveservicestaskforce.org/>) was created in 1984 and is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. All recommendations are published on the Task Force's Web site and/or in a peer-reviewed journal. The Task Force evaluates preventive interventions and depending on many factors applies a 'Grade' of A, B, C, D, or I. Definitions of each grade are at <https://www.uspreventiveservicestaskforce.org/uspstf/grade-definitions> but in general 'A' and 'B' graded interventions have the most clinical evidence for benefit. The Affordable Care Act (ACA) requires most private health plans to cover specified 'A' and 'B' grade preventive services without cost-sharing to the patient.

Of specific importance here is the June 11, 2019 USPSTF 'A' grade recommendation for PrEP and its required implementation in 2021. One way to interpret this is that this will mean there is to be no cost sharing (i.e. no out of pocket cost) to insured patients for any PrEP service – office visit, labs, medications, and potentially other services like adherence counseling.

Although there is information on this recommendation in a number of places on the internet, one source which includes input from experts is here: <https://www.poz.com/article/preventive-services-task-force-recommends-prep-hiv-prevention>. This article includes the following quotes:

"[They]...need to ensure that when this rule is implemented, all plans are not only charging zero cost sharing for access to the drug, but also to the vital clinical services that people on PrEP need to stay healthy."

"The recommendation, once implemented in 2021, will require insurers to cover PrEP with no cost sharing to patients,...The [CDC] recommends that individuals taking PrEP receive medical services every three months that include HIV and STD screening, laboratory monitoring and adherence counseling. Health insurer coverage of these clinical services as essential components of PrEP, without cost sharing, will be critical."

Another review article (<https://www.healthaffairs.org/doi/10.1377/hblog20190613.596797/full/>) alludes to the health insurance companies being able to decide what medical care is included with regard to no cost sharing:

Insurers are also allowed to use "reasonable medical management" techniques to determine the frequency, method, treatment, or setting for a preventive service if those requirements are not specified in the recommendation. Medical management techniques are typically used to control costs, meaning they can include barriers to care. It will also be important to watch how insurers implement the new recommendation and any limits they place on access to the medication based on "reasonable medical management techniques."

This brings up a number of questions, only some of which are listed below. We need robust community discussion and input from medical experts, insurance experts, insurance companies, advocates, legal experts, etc on the implementation of this recommendation BEFORE 2021.

- Does this recommendation apply to only marketplace health insurance plans or all health insurance plans such as those offered through an employer? What about Medicare, Medicaid, or other government insurance like Tricare?

When might this recommendation not apply to a health insurance plan?

- If there are no costs associated with PrEP care, patients who paid down their deductible with use of the Gilead Copay card or other outside source will not be able to 'eat up' their deductible this way since medications will supposedly have no cost. This may mean out of pocket payments that patients will be solely responsible for, and thus other non-PrEP care may remain too expensive because deductible will not be met with PrEP medication costs.
- What organizations in addition to those cited in the article (e.g. NASTAD) need to be involved NOW in order to ensure appropriate implementation of this recommendation? Perhaps national and local medical associations need to be involved (AMA)? Will insurance companies be involved or at the table with community members and other organizations involved in HIV prevention to help ensure appropriate implementation or will insurers make their own decisions behind closed doors? Will we wait until insurance companies decide what they will cover and 'hope for the best'?
- Even if generic medication becomes available, there is no guarantee they will be priced at an affordable level. Currently, Truvada and Descovy are about \$1800 for a 30 day supply. If generics are priced as low as 10% of the current brand cost, this will still be \$180 per month for PrEP medications, with no Gilead copay card available for these generics. Third-party assistance programs like PAF (copay assistance) may still be available if needed but these programs are not guaranteed to be funded and have enrollment requirements (e.g. income limits) that may continue to prevent patients from using their funds for copays.
- Who or what entity will absorb these costs if the patient is not responsible for them? What impact will this have?

Although much emphasis is placed on PrEP access for the uninsured, PrEP access for patients with health insurance is not necessarily easy or straight-forward. We have a chance to address access to PrEP and direct how insurance will cover it in the very near future but we need to start addressing this topic **now**. The various communities, organizations, agencies, advocates, and others involved in HIV Prevention have a chance to pro-actively guide how this goes, or we can just hope for the best and assume insurance companies have our best interest in mind.

Thank you for your consideration in this matter,

Rob Shore

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6/8/2020

Response to the recent The Presidential Advisory Council on HIV/AIDS (PACHA) meeting on June 1st and 2nd.

It was a pleasure to view this meeting, and I applaud the efforts for ending the HIV Epidemic.

I would like to offer a point of clarification, which highlights a larger issue for Connecticut.

Dr. Marwan Haddad, MD, MPH stated that one of the things CT had done was to “streamline” the CADAP application and enrollments process. While this is true to some degree, it unfortunately also means that outsourcing our ADAP program has resulted in difficulties for those without access to internet resources. Moreover, part of the “streamlining” also meant removing the allowable Medicaid Adjusted Gross Income (MAGI) deductions which directly affects the working poor, struggling to maintain a home, pay taxes and live with HIV/AIDS.

This highlights another disparity and barrier to care in CT. While CT ADAP program is at 400% of the Federal Poverty Level (FPL), access to the necessary core medical and supportive services to take those medications correctly and deal with the side effects, is only at 300% FPL or below via Ryan White Part A. This gap means those working poor can be hammered by medical and mental health bills and collection agencies.

I have been advocating expanded access to HIV treatment and care for over ten years now through Ryan White Part A and Part B programs. It does not seem that anyone is interested in closing this gap, and/or matching our neighboring states

such as VT, ME and MA which are at 500% FPL. In fact, when I requested that just looking at the disparity between CADAP and Parts A & B, it was taken out of our Statewide Plan and told at a public meeting “it’s never going to happen.”

In fact, the State of CT Ryan White Part B has recently just cut funding for things like Medical Nutritional Therapy, Medication Adherence, and co-pay assistance for medical and dental bills.

These gaps and barriers will make it harder to achieve a community viral suppression, possibly even jeopardizing our neighboring states with viral mutations from inadequate adherence and care.

Please share any resources or contacts that you think might help to resolve these issues.

Thank you in advance,

Rev. Alexander R. Garbera, MA, MSC, DD.

A handwritten signature in black ink that reads "Rev. Alexander R. Garbera". The signature is written in a cursive style.

Person Living with AIDS

Co-chair, New Haven Mayor’s Task Force on AIDS

Founding member of the CADAP Community Advisory Board



TECHNICAL BRIEF

HIV Planning Councils

Implications for Latinx Gay and Bisexual Men



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Effective frameworks for community empowerment progressively ensure full participation of gay and bisexual men [MSM]. Programs should be designed to transition from doing programs/activities for gay and bisexual men [MSM] to doing them with gay and bisexual men [MSM], and ultimately to programs/activities done by gay and bisexual men [MSM].ⁱ

“Be involved at every level of decision-making and specifically serve on the boards of directors of provider organizations. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.”

- Recommendations for People (Living) with AIDS, The Denver Principles

Background

In 1990 the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provided funding for the first time to four of the most impacted cities early in the epidemic (SF, NYC, LA and Miami). It required for the inclusion of People living with HIV/AIDS (PLWHA) in the planning process for Title I (Part A) program for Eligible Metropolitan Areas (EMAs) and involved consumers in implementing the Title II (Part B) program for States and Territories.ⁱⁱ

On the HIV prevention front, community planning began as an innovative initiative between the Centers for Disease and Prevention (CDC), health departments and HIV prevention organizations in 1994.ⁱⁱⁱ All 65 state, local and territorial health departments or project areas receiving prevention funds from the CDC had to partake in a planning process to identify and prioritize prevention needs involving community planning groups (CPGs). CPGs were intended to give community members a direct voice in allocation of HIV prevention funding.

Guidance for community planning processes prioritized evidence-based HIV prevention strategies and interventions, with a sound basis in behavioral and social science. According to the guidance, planning processes at the local and state levels should begin with an accurate assessment of the epidemiology of the current and projected future HIV epidemic.^{iv}

Currently, there are 52 planning councils and bodies and 53 identified hard hit areas receiving Part A Ryan White funding.^v

In the original guidance published in 1993, the main goal of CPGs was to improve the effectiveness of HIV prevention programs through the meaningful participation by people living with or affected by HIV and application of evidence-based interventions.

The three main tasks delegated to CPGs include:

- 1) Development of an **epi profile**, describing the impact of the epidemic in local jurisdictions;

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- 2) Identification of prevention needs of population at risk for HIV infection and programs or interventions to address these needs (**needs assessment, community resource inventory, and gap analysis**); and
- 3) **Priority setting** which then determines the **allocation** of HIV prevention funding.

The **HIV Planning Guidance** has been updated three times. The latest 2012 version aims to vi:

- 1) Support the implementation of high-impact prevention programs;
- 2) Ensure that HIV planning is efficient and focused on results-oriented processes;
- 3) Encourage collaboration and coordination across HIV prevention, care, and treatment services;
- 4) Reduce reporting documentation for HIV Planning Group (HPG);
- 5) Engage a broader group of stakeholders; and
- 6) Focus on streamlining communication and coordination among Health Departments (HDs), HPGs, and community stakeholders, to ensure the implementation of needed services (e.g., mental health, substance abuse, and coinfections of viral hepatitis, STDs, and TB) across the continuum of HIV prevention, care, and treatment services.

The HIV Planning Guide contains sections dedicated to Stakeholder Identification and Results Oriented Engagement Processes. However, they do not delineate specific strategies for recruiting, training, engaging, and retaining marginalized populations overly impacted by HIV infection nor for disenfranchised people living with HIV (PLWH). This includes Latinx gay and bisexual men who may also be mono-lingual Spanish speakers, immigrants/asylum seekers, homeless, unemployed, sex workers, active drugs user and/or facing behavioral health issues. Although, these concerns are mentioned as part of the principles for both recruitment and engagement, there is no built-in monitoring, evaluation or enforcement mechanism to address effective implementation and resolve potential barriers to meaningful participation of the before mentioned community members.vii Consequently, if meaningful community engagement is the driving force behind these planning efforts, are we living up to those goals/standards through current processes and if not, what are the consequences?

If meaningful community engagement is the driving force behind these planning efforts, are we living up to those goals/standards through current processes and if not, what are the consequences?

Structural Challenges

Over the years, CPGs have experienced broader challenges around simplifying the process to enable full participation from lay community members. They include effectively addressing issues such as lack of time or resources to recruit, train and retain CPG members, conflict of

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interest with CPG members representing funded CBOs, conflict of interest of Health Department staff with CPG responsibilities and underrepresentation of impacted community members among Health Department staff, and in some rare cases mismanagement of resources by funded CBOs and/or public health administrators.

Engagement and retention questions also arise, especially when community members are expected to participate in meetings lasting several hours to a full day plus participate in committees, all on a volunteer basis. Recent developments in HIV care and treatment have meant that PLWHA have returned to work, to school and/or to living full lives. Those struggling to survive the high costs of living in large urban areas or those with limited job opportunities in rural areas, at times need to work two or three jobs to make ends meet. Those underemployed, unemployed, homeless, struggling with substance use and or behavioral health issues may have competing priorities and may only be able to contribute on a limited basis to current community planning processes.

Meaningful community engagement must occur regularly, consult a range of impacted stakeholders, occur in a variety of venues and formats, accommodate the needs and preferences of community members, stretch our understanding and conventional wisdom and ideas about communities and occasionally make us uncomfortable.^{viii}

Some local and state planning processes are currently operating using a crisis framework. Crisis frameworks are useful in rapid resource scale-up but detrimental to comprehensive and planned approaches. For example, crisis responses sometimes come at the cost of ongoing support for primary prevention, as evidenced by recent increases in HIV incidence among young Latinx gay men in some jurisdictions. Unfortunately, crisis frameworks can also sometimes pit communities against each other in fights over limited resources, instead of encouraging solidarity and coordination of effort or promoting intersectional responses to HIV.

The resulting mistrust and territorialism contribute to fractured HIV prevention, care and treatment responses and perceptions that local priority setting, bidding processes, and funding decisions are determined by the politics of crisis rather than ongoing assessment of local need.



Crisis frameworks can also sometimes pit communities against each other in fights over limited resources, instead of encouraging solidarity and coordination of effort or promoting intersectional responses to HIV.

Evolving Planning Councils

In the last ten years, due in part to shrinking planning budgets, cuts in prevention dollars, changing demographics of the epidemic, introduction of treatment as prevention and attempts to integrate services, several jurisdictions have opted to create Joint Planning Councils (JPC)^{ix}

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and produce Integrated HIV Prevention and Care Plans. JPCs combine prevention and care funding streams and engage in similar planning process as Prevention Planning Councils.

Unfortunately, even before the integration, RWHAP advisory councils did not monitor their own membership demographics to ensure balance and to address disparities in their own recruitment processes. Ultimately, JPCs face similar challenges recruiting, training, engaging and retaining Latinx gay and bisexual men affected by and/or living with HIV.



In June 2015, CDC and HRSA published the Integrated HIV Prevention and Care Plan Guide including the Statewide Statement of Need CY 2017. Entities seeking funding are required to follow this guidance. It was released in order to align submission dates, reduce reporting burden, leverage resources for HIV prevention and care, utilize integrated epidemiologic profiles, and submit a multiyear plan that will cover a period of 5 years.^x According to the guidance, the Integrated HIV Prevention and Care Plan is a vehicle to identify HIV prevention and care needs, existing resources, barriers, and gaps within jurisdictions and outlines the strategies to address them.

In 2019 funding to support Ending the HIV Epidemic plans was made available to the 57 entities (DC, San Juan, 7 states and 48 counties). Notice of Funding Opportunity (NOFO) PS19-1906 B highlights the importance of community engagement and requires entities to document the level of community engagement enacted in the development of their EHE plans.^{xi}

The following recommendations are not only necessary but also timely in order to effectively address the increase in HIV infection among Latinx gay and bisexual men and the limited access to HIV care and treatment and consequently low viral suppression among Latinx PLWHA.^{xii}

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Recommendations

CDC & HRSA

- Create additional accountability mechanisms to ensure NOFO requirement and guidance are met and provide assistance to said entities to reach adherence.
- Provide adequate funding to Latinx specific CBOs that earmark funding to support leadership development and community education programming that include capacity building and trainings on planning councils and that allow for language access support and incentives to ensure the active participation of Latinx gay and bisexual men.
- Convene a national Latinx gay and bisexual men's advisory body to ensure EHE has meaningful Latinx gay and bisexual men participation.

Besides letters of concurrence. Accountability mechanisms should be integrated into all planning processes as this is at the core of the function of a planning body. When developing such accountability mechanisms, developers and implementers should ask themselves: Are communities able to provide meaningful input on resource allocation? If not, how can this be resolved?

Health Departments

- Develop built-in monitoring, evaluation and accountability mechanism to address effective implementation and resolve potential barriers to meaningful participation.
 - Proactively address time or resources limitations to recruit, train and retain Latinx gay and bisexual men planning council members, making special considerations for those that are mono-lingual Spanish speakers, immigrants/asylum seekers, homeless, unemployed, sex workers, active drugs user and/or facing behavioral health issues.
 - As financial stewards of resources that are critical to addressing the HIV disparities in prevention, care and treatment among Latinx gay and bisexual men, distribution of said resources need to be monitored and evaluated to prevent mismanagement.
 - Proactively address crisis frameworks by encouraging solidarity and coordination of efforts that are inclusive of all communities impacted by HIV.
- Strengthen quality data collection and reporting efforts by capturing primary language, sexual orientation, gender identity, country of origin and key social determinants of health (housing, employment, food access, mental health needs, substance use treatment needs) in electronic health records and other relevant state funded surveys.^{xiii}

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- Linguistically competent and culturally humble Latinx gay and bisexual men should be considered when hiring staff at all levels of health departments. Relocation incentives, competitive salaries, student loan forgiveness programs should be considered when attracting Latinx gay and bisexual professional candidates to health workforce scarce communities.^{xiv, xv}

Planning Councils

- Need to allocate financial resources to provide training sessions in Spanish, to develop and update training material that incorporates adult learning principles, to utilize multi-media to engage young Latinx gay and bisexual men, to promote mentorship opportunities and to provide incentives for participants in need of assistance to actively participate.^{xvi} These suggestions can complement already established best practices utilized by planning councils that ensure smooth onboarding such as streamlining and simplifying the application process, continuously identifying potential council members, scheduling trainings at times that meet the need of potential council members and provide annual and ongoing training throughout the year.^{xvii}
- Investment in culturally and linguistically competent interpretation and translation services, also known as Language Access to limited English proficient (LEP) individuals, should be part of every planning council budget.^{xviii} Expecting bilingual planning council members or bilingual health department staff to serve as interpreters limits their active participation in meetings and in decision-making processes. One strategy to consider is to partner with Latin-America consulates and or Latinx CBOs that may be able to provide interpretation and translation services in-kind/low cost and investing in interpretation equipment. Furthermore, back translation should be the standard in translating material into regional appropriate Spanish.^{xix}
- Strategic engagement of marginalized and/or under-represented Latinx gay and bisexual men via social media, social media influencers, incentivized online surveys on dating/hook up apps, incentivized surveys at bars/sex clubs/underground parties/drag performance venues. Listening sessions at rehab centers, detox centers, criminal justice facilities, and immigrant detention facilities, listening sessions in collaboration with immigrant rights organizations, social justice organizations, community and state colleges and Latinx gay and bisexual specific CBOs should be also considered. Planning councils need to be clear about the level of involvement and amount of participation needed from Latinx gay and bisexual men to ensure the appropriate strategy is implemented.^{xx}
- Develop mentorship/coaching guidelines to ensure retention and encourage Latinx gay and bisexual men planning council members to take on leadership roles in committees and/or at the larger planning council level. Continue identifying

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potential council members in collaboration with Latinx CBOs and CBOs serving predominately Latinx gay and bisexual men.

- Recognition and celebration events ensure that the volunteer work performed by the Latinx gay and bisexual men as planning council members is valued and remains critical to the planning councils. For those council members on a limited income or facing financial hardships, free transportation, meals and childcare/elder care should be the standard to ensure attendance at committee and general council meetings.^{.xxi}



Planning councils need to be clear about the level of involvement and amount of participation needed from Latinx gay and bisexual men to ensure the appropriate strategy is implemented.

Community Based Organizations

- Latinx CBOs and CBOs serving predominately Latinx gay and bisexual men need to be actively engaged in the identification of potential planning council members.
- Leadership development and community education and engagement programming at Latinx CBOs and CBOs serving predominately Latinx gay and bisexual men should include in-house trainings/workshops on the history of planning councils, on understanding epi data, on needs assessments, on the allocation processes, on meeting procedures, on decision making practices and on the importance of community input and participation at all levels of the process.
- As part of leadership development programming and community education and engagement curricula, Latinx CBOs and CBOs serving predominately Latinx gay and bisexual men should create check-in/follow up mechanisms for Latinx gay and bisexual men planning council members. This will allow for the provision of further training opportunities and to discuss and strategize around barriers to continuing their full participation in the planning council process. Additionally, this can also serve as an opportunity to connect Latinx gay and bisexual men planning council members with health profession pipelines or job training opportunities available in-house or at partnering agencies.

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WHAT CAN YOU DO?

As funding for planning purposes from the Ending the HIV Epidemic initiative arrives into local jurisdictions there is a unique opportunity to engage or reengage Latinx gay and bisexual men in this critical process. This document was put together in close consultation with members of the National Latinx Gay and Bisexual Men's HIV Prevention and Treatment Coalition.

We are committed to support cis-gender Latinx women, Translatinx community members, and Latinx injection drug users that may have more specific needs not addressed by this document and stand in solidarity as recommendations are developed by individuals and organizations advocating on their behalf.

Latinx gay and bisexual men advocates need to demand A SEAT AT THE TABLE, in prevention planning councils, in joint planning councils, in integrated planning councils, in health departments, in EHE planning efforts and at the level of CDC and HRSA.

Advocates should demand for the RESOURCES TO ENSURE FULL AND MEANINGFUL PARTICIPATION OF LATINX GAY AND BISEXUAL MEN in prevention planning councils, joint planning councils, integrated planning councils, EHE planning councils, health departments and at the level of CDC and HRSA.

For more information, please contact:

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Promoting Sexual Health
Through STD Prevention

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June 2, 2020

RE: 67th Presidential Advisory Council on HIV/AIDS (PACHA) Full Council Meeting

Dear PACHA Members --

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

NCSDDC is a national public health membership organization representing health department STD programs, and community-based partners across 50 states, seven large cities, and eight US territories, with a mission to advance effective sexually transmitted disease prevention programs and services in every community across the United States.

STD programs, in particular Disease Intervention Specialists (DIS), and STD clinics have been leaders in quickly responding to outbreaks for years because of their unique skills in interviewing, blood draws, and implementing culturally sensitive care, which are all essential skills needed for outbreak response. To better understand how these programs have been engaged in COVID-19, and what the effects have been on their STD response during a time when STDs are at the highest levels, NCSDDC conducted a survey of our members. I am going to discuss the results of that survey and lessons learned.

Key Challenges Identified:

NCSDDC began collecting data in March from STD program directors in the 65 jurisdictions directly funded by the CDC, our network of 1,100 DIS, and our network of 500 STD and sexual health clinics. Data was collected via SurveyMonkey and direct phone calls. The biggest impacts identified from this survey include the following:

- **DIS Redeployment:** DIS perform contact tracing by identifying individuals infected with an STD or HIV and they notify close contacts of the confirmed infected case and connect them to care. This is a core public health duty carried out by health departments across the United States, and the expertise of DIS has been used to respond to COVID-19. Our survey showed that 57 percent of DIS report that they, or other DIS in their jurisdictions have been redeployed for COVID-19.

Furthermore, COVID-19 has significantly impacted DIS field services; 78 percent of DIS have reported deferred services or field visits and only 32 percent have the capabilities to perform virtual or remote field services for contact tracing.

- **Reduced STD Clinic Capacity:** STD clinics provide a vital community resources for STD and HIV testing and linkage to PrEP. STD clinics have reported that more than 75 percent of their staff have been redeployed to respond to COVID-19, resulting in decreased capacity. Furthermore, of the clinics who were surveyed 66 percent reported a decrease in sexual health screening and testing; 60 percent of clinics are experiencing reduced capacity to treat STDs; and 22 report their capacity is reduced by more than half their normal capacity. This reduction in clinical capacity

includes restricting patients' eligibility for appointments with criteria such as must be symptomatic, need treatment, or be a current PrEP patient. In some instances, clinics are seeing about a third of their normal number of patients.

- Challenges keeping up with STD and HIV caseloads: Due to limited field visits and clinic hours many jurisdictions have been unable to maintain their STD and HIV caseloads. The survey showed that 62 percent of jurisdictions have not been able to maintain their HIV and syphilis caseloads.

Recommended solutions:

Our survey also identified what STD clinics and programs will need to be able to keep up with their HIV and STD caseloads, or to be able to return to their normal case load. These include:

- Equipping DIS with the capacity to perform field visits via a remote platform: States need to have the resources, platforms and training to allow DIS to safely perform field visits remotely. Currently, many states do not have the platform and capacity to do that safely.
- Increasing the number of DIS: States need increased DIS staff to respond to COVID-19 and to ensure that there is enough staff availability to manage the current STD and HIV caseload. States and jurisdictions will also need to be prepared with enough DIS to respond to the backlog of cases.
- Supporting STD clinics in increasing staff and laboratory capacity: Similar to increasing field outreach STD clinics will also need additional staff and lab support as they respond to COVID-19, continue to provide STD and HIV services, and prepare for a surge of clients seeking care when services are fully reinstated.
- Ensuring sexual health clinics have the necessary personal protective equipment (PPE): Many of the clinics interviewed stated that they struggle with acquiring PPE that would allow them to stay open with regular operating hours. Providing clinics with enough PPE will be essential to clinics reinstating full operating hours without restrictions.

Thank you for your time today. To see the results of the survey more in depth please feel free to visit our website at ncsddc.org.

Sincerely,

Taryn Couture
Associate Director of Policy Government Relations

ACT NOW: END AIDS Coalition: PACHA Public Comment
June 2nd, 2020 submitted by Edric Figueroa: anea@treatmentactiongroup.org

Thank you to the Presidential Advisory Council on HIV/AIDS for this opportunity to offer comment on behalf of The ACT NOW: END AIDS (ANEA) Coalition. ANEA is a national coalition of community-based organizations, health departments, and national organizations committed to ending AIDS as an epidemic in the United States. Since its official launch in 2016, ANEA has collaborated with leaders in HIV organizations across the country and is committed to augmenting true community leadership as it pertains to ending the epidemic. This comment reflects the stances of many of the community-based organizations in ANEA and does not represent the perspectives of our health department partners. In the spirit of keeping community solutions and the four pillars involved with Ending the Epidemic sustained during this pandemic, ANEA raises the following:

1. Given the current disruptions from the COVID-19 pandemic, the CDC must clarify what is happening within the components of PS19-1906 Initiative: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States.¹
 - a. In regards to Component A, how has capacity-building with health departments been disrupted by COVID-19? Has this technical assistance been used to encourage/clarify how health departments can to meaningfully engage with community partners?
 - b. In regards to Component B, we understand that CDC gave feedback on jurisdictional plans in March of 2020, however many local communities have not had access to these jurisdictional plans - even before the pandemic. All community partners must gain access to these draft jurisdictional plans and the feedback provided; transparency is key.
2. The 2020 CARES ACT brought welcome increases to Ryan White and HOPWA programs responding to COVID-19. These funds increased access to Telehealth, COVID-19 testing, PPE, housing, and other basic needs for Ryan White recipients and their households, but additional resources for prevention traditionally not funded by HOPWA and Ryan White are needed.² Resources are needed for:
 - a. Increasing access to at-home HIV testing and more education to communities on their full range of options to avoid acquiring HIV during the pandemic (including PEP, daily PrEP, on-demand PrEP, U=U, and harm reduction services).
 - b. PrEP, PEP, and harm reduction services also need support to adapt to this crisis. While new programs like Ready, Set, PrEP are welcome, clients need financial support for labs and fees to access and adhere to these programs.³
 - c. We understand that the 2020 funds for HRSA's Health Center Programs were expected to play a critical role in communities hardest hit by HIV by ensuring people have access to the services they need. However, given the pandemic situation, increased transparency around how these health centers are actually providing HIV care/prevention services with the \$54 million dollars of HRSA allocated funds is key.⁴
3. As additional testing and contact tracing scale up across the nation for COVID-19, how could that pair with and learn from efforts to end HIV as an epidemic?
 - a. CDC can create a mutually beneficial partnership with ASOs/CBOs by allowing HIV testing/prevention/treatment activities in any forthcoming COVID-19 response funds or efforts. This an opportunity for HIV health literacy especially as COVID-19 transmission and death disproportionately impact the same communities most at risk for HIV.
 - b. This is also an opportunity to learn from the HIV movement with regard to criminalization and misuse of public health surveillance. Calls to involve the criminal justice system in a pandemic response may sabotage public health outcomes by potentially exposing already at-risk to communities to COVID-19 in jails (or through contact with law enforcement) and by discouraging communities from seeking testing and care due to fears of fines, arrest, or incarceration. This is especially true among communities already experiencing disproportionate levels of profiling from police including Black people, immigrants, people of color, and LGBTQ individuals.⁵
4. Increased funding is required to respond adequately to co-occurring epidemics:

ACT NOW: END AIDS Coalition: PACHA Public Comment
June 2nd, 2020 submitted by Edric Figueroa: anea@treatmentactiongroup.org

- a. People living with HIV are disproportionately impacted by viral hepatitis; ~25% of people living with HIV also have HCV. Viral hepatitis progresses faster and causes more liver-related health problems among people living with HIV than among those who are not.
 - i. Appropriations to support the CDC scale-up of the viral hepatitis response at the jurisdictional level are necessary. These funds should anticipate pent up demand for services due to the disruption from COVID-19. In 2019 the CDC announced an expanded NOFO to build up state and local viral hepatitis surveillance systems, but it has been withdrawn and delayed until the next fiscal year due to diversion of staff and resources in jurisdictions responding to COVID-19. Very few jurisdictions provide state or local funding for viral hepatitis surveillance and rely on these federal funds.
 - ii. There is an urgent need to support and fund streamlined and expanded access to harm reduction services that prevent HIV and HCV, and to meet the needs of people at risk for both, such as long-term, take-home methadone doses; buprenorphine initiation via telemedicine; and the removal of barriers to federal funding for, and state/local legalization, of syringe service programs⁶
- b. Racism is a public health emergency as illuminated by the rates of COVID-19 and HIV transmission in Black, and other communities of color across this country.⁷
 - i. CDC must establish strategic partnerships with people of color led organizations such as the Black AIDS institute who lay out clear plans on how to tackle issues of systemic racism as they pertain to HIV and other health disparities. To quote the Black AIDS Institute's, We the People report "This [EHE] initiative is supposed to provide the "hardest-hit communities" with tools, technology, and resources to address HIV. However, a plan to end the HIV epidemic without specific attention paid to structural oppression that marginalizes at-risk communities will always fail."⁸

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Public Comment from Development Associates LLC to the Presidential Advisory Committee on HIV/AIDS (PACHA)

Who are We?

At Development Associates LLC, our Mission is to provide strategic services to mitigate the challenges facing International and domestic Health Systems. We envision a world where people are equipped with the adequate resources that will transform their social, economic and political cultures.

Work we have done?

In the initial stages, we were provided monitoring & evaluation services for partners such as CDC, UNAIDS and Global Fund in supporting the response from governments, civil society and international organizations to provide treatment, support and prevention for people living with HIV/AIDS. Over the years, we have grown into a team of 30 consultants ranging across policy, health information technology, epidemiology, health education and strategic management.

At Development Associates we believe real change occur when institutions are stronger in their efforts to fight the pain many have suffered by the disease. Our approach to institutional strengthening has focused on education and training to ensure that clients, healthcare providers and administrators approach the issues surrounding HIV/AIDS with the tools and resources. Effective programs should possess cutting edge research into the methods of treatment care and prevention. We believe that more than ever, there is a need for HIV services to be delivered in a customer friendly environment free from discrimination, societal bias and stigma.

In closing, we are heartened by the words of George William Curtis, a writer, editor and civil rights leader who said, “Happiness lies first of all in health.” Let us take this time to remove all bias, discrimination and stigma and work together to ensure greater happiness, peace and prosperity for all.

Collin Haynes MPH MBA

CEO of Development Associates LLC

Public Comment from Treatment Action Group (TAG)

June 2, 2020

Delivered by Elizabeth Lovinger, Government Relations & Policy Officer

Thank you to the Presidential Advisory Council on HIV/AIDS for this opportunity to offer comment on behalf of Treatment Action Group, or TAG. TAG is an independent, activist and community-based research and policy think tank fighting for better treatments, a vaccine, and a cure for HIV, and related co-morbidities tuberculosis and hepatitis C virus. Our comment today calls for PACHA to release a statement on the importance of scaling up investment in HIV research to address COVID-19 related disruptions, concerns about rigorous and ethical SARS-CoV-2 research, and the dangers of politicizing NIH grant funding.

We have been monitoring the research and development (R&D) field since our founding 28 years ago, and have continued doing so with the emergence of COVID-19 as a significant public health threat, which has dramatically disrupted HIV R&D in several ways. First, basic research and preclinical trials have been interrupted if not deemed essential¹ as labs are closed and researchers ordered to stay at home to reduce exposure to SARS-CoV-2. This will have a lasting impact on the research pipeline for years to come. Even clinical trials such as the large, recently initiated phase III HIV vaccine efficacy trial, Mosaico,² have been completely paused – which will have a tremendous impact on the timeline and costs of this research.

Second, participants in clinical trials have also had their movement restricted, making participation in trials extremely difficult. Some trials have found solutions through electronic monitoring and deliveries of medicines. However, if trials require in-person visits for injectable treatments and other technologies, participants must obtain special documents to permit travel which can include extensive paperwork and significant investment. This will, no doubt, raise the costs of administering trials.

These costly disruptions threaten the future of HIV R&D, and will require sustained and increased public funding to keep us on track of fulfilling our commitments to end HIV. Prevention and treatment have advanced significantly in past years, and additional investments now can save countless lives in the near future. Some innovative technologies being studied make interventions more accessible, acceptable, and effective – thereby increasing their uptake and saving lives. With sustained investment, an HIV vaccine and a cure could be on the horizon – which would not only improve quality of life and reduce mortality, but also avoid costly treatments for centuries to come. The Ad Hoc Group for Medical Research has requested an additional \$31 billion in emergency supplemental funding for NIH to recover costs from COVID-19 disruptions to research.

¹ AVAC. Biomedical HIV Prevention Trials: Results, milestones and more. 2020 May 27. <https://www.avac.org/infographic/biomedical-hiv-prevention-trials>

² ClinicalTrials.gov. Bethesda (MD): National Library of Medicine (U.S.). 2020. Identifier, NCT03964415, A Study of Heterologous Vaccine Regimen of Adenovirus Serotype 26 Mosaic4 Human Immunodeficiency Virus(Ad26.Mos4.HIV), Adjuvanted Clade C gp140 and Mosaic gp140 to Prevent HIV-1 Infection Among Cis-gender Men and Transgender Individuals Who Have Sex With Cis-gender Men and/or Transgender Individuals (MOSAICO); 2019 May 28. <https://clinicaltrials.gov/ct2/show/NCT03964415>

HIV R&D has also greatly benefited scientific advancement related to COVID-19 prevention and treatment. One arm of the World Health Organization SOLIDARITY trial investigating second uses of existing treatments is studying lopinavir/ritonavir, an HIV treatment commonly used in pediatric regimens. Moreover many of the NIH-funded HIV research networks and clinical trials sites are well-poised to participate and make major contributions in research on diagnostics and vaccines for SARS-CoV-2 and treatments for COVID-19 disease.

Vaccine platforms developed with HIV research funds are also contributing towards this effort. Janssen's Ad26 vector, used in the aforementioned Mosaico trial and the Imbokodo HIV vaccine efficacy trial, is now being adapted for COVID-19 vaccine candidates. Chimpanzee adenoviral vectors, also used in HIV R&D, are also being studied through an Oxford University COVID-19 vaccine platform.

While this research shows tremendous potential, advisory and decision-making bodies – including the National Institute of Health's ACTIV private-public collaboration – must be inclusive of, and responsive to, HIV research advocates' and other community-based advocates' demands. Amongst the urgency of a global pandemic, some troubling indications of lax research ethics and rigor have already emerged in COVID-19 R&D, as some trial results are not being made public in full transparency or with sufficient explanation. Even some emergency use authorizations have been approved in the absence of reliable efficacy and safety data. Dangerous compromises to ethical standards in human subject research, including human challenge trials, are also being considered.

Despite the need for rapid responses to COVID-19, relaxing research standards – such as by cutting safety or ethical corners – could backfire and worsen the pandemic. Without sufficient information from robust clinical trials, physicians and patients will have little knowledge about whether observed side effects are associated with an administered treatment or rather with the virus itself. Indeed, troubling anecdotal and observational evidence has already emerged about the dangers of chloroquine use. A recent study of hydroxychloroquine among hospitalized COVID-19 patients showed increased risk of death, despite the fact that it had already received emergency use authorization.³

Many of these risks and oversights can be avoided by including input from HIV research advocates, and learning from past mistakes from the HIV epidemic. As one example, Good Participatory Practice guidelines⁴ provide trial funders, sponsors, and implementers with the systematic guidance on how to effectively engage with all stakeholders in the design and conduct of biomedical HIV prevention trials. These guidelines should be applied and expanded to ongoing COVID-19 research as well.

Lastly, all publicly funded research, and indeed all R&D, must be safeguarded from political interference. The recent cancellation of NIAID funding for the EcoHealth Alliance sets a

³ MedRxiv. Cold Spring Harbor (NY): Cold Spring Harbor Laboratory (U.S.). 2020. Identifier 10.1101/2020.04.16.20065920, Outcomes of hydroxychloroquine usage in United States veterans hospitalized with Covid-19; 2020 April 23. <https://www.medrxiv.org/content/10.1101/2020.04.16.20065920v2>

⁴ AVAC. Good Participatory Practice (GPP) Guidelines. 2020. <https://www.avac.org/good-participatory-practice>

dangerous precedent in which political priorities could overshadow the unbiased evaluation of data and pursuit of scientific knowledge.

Political interference in the EcoHealth Alliance grant also seems to echo the recent withdrawal of Federal funds for fetal tissue research, which will have profoundly negative consequences for HIV research. Fetal tissue research has contributed to the advancement of therapeutics and the understanding of immunology and disease pathogenesis, including that of HIV.⁵ Humanized mouse models could also contribute to the development of COVID-19 therapeutics,⁶ but these promising opportunities are cut short without fetal tissue research funding. We must not hinder scientific advancement, especially at a time when the Federal government is tasked with leading the development of much needed therapeutics and vaccines.

We urge the Presidential Advisory Council on HIV/AIDS to do everything in its power to safeguard the integrity of HIV research and protect the nation's public health. TAG looks forward to working in partnership with you to end HIV and all infectious diseases through ethical and rigorous health research.

⁵ McCune JM, Weissman IL. The Ban on US Government Funding Research Using Human Fetal Tissues: How Does This Fit with the NIH Mission to Advance Medical Science for the Benefit of the Citizenry?. *Stem Cell Reports*. 2019;13(5):777-786. doi:10.1016/j.stemcr.2019.10.003
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6895704/>

⁶ Goldstein A. Trump ban on fetal tissue research blocks coronavirus treatment effort. *Washington Post*. March 18, 2020. https://www.washingtonpost.com/health/trump-ban-on-fetal-tissue-research-blocks-coronavirus-treatment-effort/2020/03/18/ddd9f754-685c-11ea-abef-020f086a3fab_story.html

June 3, 2020

To whom it may concern:

Co-Chairs and members of the Presidential Advisory Council on HIV/AIDS (PACHA) my name is Jose Rodriguez, Senior Policy & Advocacy Manager with the HIV Medicine Association (HIVMA). I am pleased to provide testimony on behalf of HIVMA regarding the importance of ensuring a robust infectious disease and HIV workforce to respond to ongoing public health epidemics like HIV and to prevent and respond to new ones like the fast-moving coronavirus. HIVMA members provide medical care and treatment to people living with HIV in the U.S., lead HIV prevention programs and conduct research that has led to the development of effective HIV prevention and treatment options.

As more people need lifelong HIV care, the number of HIV clinicians entering the field falls far short of demand, creating critical access issues. In February of this year, Rep. John Lewis introduced H.R. 5806, the HIV Epidemic Loan-Repayment Program (HELP) Act, to boost the number of HIV health care workers by repaying often devastating student loans, enabling new health practitioners to work in areas with high need, which include the South and rural states, where we are seeing HIV outbreaks due to the epidemic of substance use disorders.

HIVMA Board member Dr. Marwan Haddad, MD, MPH, provided comments yesterday regarding strategies to support HIV prevention and care post-COVID-19 and noted the workforce challenges that have been compounded by the role that ID and HIV providers are playing in responding to the pandemic.

While we do not have data yet on the impact of the pandemic on the ID and HIV clinical workforce, a study published in March in *Clinical Infectious Diseases* evaluated the HIV clinical workforce capacity in 14 states in the South. The researchers found that 81 percent of the counties studied did not have an experienced HIV clinician and that workforce disparities were greater in rural areas. As Dr. Haddad noted in his presentation yesterday, to attract more clinicians to the field, we need to address the lower reimbursement for cognitive services and to provide loan repayment to clinicians in communities with insufficient experienced HIV providers.

The HELP Act recognizes the need to retain current HIV clinicians and to encourage more health professionals to do this critical work. The bill would provide loan repayment of up to \$250,000 for up to 5 years of services for physicians, nurse practitioners, physician assistants and dentists who work in a Ryan White-funded clinic or a health professional shortage area.

This need is especially critical in communities of color, who as this group has discussed, experience higher rates of HIV and AIDS-related deaths. Research has shown that people living with HIV have better health outcomes when under the care of expert HIV clinicians.

The pandemic has highlighted the critical need for a robust ID and HIV workforce to prevent and respond to public health crises as well. As we work to mitigate the impact of COVID-19 while continuing efforts to end HIV as an epidemic in the U.S., we urge support for interventions to bolster the ID and HIV workforce, such as the loan repayment offered by the HELP Act. A well-trained and adequate HIV and ID clinical workforce was always needed to dramatically impact the HIV epidemic as envisioned by the Federal Ending the HIV Epidemic initiative, but with the pandemic that need is now even greater.

Best,

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Greetings!

I would like to thank Rita Harcrow and her team for their dedicated service to represent the housing needs of persons living with HIV/AIDS in the country. At the time of COVID-19 pandemic as well they have looked in detail the possible needs of the affected persons and communities and providing needed support to the grantees like us. We really appreciate that. Thanks

Harvinder



Learn more about our commitment to [fair housing](#).



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June 9, 2020

Re: Positive Women's Network-USA Public Comment to the Presidential Advisory Council on HIV/AIDS

Dear Members of the Presidential Advisory Council on HIV/AIDS:

I am writing on behalf of the Positive Women's Network-USA (PWN) in response to the call for public comments. PWN is the only nationwide membership organization comprised of women and people of transgender experience living with HIV. We work to strengthen the strategic power of all women living with HIV, including people of trans experience, by inspiring, informing and mobilizing members to advocate for changes that improve our lives and uphold our rights. Our work is grounded in social justice and human rights, and we explicitly apply a racial justice and gender justice lens to address the multifarious barriers women living with HIV face in all aspects of our lives.

We are here today to express concerns about the Trump Administration's *End the HIV Epidemic Plan* (EHE plan) and the Notice of Funding Opportunity 20-2010 (NOFO) from the Centers for Disease Control and Prevention (CDC). Our concerns fall into the following three categories: lack of meaningful community involvement, lack of focus on structural barriers to prevention and care, and new surveillance and testing technologies which increase potential for human rights abuses that will affect people living with HIV.

In addition to the above concerns, we highlight the intersection of HIV and COVID-19 criminalization. Systems developed to track and respond to COVID-19 are imported from the HIV prevention and treatment systems—systems that are deeply flawed for reasons we highlight in our EHE discussion.

I. Lack of Representation

Any plan intended to address community concerns must include and engage with that community from start to finish. Unfortunately, that has not been the case for the EtE plan. PWN is concerned with the government's failure to meaningfully involve community members, including key stakeholders such as the national people living with HIV (PLHIV) networks, as EtE plans are created.

Of note, the NOFO requires or suggests involving community members at various points in the development of state EtE plans. However, there is no clear guidance about how many people living with HIV should be included in state EtE plans, how they should be included, how community members will be selected for involvement, or the process by which recipients will be held accountable to people living with or vulnerable to HIV. The NOFO also does not specifically advise recipients to prioritize including Black and non-Black people of color, women, gender non-conforming people, and transgender people living with HIV – groups that have traditionally been shut out of such advisory groups or advocacy spaces and which are disproportionately

represented in the domestic epidemic. It is neither possible nor desirable to attempt to “end the HIV epidemic” without robust consultative participation by Black, Indigenous, and People of Color living with HIV.

II. Biomedical Approach

PWN is also concerned with the EtE plan’s failure to address structural and policy barriers that limit access to health care and prevention services for low-income communities and Black and non-black people of color in the first place. The EtE plan is founded on the assumption that HIV treatment, including biomedical prevention, is the only solution to addressing the HIV epidemic. However, treatment is of little use without the means to get it to people, including a strong safety net and wrap around services, which the Trump Administration is concurrently decimating.

Further, access to health care alone is not the only cause of disparities in health outcomes. If we truly hope to end the HIV epidemic in the U.S., we must address all the barriers to care for communities living with and impacted by HIV. Providers and clinicians must universally treat and support their patients in an affirming manner and should not be permitted to discriminate against any client of any gender identity, sexual orientation, race, or any other factor.

For example, despite the disproportionate burden of the epidemic on women of trans experience, the Administration has repeatedly proposed regulations that enhance discrimination against trans communities.¹ Simultaneously, the Administration has taken multiple steps to dismantle the Supplemental Nutrition Assistance Program (SNAP), on which nearly half of PWN’s members nationally rely on.² People living with HIV cannot take their medications when they do not have food to eat.

Importantly, over 30 states and U.S. territories have laws criminalizing people living with HIV, which represent an institutionalized form of stigma, and mean that people can go to jail for knowing their HIV positive status.³ Data shows that these laws may have a chilling effect on efforts to expand testing and treatment, since you can only be prosecuted if you know you are living with HIV. Yet, the ETE plan is silent on these structural barriers to HIV testing, treatment and health care.

III. HIV Surveillance and Recency Testing

Finally and most importantly, PWN and other networks of people living with HIV are extremely concerned with the focus on Molecular HIV Surveillance (MHS), a cornerstone of the domestic EtE plan,⁴ and on the

¹ See, e.g., Non-discrimination in Health and Health Education Programs, 84 Fed. Reg. 27846 (June 2019); Supplemental Nutrition Assistance Program: Requirement for Able-Bodied Adults Without Dependents, 84 Fed. Reg. 980 (Feb. 2019); Implementing Legal Requirements Regarding the Opportunity Clause’s Religious Exemption, 84 Fed. Reg. 41677 (Aug. 2019); Office of the Assistant Secretary for Financial Resources; Health and Human Services Grant Regulation, 84 Fed. Reg. 63831 (Nov. 2019).

² Positive Women’s Network-USA, *Protecting Access to Food, Housing, and Health Care for People Living with HIV Economic Justice Factsheet* (2019), available at <https://www.pwn-usa.org/issues/policy-agenda/economic-justice/economic-justice-factsheet/>.

³ Center for HIV Law and Policy, *HIV Criminalization in the United States* (2018), available at <https://www.hivlawandpolicy.org/sites/default/files/CHLP%20HIV%20Crim%20Map%20030119.pdf>.

⁴ See generally, Centers for Disease Control and Prevention, *Ending the HIV Epidemic: A Plan for America* (2018), available at <https://www.cdc.gov/endhiv/index.html>.

newer indication in CDC's Notice of Funding Opportunity 20-2010 that a recency tool will be integrated into jurisdictional plannings. MHS is the process of tracing networks of HIV transmission by using HIV genomic sequence data that is obtained when a person living with HIV gets a resistance test. PLHIV networks are concerned because this data is obtained and used without consent from the party in question (or even their knowledge). As previously described, laws criminalizing alleged HIV non-disclosure, exposure, or transmission exist in more than 30 states, and, as demonstrated in a report by the National Association of State and Territorial AIDS Directors, the data privacy and data sharing environment varies widely from state to state.⁶ Thus, there is no real assurance that this data can be protected from use by law enforcement. PWN, the U.S. People Living with HIV Caucus, and many other organizations have called for a moratorium on the use of MHS until HIV is fully decriminalized and until people living with HIV can be assured that their human rights will be fully protected.

Furthermore, CDC has proposed to integrate the use of a recency tool into its prevention efforts, which would provide estimates of the recency of an HIV acquisition, and which requires the collection, storage and transport of an individual's blood, serum or plasma across state lines. The NOFO states on page 7 that a desired short-term outcome of Component B is to "collect recency based assays from all persons aged 13 years and older with a new HIV diagnosis."⁷ Page 19 further stipulates that jurisdictions must agree to maintain these specimens and make them available for future recency tools that become available.⁸ This raises tremendous human rights concerns as CDC is essentially proposing to build a data bank of blood, plasma, and serum specimens from people diagnosed with HIV and to maintain this data bank in perpetuity for use as it deems appropriate.

There are no provisions in place for patient consent, nor to protect this data from use in criminal, civil, or immigration proceedings. There is no direct benefit to the patient because treatment decisions in the U.S. are not based on recency of HIV acquisition. While some have argued that MHS does not show directionality and thus does not present a risk in criminal proceedings, recency data could be layered on top of MHS data to infer directionality, whether or not it can be scientifically proven. In addition, the benefit to public health allocation of resources remains unclear: CDC has not provided a cost analysis of this intervention in the U.S.

Recency testing has been rolled out as part of the President's Emergency Plan for AIDS Relief (PEPFAR) program and has raised concerns globally, related to criminalization of key populations as well as risks related to disclosure and violence.⁹ MHS and recency tools could, even unintentionally, place people with HIV at risk

⁵ Centers for Disease Control and Prevention, *Funding Opportunity Announcement PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States* (2020), available at <https://www.cdc.gov/hiv/funding/announcements/ps20-2010/index.html> [hereinafter *Funding Opportunities Announcement*].

⁶ National Association of State and Territorial AIDS Directors, *HIV Data Privacy and Confidentiality: Legal & Ethical Considerations for Health Department Data Sharing* (2018), available at <https://www.nastad.org/resource/hiv-data-privacy-and-confidentiality>.

⁷ *Funding Opportunity Announcement* at 17.

⁸ *Id.* at 19.

⁹ See, e.g., PEPFAR Solution Platform (Beta), *Surveillance of Recent HIV Infections: Using Point-of-Care Recency Tests to Rapidly Detect and Respond to Recent Infections* (2018), available at <https://www.pepfarsolutions.org/emerging-technologies-innovations/2018/7/11/surveillance-of-recent-hiv-infections-using-point-of-care-recency-tests-to-rapidly-detect-and-respond-to-recent-infecti>

for prosecution. This is of particular concern for communities that already face high levels of surveillance and criminalization, independently of HIV status, including Black and non-black communities, immigrant communities, people who trade sex, people who use drugs, and people who live on the street. In the context of the U.S. domestic epidemic, it is our firm position that recency diagnostics are not an appropriate or necessary tool. We strongly urge PACHA to issue a public statement expressing concern about the use of recency tools and molecular HIV surveillance as components of the domestic HIV and global response.

By dismantling systems that perpetuate racism and oppression; by upholding human rights and rejecting discrimination; by ensuring that policy recommendations are driven by priorities set by the most impacted communities; and by treating health care as a human right, we could stop the HIV epidemic within our lifetime. We look forward to working with the President's Advisory Council on HIV/AIDS to achieve this goal.

IV. Criminalization of COVID-19 Undermines Public Health.

In the United States, policing and criminal justice practices tend to reinforce societal inequity by targeting communities that are already marginalized and oppressed. In particular, Black, Indigenous and people of color, LGBTQ people, people who use drugs, sex workers, no- to low-income people, and immigrants are disproportionately targeted by law enforcement and too often face violent interactions with police.

Federal, state and local officials have called for new guidance in response to COVID-19 and increasingly harsh enforcement of public health guidance.¹⁰ However, communities already heavily surveilled, policed, and criminalized will likely bear the brunt of COVID-19 related surveillance, policing, criminal charges and/or penalty enhancements. A response rooted in policing and criminalization not only undermines public health and human rights, but jeopardizes the long-term survival of marginalized communities. It is critical that legislative and policy responses to COVID-19 be rooted in the human rights, safety, health, and the well-being of our communities.

There is a long history of medical surveillance under the pretext of protecting public health that has driven criminalization, policing, and punishment of stigmatized populations and health conditions instead of improvements in health. Failure to disclose one's HIV status can lead to criminal penalties in over 30 states.¹¹ Sex workers are also disproportionately impacted by HIV criminalization laws; the names, faces, addresses and HIV status of sex workers who are living with HIV have been made public by public health authorities, ostensibly out of concern for public health.

Responses to public health crises must be decoupled from any type of law enforcement and surveillance. Currently, 35 states are sharing the addresses of persons with COVID-19 with law enforcement. 10 states are also sharing their names. For example, Alabama and Massachusetts passed legislation requiring that the Departments of Health provide law enforcement with the addresses of people who have tested positive for

¹⁰ Sarah Mervosh, Denise Lu, and Vanessa Swales, *See Which States and Cities Have Told Residents to Stay at Home*, N.Y. Times, Apr. 7, 2020, <https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html>

¹¹ Center for HIV Law and Policy, *HIV Criminalization in the United States* (2018), available at <https://www.hivlawandpolicy.org/sites/default/files/CHLP%20HIV%20Crim%20Map%20030119.pdf>.

COVID-19.¹² Although these laws are intended to protect first responders, they create a false sense of safety, are outdated in their understanding of the coronavirus and violate an individual's privacy. In Kentucky, courts have ordered the use of GPS ankle monitors to track individuals with coronavirus who have violated quarantine orders.¹³ The use of ankle monitors are not only dehumanizing for the individual but jeopardizes their safety.

Finally, criminalization compromises public health. Experience shows us that the surveillance, policing, and criminalization of stigmatized populations—including people living with HIV—leads to negative health outcomes and discrimination in health care settings, which further encourages people to avoid interacting with the health care system. When a person's health is criminalized, they avoid testing and treatment to avoid police, criminal penalties, and stigma. The situation will be no different with COVID-19. Articles have already documented widespread fears in immigrant communities that seeking care will lead to deportation for people who are undocumented. People who are legal permanent residents fear that accessing needed care will violate newly intensified public charge rules.

We urge PACHA to issue a public statement on the intersection of HIV and COVID-19 criminalization and also include concrete policy solutions to them. PWN has provided federal solutions below:

- Explicitly prohibit the sharing of an individual's health data with law enforcement.
- All legislation responding to the pandemic must include an explicit prohibition on the use of federal funds for law enforcement to criminalize actual or perceived violations of public health orders around COVID-19. Federal relief packages must invest in testing, treatment, care, and community support; not criminalization.
- Awards of federal funding to states and local governments should prohibit the adoption and enforcement of laws criminalizing the potential for or actual transmission of COVID-19.

Thank you for the opportunity to submit a comment. Please do not hesitate to contact Breanna Diaz, Policy Director, to provide further information.

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breanna@pwn-usa.org

¹² Liz Landers, *Alabama and Massachusetts Are Handing the Addresses of People With Coronavirus Over to Police*, Vice, Marc. 31, 2020, https://www.vice.com/en_us/article/jge938/alabama-and-massachusetts-are-handing-the-addresses-of-people-with-coronavirus-over-to-police.

¹³ Nexstar Media Wire, *Kentucky is Putting Ankle Monitors on Coronavirus Patients Who Ignore Self-Isolation Order*, Tristate, Apr. 2, 2020, https://www.tristatehomepage.com/news/kentucky-is-putting-ankle-monitors-on-coronavirus-patients-who-ignore-self-isolation-order/?fbclid=IwAR3_9vmPoJTgXN7cVjV7lm3J1rEXCDdCROGjVTa7l-_HE-ixBzgh92aaICg.