

Presidential Advisory Council on HIV/AIDS (PACHA)

71st Meeting (Virtual)

August 3–4, 2021

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, Professor, Gillings School of Global Public Health, Health Policy and Management, The University of North Carolina at Chapel Hill, Chapel Hill, NC

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

Guillermo Chacón, President, Latino Commission on AIDS; Founder, Hispanic Health Network, New York City, NY (*Day 2 only*)

Tori Cooper, M.P.H., Director of Community Engagement for the Transgender Justice Initiative, Human Rights Campaign, College Park, GA (*Day 2 only*)

Raniyah Copeland, M.P.H., President and CEO, Black AIDS Institute, Los Angeles, CA (*Day 2 only*)

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

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

Marlene McNeese, Assistant Director, Houston Health Department, Houston, TX (*Day 2 only*)

Marc Meachem, M.B.A., Head, External Affairs, ViiV Healthcare North America, Washington, DC (*Day 1 only*)

Leo Moore, M.D., M.S.H.P.M., Medical Director for Clinic Services, Los Angeles County Department of Public Health, Los Angeles, CA (*Day 2 only*)

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

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

Kayla Quimbley, National Youth HIV and AIDS Awareness Day Ambassador, Advocates for Youth, Columbus, GA (*Day 2 only*)

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

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

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

Adrian Shanker, Founder and Executive Director, Bradbury-Sullivan LGBT Community Center, Allentown, PA (*Day 2 only*)

Justin C. Smith, M.S., M.P.H., Director, Campaign to End AIDS, Positive Impact Health Centers; Behavioral Scientist, Rollins School of Public Health, Emory University, Atlanta, GA
Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, Lead Provider and HIV Specialist, Eau Claire Cooperative Health Centers (Now Cooperative Health), Columbia, SC
Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., Provost and Senior Vice President for Academic Affairs, Iona College, New Rochelle, NY (*Day 2 only*)

Council Members—Absent

Wendy Holman, CEO and Cofounder, Ridgeback Biotherapeutics, Miami, FL

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

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

Staff

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

Federal Partners

Laura Cheever, M.D., Sc.M., Associate Administrator, HIV/AIDS Bureau, HRSA
Demetre C. Daskalakis, M.D., M.P.H., Director, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention (NCHHSTP), CDC (*Day 1 only*)
Neeraj Gandotra, M.D., Chief Medical Officer, Substance Abuse and Mental Health Services Administration
Maureen M. Goodenow, Ph.D., Associate Director for AIDS Research, Director, Office of AIDS Research, National Institutes of Health (NIH)
Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development (HUD) (*Day 1 only*)
Timothy Harrison, Ph.D., Deputy Director for Strategic Initiatives & Senior Policy Advisor, Office of Infectious Disease and HIV/AIDS Policy (OIDP)
Rick Haverkate, M.P.H., National HIV/AIDS & Hepatitis C Program Coordinator, Indian Health Service (IHS)
David Johnson, Deputy Assistant Secretary, Office of Regional Health Operations, HHS (*Day 2 only*)
Harold J. Phillips, M.R.P., Director, White House Office of National AIDS Policy (ONAP)
Crystal Simpson, M.D., Medical Officer, Office of Medicare, Centers for Medicare & Medicaid Services (CMS) (*Day 2 only*)
Judith Steinberg, Chief Medical Officer, OIDP
CAPT Samuel Wu, Pharm.D., Public Health Advisor, Office of Minority Health, HHS
Sara Ziegler, Associate Director for Planning and Policy, NCHHSTP, CDC

Day 1

Opening Remarks from the PACHA Co-Chairs

Carl Schmid, M.B.A., and John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chairs

Carl Schmid, M.B.A., PACHA Co-Chair, called the meeting to order at 1:01 p.m. (This meeting was broadcast live online; the recorded broadcast is available online, <https://www.hiv.gov/federal-response/pacha/about-pacha>) He appreciated that President Joseph Biden and his administration have fully embraced EHE. The administration's proposed budget includes substantial funding increases for EHE, HUD's Housing Opportunities for Persons with AIDS (HOPWA) program, the Ryan White HIV/AIDS Program, and other programs, demonstrating a meaningful commitment to ending HIV in the United States. John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, outlined the agenda, which included updates from Federal, State, and local partners on EHE plans and community engagement.

Welcome

Rachel L. Levine, M.D., Assistant Secretary for Health (ASH), HHS

Rachel L. Levine, M.D., pointed out that she began her medical career at the dawn of the AIDS crisis and is committed to working with stakeholders to end HIV. She hopes to apply her medical background and public health experience to address the syndemic of HIV, sexually transmitted infections (STIs), hepatitis, substance misuse, and mental health disorders.

Dr. Levine thanked Kaye Hayes, M.P.A., PACHA Executive Director and acting director of ODP, for helping her get up to speed on the issues in the ODP portfolio, calling out Ms. Hayes' commitment, enthusiasm, and leadership. HHS recognizes that PACHA membership should reflect the diversity of the HIV epidemic, and the agency is working to fill Council vacancies. Dr. Levine emphasized that EHE remains a priority for this administration, and she asked PACHA to consider what is going well with EHE implementation, what challenges have emerged, and where opportunities exist to enhance, accelerate, or innovate, particularly in terms of critical aspects of health equity that affect racial and ethnic minorities and sexual and gender minorities.

Dr. Levine congratulated Harold J. Phillips, M.R.P., formerly the senior HIV advisor of EHE, for being named director of the White House ONAP. She noted that Timothy Harrison, Ph.D., ODP's deputy director for strategic initiatives and senior policy advisor, will lead the EHE initiative. A key component of the initiative, America's HIV Epidemic Analysis Dashboard (AHEAD), is adding new data on social determinants of health (SDH)—such as homelessness, HIV stigma, and poverty—along with HIV indicators, so that users have more context about the complex mix of factors affecting people with HIV (PWH).

ODP is enhancing the Ready, Set, PrEP (preexposure prophylaxis) program to address the challenges of distributing and administering effective HIV drugs. The Prevention through Active Community Engagement (PACE) program has deployed U.S. Public Health Service commissioned core officers to support EHE activities in three regions that encompass 36 of the 57 EHE jurisdictions. Dr. Harrison is working with the HHS Office of Population Affairs to enhance HIV services in Title X family planning clinics and teen pregnancy and adolescent

health programs. Efforts are underway to partner with the Office of Minority Health on a new anti-stigma initiative.

Dr. Levine noted that these OASH activities are bolstered by work at CDC, HRSA, IHS, and NIH to support health departments, Ryan White clinics, community health centers, Tribal and urban IHS facilities, and scientific research efforts in collaboration with EHE jurisdictions. She concluded that she is optimistic that—by working together with intention, patience, persistence, innovation, and creativity—the goal of ending the HIV epidemic will be achieved.

Roll Call

Ms. Hayes called the roll.

Message from the White House

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

Mr. Phillips observed that restoring ONAP is a clear sign of the Biden-Harris administration's commitment to EHE. The White House appointed Mr. Phillips ONAP director on June 15 at a webinar, "40 Years of Progress: It's Time to End the HIV Epidemic Commemorative Dialogue," which served as an opportunity to reflect, reenergize, and reengage. Although ONAP has no budget or staff for 2021, Mr. Phillips commented that the situation is familiar, and there are many ways to get the work done. He is tasked with revising the *HIV National Strategic Plan* to embed key goals of the Biden-Harris administration, specifically addressing SDH; taking a cooperative, whole-of-government approach; and obtaining community input. Mr. Phillips aims to release the updated plan by December 1, 2021.

Other priorities include accelerating work toward equity by addressing stigma, discrimination, and HIV criminalization and improving health care access for PWH. The HIV movement has evolved and now needs more involvement from other entities that address SDH, such as housing services. Efforts should be broadened to address PWH who are not in care and people and communities at high risk for HIV. Mr. Phillips hoped to advance work around the syndemic approach to HIV, STIs, and hepatitis using new funding that supports delivery of comprehensive services. As Dr. Levine noted, behavioral health plays a role in the syndemic, and Mr. Phillips hopes to identify more ways to integrate services toward more comprehensive care. The COVID-19 pandemic gave rise to more telehealth options that should be maintained, with the caveat that telehealth should improve access and not create a new digital divide.

The *HIV National Strategic Plan* describes Federal, State, and community efforts, but more can be done to engage the private sector in the HIV response. Mr. Phillips stressed that PACHA and ONAP have the capacity to bring together the public and private sectors to discuss a more holistic approach, given the shared interest in the communities that each sector serves. He expressed excitement that the Federal AIDS Policy Partnership plans to provide a list of priority issues and strategies to address HIV, and other national organizations have volunteered to give their insights into the national strategy, such as Act Now: End AIDS, the Southern AIDS Coalition, and the U.S. People Living with HIV Caucus.

Mr. Phillips proposed exploring how to use ONAP's White House platform, the [HIV.gov](https://www.hiv.gov) website, and other mechanisms to ensure awareness of PACHA and EHE and gather public input. He noted that in promoting the EHE initiative, it is important to highlight lessons learned from the priority areas that can be implemented in other jurisdictions. Mr. Phillips pointed out that the Biden-Harris administration's push to expand public infrastructure would have an important effect on PWH by addressing such areas as public transportation and internet access.

Discussion

Dr. Wiesman anticipated that minority-led and minority-serving community-based organizations (CBOs) would be key to addressing disparities, and he asked about White House plans to increase support for such organizations. Mr. Phillips replied that an effort is underway to assess procurement and contract processes across the Federal government to determine how to better fund minority-led CBOs, which often include participants with relevant lived experience and close ties to their communities. The Minority HIV/AIDS Fund also will be assessed.

PACHA Subcommittee Reports

EHE and the Updated National HIV Strategy

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

John Saperro reported that the Subcommittee helped craft the agenda for this meeting, with the goal of highlighting the most creative and forward-thinking EHE jurisdictional plans. The group will continue to review the EHE jurisdictions' initiatives and work with Federal partners to inform national efforts. The Subcommittee has provided feedback to Federal partners on cost assistance needed for Ready, Set, PrEP, which covers PrEP medication for uninsured people but not the costs of the required medical visits and laboratory tests.

Stigma and Disparities

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

Justin C. Smith, M.S., M.P.H., explained that the Subcommittee also helped craft the agenda for this meeting, with particular attention to spotlighting community perspectives on EHE. He was heartened that Dr. Levine and Mr. Phillips recognized the importance of equity and the need to center the voices of the community in the work, but he pointed out that it is now time to translate verbal commitments into action. There is a continued need to ensure that racism, sexism, homophobia, transphobia, and other SDH are part of the conversation. Mr. Smith noted that PrEP remains underused. He emphasized that the meeting agenda aims to draw attention to solutions.

Global

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

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), expressed that the Subcommittee brings a vital international perspective to PACHA and monitors the work of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). He noted that investment in HIV catalyzes investment in related conditions and issues, such as STIs, sexual violence, tuberculosis, and malaria. Gregg H. Alton, J.D., added that once the President appoints a permanent global AIDS coordinator to oversee PEPFAR, the Subcommittee plans to develop a resolution in support of the administration's global HIV/AIDS work.

EHE Jurisdictional Plans

Thematic Review of Jurisdictional EHE Plans and Next Steps

Demetre Daskalakis, M.D., M.P.H., Director, Division of HIV/AIDS Prevention, NCHHSTP, CDC

CDC recently awarded substantial funds to State and local health departments to help rebuild and expand HIV prevention and treatment efforts as the country continues to recover from COVID-19. Overall, CDC plans to distribute \$150 million in fiscal year 2021 for EHE. Analysis of the EHE plans of 32 State and local health departments (representing the 57 priority jurisdictions funded) revealed that most awardees had sought nontraditional and new partners, and 25 plans described engagement of PWH specifically. Jurisdictions identified a wide range of systemic and structural barriers, with most highlighting economic insecurity, education, housing, health care access, and stigma as their top concerns. In relation to the four pillars of EHE, planned activities fall mostly in the categories of diagnosis and prevention, with fewer efforts focused on treatment and response. Most jurisdictions described plans to address crosscutting issues, such as opioid addiction; the syndemic of HIV, hepatitis, and STIs; and State and Federal policies (e.g., immigration, Medicaid expansion, and HIV criminalization).

Nearly all plans described the need for funding and cooperation with HUD and its HOPWA program, and some described potential funding or partnership with other Federal agencies. Notably, none of the plans mentioned the Veterans Health Administration. As jurisdictions implement their plans, they are expected to modify them to meet the HIV prevention needs of their communities and to address current service challenges, with assistance from CDC.

Demetre Daskalakis, M.D., M.P.H., called on CDC and its Federal partners to—

- determine whether they are adequately coordinating resources across agencies to maximize the impact of funding;
- clarify how CDC will hold jurisdictions accountable for EHE implementation; and
- consider how to direct more funding to grassroots efforts and CBOs to address systemic challenges.

He recommended that jurisdictions—

- do more to ensure that PWH and those disproportionately affected by HIV are part of local EHE planning and implementation;
- assess whether they are coordinating and leveraging all available resources; and
- seek out resources and lessons learned from the COVID-19 pandemic that can be applied to their EHE plans as well as their core HIV work.

Discussion

PACHA members expressed concerns that some jurisdictions did not engage PWH in planning, did not describe links to PrEP programs, or did not identify the need for a syndemic approach. Dr. Daskalakis said CDC will continue to work with jurisdictions in an iterative approach to planning, particularly emphasizing the importance of having PWH at the table. He added that community engagement is key. Dr. Daskalakis acknowledged that much more work remains to be done, although the pandemic may have complicated some jurisdictions' engagement efforts. He did not know whether jurisdictions would be able to use EHE funding to support their

planning processes, but community engagement is a core expectation of the funding. Dr. Daskalakis pointed out that EHE funding is intended to be an “equity boost” to existing HIV services.

Dr. Daskalakis said CDC is thrilled that CMS explicitly stated that private insurers and Medicaid and Medicare providers must cover the ancillary services needed for PrEP, given that PrEP has a grade A designation from the U.S. Preventive Services Task Force (USPSTF). CDC is exploring ways to expand HIV wraparound services.

Dr. Daskalakis supported home testing as a way to reach more people at risk and overcome stigma. CDC has an online ordering program to provide access to home HIV testing kits, although it is currently capped at 100,000 tests. The agency also is considering how to collaborate with CBOs to deliver home testing kits, effectively expanding capacity in areas that lack testing infrastructure.

CDC is finalizing plans for how jurisdictions will monitor progress. Dr. Daskalakis emphasized that monitoring will use the same metrics as other HIV programs, such as the Medical Monitoring Project, and align with the AHEAD indicators, but data will be collected from more sources. CDC has not identified measures for assessing client experience and satisfaction with EHE-funded programs, but Dr. Daskalakis hoped that CDC would delve into the issue further. He also noted that much work remains to be done to determine how Federal partners can support jurisdictions that are tackling policy barriers.

EHE Jurisdictional Plans from the Local Government Perspective and Next Steps in Implementation

Facilitator: John Sapero, PACHA Member

PACHA asked representatives of three EHE jurisdictions to describe the development of their plans and specifically outline the engagement of PWH in planning.

Ending the Epidemic: South Carolina (EtE SC)

Felicia M. Pickering, Dr.H.A., M.B.A., CSPS, Community Engagement Program Manager, STD/HIV/Viral Hepatitis Division, Bureau of Communicable Disease Prevention and Control, South Carolina Department of Health and Environmental Control

EtE SC addresses HIV, STDs, viral hepatitis, and substance use disorders. Its community engagement efforts work to bring to light the implications of these conditions for rural areas, which bear a disproportionate burden of HIV. EtE SC leveraged its existing planning body—which includes PWH, providers, State agency representatives, and community members—as the basis for a statewide working group that also engaged nontraditional partners and PWH not in care.

EtE SC recruited regional planning coordinators to organize regional forums to gather community input. It also hired a data manager to prepare and share statewide, regional, and countywide epidemiologic data at the public forums. Although planned as in-person forums, all 24 forums were conducted virtually because of the pandemic. To engage PWH at different stages of the needs assessment process, several consultations and four forums were exclusive to PWH.

Some meetings focused on Latinx and Spanish-speaking populations. The first series of regional forums focused on strategies for diagnosis and prevention, and a second series addressed treatment and response.

Felicia M. Pickering, Dr.H.A., M.B.A., CSPS, explained that EtE SC worked to ensure that people throughout the State had opportunities to participate in all aspects of planning and learn about plans specific to their communities. Also, EtE SC held summary meetings to ensure it had captured feedback accurately. Forum participants were encouraged to contact the organization by email with additional input.

Ending the HIV Epidemic in Philadelphia

Coleman Terrell, Acting Director, Division of Disease Control, Philadelphia Department of Public Health

Coleman Terrell said the EHE planning process identified some critical factors for success:

- Embed a health equity approach in all planning, implementation, and evaluation.
- Use public health data to drive decisions.
- Focus on addressing structural barriers.
- Encompass all available funding streams.

Using targeted data, for example, Mr. Terrell and colleagues demonstrated to providers the persistent gaps in the continuum of care, such as the number of PWH who are not virally suppressed and are not receiving regular care. These data underscore disparities among key populations and thus the need for radical, systemwide change. The Philadelphia Department of Public Health hired a health equity advisor for HIV programs and developed health equity policies and goals for its HIV division. It has redirected HIV prevention funds to CBOs that provide a range of sexual health services; it also targeted funding to serve populations and geographic areas at high risk for HIV.

Health department staff collaborated with care providers to identify and reengage PWH who were out of care. The effort revealed a number of barriers to remaining in care that could be addressed by better informing patients of their rights and eliminating unnecessary systemic blocks. Many proposals to overcoming these barriers involved employing community health workers and using medical case-management techniques. Finally, the health department recast its mission from funding HIV clinics to funding health systems to develop the capacity to end the HIV epidemic and holding the health systems accountable for outcomes. It created “Pillar Zero,” a list of the foundational steps needed to end HIV:

- Provide radical customer service at all levels that results in meaningful relationships and breaks down barriers to prevention and treatment services.
- Reduce stigma through policies and procedure changes, education, and anti-bias programs.
- Provide safe and secure housing along with accessible public health programs that support the needs of people living in poverty and with insecure housing.
- Admit that the health care system is broken and fix its systems and structures. Center the work around the needs of the people served.

Community Engagement Activities: Detroit Health Department

Angelique Tomsic, HIV/STI Program Director, Detroit Health Department

Angelique Tomsic described how the Detroit Health Department reevaluated the priorities and capacities of its initial EHE plan in light of the pandemic. To enhance community engagement during the pandemic and ensure participation of PWH in planning, the department recruited participants from community groups with diverse PWH membership and clinician groups, sent providers an online survey, and conducted telephone interviews. PWH participating in these efforts received a \$25 gift card.

In the individual interviews, participants frequently identified increased education and work opportunities for PWH as the highest priority among the six areas originally identified by the health department's first EHE plan. Interviewees also highlighted the need to educate the public about HIV and the importance of opportunities for PWH to become advocates. The group discussions among PWH resulted in less consensus, but slightly more people supported prioritizing interventions led by Black men who have sex with men (MSM) and using data to reengage PWH in care. As the discussion turned to ending the HIV epidemic, the groups prioritized education and the use of community health workers or peers to facilitate interaction. All of the group discussion participants agreed with the need to have more PWH working in the field. Discussions about the importance of providing housing and reducing stigma quickly transitioned to the need for education and employment opportunities.

The clinician group also discussed education at length, particularly the need for education at different levels. For example, physicians, especially pediatricians, need more information about PrEP and postexposure prophylaxis (PEP), and educators should be more informed about the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. Across all of the community engagement mechanisms, education and work emerged as the top priority, followed by the use of data to reengage PWH in care. As a result, the health department funded area Ryan White programs to implement an education and work project based on the city's successful Mpowerment projects, a model program for HIV prevention among young MSM. The department believes that these projects centering education and work will affect the other priorities of mobilizing young MSM as advocates and peer educators, engaging PWH in programming, improving housing, and reducing stigma.

Discussion

Asked about innovations in South Carolina to reach Black MSM specifically, Dr. Pickering responded that EtE SC has a good partnership with some key CBOs that represent transgender people and men of color and whose representatives serve on its planning bodies, and it is always looking for more ways to engage with the LGBTQ community. Dr. Pickering added that she is working with area PACE officers on two community events about combating stigma. She proposed that stigma reduction be a separate pillar under EHE. Mr. Sapero noted that the pandemic may have thwarted intentions in some jurisdictions to engage PWH in planning.

EHE Jurisdictional Plans from the Community Perspective and Next Steps

Facilitator: Justin C. Smith, M.S., M.P.H., PACHA Member

*Panelists: Jose de Marco, Community Organizer, ACT UP Philadelphia
Venita Ray, J.D., Co-Executive Director, Positive Women's Network-USA*

Mr. Smith posed questions to two experienced community activists to elicit ways to improve jurisdictions' EHE planning processes.

How were you involved in your jurisdiction's planning process? What worked and what could be improved in that respect?

Jose de Marco explained that he founded Black and Latinx Community Control of Health, an offshoot of ACT UP Philadelphia, to address the most significant barrier to ending HIV: white supremacy. He said people of color (POC) have little control within the large AIDS service organizations that date back to the beginning of the HIV/AIDS epidemic, which often are led by white people; smaller organizations that serve Black, Latinx, and transgender people are struggling. Black and Latinx Community Control of Health held a symposium to gather information and brought its recommendations to the Philadelphia Health Department.

Venita Ray, J.D., stated that in 2016, advocates in Houston pushed for an intersectional social and racial justice approach to ending HIV, but the city was not ready to take on such issues. Houston's health department submitted a plan for the EHE initiative, but only now is the community involved. The city is undertaking a root cause analysis and applying a racial justice lens to its EHE plan. Taking a broader perspective, Ms. Ray observed that Federal Implementation Plans for NHAS were designed in a way that did not center PWH. The U.S. People Living with HIV Caucus developed an agenda and recommendations from the perspective of PWH, including attention to quality of life. Ms. Ray said processes could be improved by establishing formal methods to involve the HIV community, incorporating quality-of-life indicators, defining the communities that should be engaged in planning, and centering PWH. Efforts should apply a race- and gender-equity lens and acknowledge the harm caused by focusing solely on biomedical approaches to care.

What role should your organization play in EHE over the next few years?

Mr. de Marco said Black and Latinx Community Control of Health would like to maintain an ongoing relationship with the health department. He pointed out that most of the EHE funding is likely to go through a Ryan White program planning council, which is problematic. Such councils often are dominated by those who have significant experience with the systems in place, and the PWH members who lack such experience have little say, so most of the money goes to organizations run by white people. Mr. de Marco emphasized that it is time for white leaders to either cede power or share it, and Ms. Ray agreed. The disproportionate number of Black and Latinx people affected by HIV, COVID-19, and incarceration is a clear indication that the current systems are not working, Mr. de Marco stated.

Ms. Ray added that the need for racial and social justice must be acknowledged before progress can be made. She agreed that it is time to examine the power held by local decision-making bodies and the need for diversity and representation of the community served. She reiterated her concern about the harm to vulnerable communities caused by focusing only on biomedical approaches to HIV. The Positive Women's Network (PWN) aims to have an impact on EHE, the

updated *HIV National Strategic Plan*, and the corresponding implementation plans. Within those initiatives, PWN would like clear, actionable, resourced, community-led initiatives around HIV that recognize that HIV stigma is rooted in racism, homophobia, and transphobia.

Furthermore, Ms. Ray noted, she would like to see the Federal government and community advocates collaborate to tackle HIV criminalization at the State level. Sexual and reproductive health issues also should be addressed. Ms. Ray pointed out that ending the epidemic means ending it for all communities, not just some. If the EHE plans are, in fact, living documents, as CDC claims, there should be time to add these important considerations and have the conversations with the HIV community and others that are needed to improve the plans.

What innovative ideas have emerged from the HIV community through jurisdictions' community engagement efforts?

Mr. de Marco emphasized that housing is a core component of HIV prevention that is overlooked. Housing people at risk for HIV can prevent HIV and other health conditions and save a lot of money. Another concept that has emerged is the importance of addressing stigma by building bridges with heterosexuals, especially among Black and Latinx people, in the recognition that all POC are affected by white supremacy.

Ms. Ray said that community discussions highlight that HIV is a racial justice issue. That concept extends to equity around language, which goes beyond interpreters and translation. EHE should be expanded to include immigrants, sex workers, and people who use drugs, so that the most vulnerable communities are engaged. In addition, to support involvement, PWH and others with useful experience should be paid for their time. They should be part of grant writing, design, and implementation planning. Hiring guidelines should be adjusted to bring forth more qualified candidates who are PWH. Their insights can reveal barriers and how to address them. Ms. Ray echoed Mr. de Marco's comments that most grant funding goes to organizations led by white people, while minority-led organizations struggle for resources. Ms. Ray commented that the more funding that goes to those closest to the communities in need, the better.

How can jurisdictions attract more nontraditional partners to their EHE efforts?

Ms. Ray pointed to the importance of addressing basic needs to mitigate the vulnerabilities that people face as a result of systemic and structural biases. Such issues as providing housing, ending mass incarceration, promoting health care access, and improving the health care experience all contribute to overall health. Framing the HIV response in the narrow context of prevention, testing, and treatment ignores the larger problem of vulnerability. To end the epidemic, it is necessary to expand and elevate the vision of what the health care workforce should do, a topic that is not addressed in EHE.

Mr. de Marco added that building meaningful relationships with underrepresented and overlooked populations—such as injection drug users, sex workers, and homeless people—brings to light the barriers they face and offers opportunities to address these barriers. Diversity among advocacy organizations and service providers is important, because the “face” of the epidemic is much different now than it was in the beginning. Mr. de Marco echoed Ms. Ray's comments about racial injustice, stating, “HIV is proof-positive of injustice.”

How can advocates cultivate partners in the media and popular culture who can have influence around ending HIV?

Ms. Ray said that pervasive stigma still prevents pop culture icons from speaking up—for example, to counter homophobic remarks made recently by rapper DaBaby on social media. She called for empowering people on the periphery, such as sex workers, and engaging advocates involved in criminal justice, housing, and immigration rights. Although she had no specific suggestions, Ms. Ray recognized the need to bring together movements with intersecting interests.

Mr. de Marco commented that white people who are not actively working to dismantle white supremacy are complicit. He urged everyone to ask themselves what they are doing to dismantle the systems of oppression. Ms. Ray added that the EHE initiative cannot ignore the social and political context in which people are being disenfranchised by voter suppression laws. It also is important to recognize that the pandemic and unemployment, along with longstanding racial and social injustice, make it difficult for some to look beyond meeting their basic needs for survival.

What essential resources are missing for ending the HIV epidemic?

Ms. Ray said funding is needed to ensure that those most impacted are represented in planning and implementation of programs, including funding to compensate participants for their time. She added that molecular HIV surveillance mechanisms must not proceed without adequate, uniform data safety and security because they threaten individuals' right to privacy. Such surveillance is an outgrowth of a narrow biomedical approach to HIV care that does not take into account quality of life or cultural contexts.

Mr. de Marco reiterated that funding should not be filtered exclusively through Ryan White programs; money should go directly to minority-led organizations that serve POC. Mr. Smith noted that other activists have identified the need for Federal partners to require accountability and corrective actions for organizations that continue to receive large Federal grants despite poor track records in their communities.

What specific changes would improve EHE?

Ms. Ray underscored the need to have PWH at the table and urged more forthright discussion about race and gender inequity. Structural and systemic barriers must be acknowledged and addressed. Mr. de Marco called for more funding for housing as a key step in preventing and treating HIV. He reiterated that white people must cede or share power to dismantle white supremacy.

Closing Remarks and Recess

Dr. Wiesman particularly appreciated the insights from PWH and the concrete suggestions from presenters. He emphasized the importance of naming white supremacy and doing the anti-racism work to address the power structures that perpetuate racism. Dr. Wiesman stated that it is unacceptable that some EHE jurisdiction plans moved forward without input from PWH, but it underlines the need to better define community engagement and describe what it means to cede power. Presenters also highlighted that ending HIV cannot be achieved through biomedical approaches alone but rather requires attention to SDH and quality-of-life issues, and the new administration appears to be open to a broader approach.

Dr. Wiesman outlined some topics for PACHA to delve into further, such as defining intersectional stigma and taking a collaborative approach to address it; incorporating economic empowerment and justice into the work of ending HIV; improving equity and targeting SDH; and targeting programs to meet the need of people at risk of HIV, as well as PWH. He committed to ensuring that community voices are heard and to working toward accountability from Federal, State, and local partners. Dr. Wiesman concluded that ending the HIV epidemic for white people is not enough; the goal must be to end HIV for all at the same time.

Mr. Schmid recessed the meeting for the day at 5:02 p.m.

Day 2

Opening Remarks from the PACHA Co-Chairs

Mr. Schmid and Dr. Wiesman welcomed the participants at 1:00 p.m. They reviewed the proceedings of Day 1 and the agenda for Day 2. On behalf of the White House, Mr. Phillips welcomed the new PACHA members to be sworn in today and thanked current members for their work.

Oath of Office: New Members and Term Reappointments

Rachel L. Levine, M.D., ASH, HHS

Dr. Levine administered the oath of office to eight new PACHA members:

- Marlene McNeese, Assistant Director, Houston Health Department, Houston, TX
- Guillermo Chacón, President, Latino Commission on AIDS; Founder, Hispanic Health Network, New York City, NY
- Tori Cooper, M.P.H., Director of Community Engagement for the Transgender Justice Initiative, Human Rights Campaign, College Park, GA
- Raniyah Copeland, M.P.H., President and CEO, Black AIDS Institute, Los Angeles, CA
- Leo Moore, M.D., M.S.H.P.M., Medical Director for Clinic Services, Los Angeles County Department of Public Health, Los Angeles, CA
- Kayla Quimbley, National Youth HIV and AIDS Awareness Day Ambassador, Advocates for Youth, Columbus, GA
- Adrian Shanker, Founder and Executive Director, Bradbury-Sullivan LGBT Community Center, Allentown, PA
- Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., Provost and Senior Vice President for Academic Affairs, Iona College, New Rochelle, NY

Dr. Levine noted that Ms. McNeese would serve as PACHA Co-Chair alongside Dr. Wiesman as of Day 2 of this meeting. She then announced the reappointment of three PACHA members whose terms recently expired: Mr. Alton, Mr. Narváez, and Michael Saag, M.D.

Roll Call

Ms. Hayes called the roll.

Advancing PrEP Access

Advancing PrEP Access from a Federal Perspective: Coverage by Payers and the Uninsured

*Facilitators: Carl Schmid, M.B.A., PACHA Co-Chair
John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair*

Federal Guidance on PrEP Coverage

Jeff Wu, J.D., Acting Director, Center for Consumer Information & Insurance Oversight (CCIIO), CMS

Jeff Wu, J.D., explained that PrEP should be treated the same as other USPSTF-recommended preventive services, which must be covered with no cost-sharing. Although the USPSTF designation went into effect in 2020, CCIIO has received complaints that insurers are interpreting the regulations narrowly, covering only the PrEP medication and not the supportive services essential to administration. Those services are explicitly described in the USPSTF recommendation for PrEP. In July 2021, HHS, the U.S. Department of Labor, and the U.S. Department of the Treasury clarified that insurers must implement the entire USPSTF recommendation without cost-sharing, including related items and services, as well as office visits associated with these elements.

The clarifying guidance addressed issues around medical management. For example, because the USPSTF recommendation does not require use of a specific brand of PrEP medication, insurers can limit their coverage to generic forms. However, insurers must make accommodations if a health care provider determines that the generic form would not be medically appropriate for a given individual. CCIIO also heard complaints that some insurers restricted the number of times an individual may begin a PrEP regime, and the guidance made clear that such restrictions are not considered reasonable medical management.

Mr. Wu pointed out that the Federal government and States share responsibility for enforcing legislation with respect to private insurance companies. CCIIO works closely with States, in part by making sure all States are aware of new guidance and rules, answering questions, and providing clarification. The recent guidance offers a 60-day “safety period,” so full enforcement will begin in mid-September of 2021.

The State of PrEP: Public Programs

Judith Steinberg, M.D., Chief Medical Officer, OIDP, OASH, HHS

Judith Steinberg, M.D., explained that under the Affordable Care Act, Medicaid expansion programs must cover USPSTF-recommended preventive services, including PrEP medication and the associated services, without copays. Traditional Medicaid programs may impose nominal copays and require prior authorization for the medication and the associated services. Most States and the District of Columbia do not require prior authorization. Sixteen States do not require copays for PrEP services.

Medicare includes antiretroviral therapy in its Part D programs without prior authorization, but copays can be imposed. It is estimated that a Medicare beneficiary might pay \$1,300 to \$2,400 per year for PrEP. Low-income Medicare beneficiaries have access to a sliding scale for

copays. Until recently, Medicare did not cover preventive services, but a new statute requires full coverage without cost-sharing under its Part B program for USPSTF-recommended services that Medicare determines to be appropriate for its beneficiaries. For example, the antiretroviral cabotegravir is administered at an office visit and thus falls under Part B and is covered. PrEP medication is covered through Part D, to which the new preventive services statute does not apply, so the medication, laboratory services, and related office visits are subject to cost-sharing.

Beginning in 2020, EHE allotted about \$50 million per year through 2022 to HRSA health centers through the Primary Care HIV Prevention awards, resulting in nearly 63,000 patients prescribed PrEP in 2020 alone. The awardees also provide PrEP prescribing data that have not been captured previously.

Gilead, which donates PrEP medications for the Ready, Set, PrEP program for uninsured patients, has indicated that it will not reimburse for PrEP medication purchased through the 340B drug pricing program. This action poses problems for health centers that rely on revenue from the 340B program to pay for PrEP clinic and laboratory tests for uninsured patients. Similarly, use of less-costly generic PrEP medications, purchased through the 340B program, results in less revenue for hospitals than brand-name drugs.

Other federally funded programs are striving to increase PrEP access:

- IHS uses Minority HIV/AIDS Funds to integrate PrEP in Federal, Tribal, and urban health clinics. During the pandemic, IHS implemented a telehealth option that increased the number of clinicians prescribing PrEP.
- The Department of Veterans Affairs (VA) has its own plan for ending HIV, which will expand pharmacists' role in prescribing PrEP. Moreover, VA pharmacists have extensive databases that help them identify candidates for PrEP and related quality data.
- OIDP has engaged nearly 32,000 pharmacies across the country to support Ready, Set, PrEP. It is exploring how to increase program participation and monitor data.

Dr. Steinberg concluded that PrEP access is expanding, but policy, program, and cost barriers remain. Telehealth options and pharmacist- and nurse-led programs can increase access to PrEP. New data collection components will facilitate monitoring, but more data reporting is needed. Concerns persist about how changes to 340B program eligibility will affect PrEP access.

Discussion

Mr. Wu said CCIIO welcomes all input from stakeholders to identify issues that should be investigated. Following confirmation of a concern, the first step is to make sure that the insurer understands the requirements. In some cases, Federal officials may work with States and the National Association of Insurance Commissioners to address policies more broadly.

Mr. Wu noted that CCIIO recognizes that the requirement for prior authorization is a sticking point for many services, not just PrEP. Some organizations use blanket prior authorization for certain services to increase efficiency. Dr. Steinberg contributed that HHS convened an affinity group around hepatitis C that led many States to develop a standardized prior authorization form for public and private providers, and that model could be applied to PrEP. Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, noted that prior authorization and copays are among the

significant barriers that prevent even privately insured patients from getting PrEP. To end HIV, such barriers must be eliminated. Strategies should be implemented to make PrEP easier for clinicians to provide and for patients to access, Dr. Stewart commented.

Dr. Steinberg observed that ensuring PrEP coverage under traditional Medicaid would require statutory changes. Dr. Saag proposed modifying the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to cover PrEP and related services.

Laura Platero, J.D., called on IHS to provide direct access to PrEP through IHS pharmacies, just as the VA does. Updating this policy would increase PrEP access for American Indian and Alaska Native people.

Dr. Steinberg indicated that OIDP resources and training for pharmacies and pharmacists about PrEP also cover PEP. However, States' regulations vary as to whether pharmacists can prescribe PrEP and PEP. Dr. Steinberg said HHS might want to consider expanding Ready, Set, PrEP to include PEP. Via chat, an evaluation was suggested that would compare PrEP access and uptake in States that have or have not expanded their Medicaid programs.

Advancing PrEP Access from an Implementation Perspective¹

Facilitators: Michael Saag, M.D., PACHA Member

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

Panelists: Ellen LaPointe, J.D., CEO, Fenway Health

Kirk Myers, M.P.H., Founder and CEO, Abounding Prosperity, Inc.

Eboni C. Winford, Ph.D., Director of Research and Health Equity, Licensed Psychologist and Behavioral Health Consultant, Cherokee Health Systems

What is your program doing to implement PrEP access?

Kirk Myers, M.P.H.: Abounding Prosperity provides PrEP and PEP to low- and middle-income people, and primarily Black people, in the Dallas, TX, area, most of whom were unaware of these treatment options before the organization's educational efforts. The program went from 22 PrEP patients in 2019 to 1,001 to date and continues to grow. COVID-19 has affected every aspect of the program, from outreach to testing to linkage to care, but Abounding Prosperity has adapted by offering telehealth, telescreening, and mobile health units. It offers rapid-start PrEP through its telehealth and mobile health programs. Abounding Prosperity operates in an area with very low PrEP uptake among Black people.

Eboni C. Winford, Ph.D.: Cherokee Health Systems is a large Federally Qualified Health Center (FQHC) with 24 locations across Tennessee. It receives HRSA and EHE funds. It initiated PrEP services at the end of 2019 and has had to work around the pandemic to incorporate PrEP into the workflow of its fully integrated health care systems. Cherokee Health hired three PrEP navigators to conduct community outreach and identify those at highest risk for HIV transmission. Its mobile clinic seeks to serve PrEP candidates in hard-to-reach areas. Cherokee Health also supports the Wellspring clinic, which offers hormone therapy, PrEP, HIV care, and medication-assisted treatment for substance use disorders to all patients, with particular attention to people of marginalized identities. Cherokee Health raises awareness about PrEP by

¹ Panelists' responses are summarized and paraphrased here.

embedding it into routine care as part of overall wellness. Most Cherokee Health clinics offer the only medical services in very rural areas.

Ellen LaPointe, J.D.: Fenway Health is an FQHC in Massachusetts that serves 34,000 patients; through telehealth over the past year, it has reached people in 38 States. Fenway Health puts underserved communities—including lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other sexual and gender minority people (LGBTQIA+) and Black people, Indigenous people, and people of color (BIPOC)—at the center of its work. Its direct clinical and supportive services address sexual health and well-being, drug use or access, housing, and legal aid. Fenway Health was among the U.S. research sites that demonstrated the efficacy of PrEP, and its primary care providers have prescribed PrEP routinely since 2011. Integrating PrEP into primary care has been key to reaching good candidates and creating a bridge for patients to seek overall health and wellness care. Fenway Health promotes the mindset that there is no “wrong door”; that is, patients are linked to a broad range of care and services regardless of how they approach the system. Of the 6,400 people prescribed PrEP since 2011, about 80 percent identify as white, cisgender, gay men, which reveals a gap in opportunity.

What barriers does your program face in expanding PrEP access to hard-to-reach populations?

Dr. Winford: It is difficult to provide routine care and follow-up for people without homes. Also, for adolescents or young adults who are covered under a parent’s insurance plan, it is difficult to maintain privacy about the nature of services provided. Although Cherokee Health clinics try to ensure that documents are sent only to a consenting adolescent or young adult, the process does not always work. Taking a pill daily may be an unrealistic expectation; more support of event-based or “2-1-1” PrEP regimens, particularly for people without homes, would be helpful.

Mr. Myers: Many people are not even aware of PrEP. Moreover, stigma persists, as some people believe that a person who takes PrEP medications has HIV. Stigmas can be overcome by changing social norms and raising awareness about PrEP. Services often are not available at times and locations that are convenient for the intended population.

Ms. LaPointe: Providers need more training on how to talk with PrEP candidates in a way that is welcoming, encouraging, and thoughtful, with the goal of informed decision making. Before that point, however, it is necessary to seek every opportunity to reach potential candidates by ensuring that providers’ mindsets are oriented toward integrated care. Every primary care provider should routinely assess risk for HIV and know how to have respectful conversations with patients about PrEP and other services.

Does your program use the Ready, Set, PrEP program?

Ms. LaPointe: Most people in Massachusetts have access to health insurance, so few people are candidates for Ready, Set, PrEP. Getting a prescription for PrEP requires access to a prescribing provider, which might be a factor that limits program uptake.

Dr. Winford: Cherokee Health has tried to use the program, mostly unsuccessfully, because so few pharmacies in the State participate. Patients can pick up PrEP medications at Cherokee Health pharmacies located in the clinics, but going through Ready, Set, PrEP means that

Cherokee Health cannot use its 340B drug pricing discount. In some cases, Cherokee Health must communicate with a pharmacy and arrange for the drug to be mailed to its pharmacy or to the patient's home directly—if the patient has a fixed address. The program has too many barriers and additional steps. In the rural areas, there is one retail pharmacy that provides specialty pharmacy services with which Cherokee Health can partner.

Mr. Myers: Abounding Prosperity has its own specialty pharmacy, but the barriers noted by the other speakers are also concerns. A lot of presumptions are made about how POC will access programs like Ready, Set, PrEP that do not translate to the real world. There should be more entry points for access, such as VA clinics, STD clinics, and CBOs. The county health department has low PrEP uptake because its programs lack cultural competence, relevance, and convenience. For community health clinics like Abounding Prosperity—that are not funded by HRSA, that operate in States without Medicaid expansion programs, and that primarily serve POC who are uninsured—engaging with Ready, Set, PrEP could be useful, but it is not clear how candidates would get a prescription for PrEP, where “free” PrEP is available, who pays for providers to see patients in underserved communities, and who pays for the required laboratory services.

Has your program conducted strategic planning that involves the whole community and identifies all potential partners?

Mr. Myers Abounding Prosperity has a great partnership with Dallas County's health department and works closely with the Houston health department because so many people travel back and forth between the two metropolitan areas. When the Dallas County health department was focused solely on COVID response, many patients from its STD clinic were referred to Abounding Prosperity, which offered a great opportunity to address stigma and educate about PrEP. One local FQHC acknowledged that it did not know how to deal with HIV, let alone PrEP, so it refers people to Abounding Prosperity. Abounding Prosperity also provides HIV testing and PrEP to area CBOs that receive direct Federal funding.

Dr. Winford: Cherokee Health has partnered with a local agency that provides services to individuals without homes. Its mobile unit was underused until the organization made an effort to work with trusted cultural “brokers” in the community to identify what the community needed. No one in the community expressed a need for PrEP, but wound care—specifically foot care—was in high demand among people without homes. As a result, providers treating wounds in the mobile clinic took the opportunity to screen for depression, anxiety, substance use, and hepatitis C risk. In figuring out where and how to provide services, it is important to look closely at what went wrong and how to fix it.

Ms. LaPointe: Fenway Health is well resourced and has a longstanding presence in the LGBTQIA+ space. When the organization began offering HIV services and treatment, the focus was primarily on white, cisgender gay men, although it has since evolved to serve gender-nonbinary, gender-diverse, and transgender people, as well as people in the BIPOC community. Fenway Health has close relationships with the State health department, the Boston Public Health Commission, and CBOs that advocate for queer youth, transgender and gender-diverse people, and incarcerated people. It has three sites in Boston, where most of the State's new HIV diagnoses occur. Despite these partnerships and resources, HIV outbreaks and infections persist. The relationship-building described by Mr. Myers and Dr. Winford is the kind of basic public

health approach needed to meet people where they are and to provide holistic health care. Educating and training providers around the country to offer culturally competent, respectful care is key.

What major concern or message do you want to convey to PACHA and the Federal partners at this meeting?

Mr. Myers: With all the challenges that society faces, Black and Brown people and the organizations that serve them should not be written off as collateral damage.

Ms. LaPointe: There must be a focus on educating and training providers and promoting the “no wrong door” approach.

Dr. Winford: Think about the funding. Just because programs are equally available does not mean they are equally accessible.

Discussion

Regarding changes to Gilead’s reimbursement of PrEP drugs, Ms. LaPointe said that Fenway Health, like other FQHCs, relies on proceeds from the 340B program to cover unfunded costs. As others have pointed out, PrEP requires not just medication but an array of wraparound services. All of the pending changes around PrEP medication costs and payment are extremely concerning and will affect Fenway Health’s core operating budget. The potential collateral damage is not yet clear, but there will definitely be a financial gap. For some less well-resourced organizations, the changes could put them out of business. Dr. Winford expressed that the rationale for the changes is unclear, particularly who is meant to benefit from them. She added that any changes should consider the full spectrum of preventive services, including PEP, which is cost-prohibitive for many people and not available through pharmacies in a timely manner.

Asked about the potential availability of injectable PrEP, Dr. Winford shared that Cherokee Health had good success with injectable naltrexone, particularly for people who have significant barriers to taking daily medication. Injectable PrEP could increase the likelihood that people are getting the protection they need. Mr. Myers said his organization is preparing for the possibility of injectable PrEP, although many delivery systems, including some FQHCs, are not. The treatment must be rolled out equitably and not just for insured people.

Mr. Myers emphasized that most of those in need in his State are uninsured people without access to Medicaid expansion programs, typically between ages 19 and 34 years. Gilead’s decision demonstrates how very fragile the U.S. health care system is. Although it is not Gilead’s responsibility alone to serve uninsured POC, Mr. Myers stated, payment changes will be a severe setback to the already underserved and to populations among whom PrEP uptake is poor. They will exacerbate disparities and increase HIV incidence, thwarting the EHE goals. Mr. Myers emphasized the need for more discussion with Federal partners, because the currently funded testing programs are meaningless if they are not linked to effective programs for starting people on PrEP, especially Black people.

To improve provider awareness in rural areas, Ms. LaPointe noted that her organization has a national LGBTQIA+ education center that provides training for clinicians and clinical programs. It offers, for example, a PrEP action kit and resources for clinicians. More work must be done so

that providers feel comfortable treating PWH. The pandemic opened up telehealth services, which had a significant impact in rural areas. Ms. LaPointe hoped that the emergency provisions put in place to allow telehealth services would be preserved to expand access. Dr. Steinberg added that OI DP is training primary care and other providers through professional societies, academic institutions, and practices in Regions 4, 6, and 9. Also, OI DP is working with national professional societies to disseminate education and resources. Via chat, it was suggested that training about PrEP and PEP—and all USPSTF recommendations—be required for all FQHCs.

Mr. Myers observed that for small, minority-led organizations to remain competitive against larger organizations seeking Federal funding, small organizations must diversify—for example, by seeking funding for COVID prevention among its target population. Federal agencies must step up to help pay for the ancillary services around PrEP and PEP to sustain availability of those regimens. Via chat, it was suggested that some [CDC EHE funding](#) could be used for PrEP wraparound services.

Mr. Myers particularly asked for a focus on States that did not expand their Medicaid programs, because they align with where the majority of POC live. It was noted via chat that Ready, Set, PrEP does not address the barriers of stigma and disparities in access to care.

In the chat box, it was proposed that the scope of practice for nurses be expanded so that they can address sexual health, HIV treatment, PrEP, PEP, and other issues. The [areas with the greatest needs for care](#) overlap with the areas that have the greatest barriers to nurses providing care.

Mr. Phillips noted that in 2022, OASH and the White House plan to target engagement of nurses.

In light of the conversation, Ms. McNeese hoped that PACHA would revisit the issue of access to telehealth as an effective way to expand PrEP and PEP access.

Public Comments

Eiman Elmileik, a medical student at Michigan State University and HIV policy advocate intern at the AIDS Institute, said her research has determined that African-born women living in the United States may be disproportionately affected by HIV/AIDS. HIV/AIDS data on African-born people living in the United States are limited. Most State databases do not distinguish between U.S.-born and African-born Black people. Only Minnesota and Washington State report data on HIV/AIDS among African-born people, and in both States, the data show that they are disproportionately affected. Ms. Elmileik proposed that data about African-born people with HIV and AIDS be included in the HIV/AIDS annual surveillance report by every State that has an African-born population greater than 40,000. Reporting these data will allow a greater understanding of how this population is affected by HIV/AIDS and what disparities affect them. It also will ensure that this population is not being neglected and allow the implementation of targeted and culturally sensitive interventions to reduce the incidence of HIV/AIDS.

Kenyon Farrow, managing director of advocacy and organizing with PrEP for All and a PrEP user since 2015, raised concerns that uneven PrEP access over the past 10 years has exacerbated the existing racial, gender, economic, and regional HIV disparities. As a result, the country is close to ending the epidemic among white people, particularly white gay men, but not among any other group. PrEP for All believes that the availability of generic PrEP medications is one of the best hopes for delivering and scaling up HIV prevention programs to communities

most in need. Mr. Farrow noted from personal experience that the availability of generic medications means that he does not have to visit a specialty pharmacy on a monthly basis, but rather can obtain a 90-day supply of medication. Much more work remains; recent system changes around drug pricing have affected many of the CBOs that work to reach communities in need, particularly in States that have not participated in Medicaid expansion. PrEP for All applauds the recent guidance by CMS to make all payers aware that they must fully cover not only PrEP medications but also related HIV clinical visits. However, in non-Medicaid-expansion States where CBOs cover more people who are uninsured, gaps remain. Mr. Farrow said he was encouraged that CDC is exploring ways to become a payer of last resort. PrEP for All has advocated to allow CBOs to use their CDC funding to pay for PrEP services. Much more work is needed to deliver services in more innovative ways to reach people across the country.

Alex Vance spoke on behalf of the International Association of Providers of AIDS Care (IAPAC) and the Fast-Track Cities Institute. He said the makeup of the current PACHA underscores the Biden administration's commitment to health equity and the HIV response. Regarding CDC's thematic review of jurisdictions' EHE plans, it was alarming to learn that not all jurisdictions engaged PWH, people who use drugs, transgender people, and other key populations in their planning processes. As these iterative processes move forward, IAPAC and the Fast-Track Cities Institute encourage CDC to promote jurisdictions' further meaningful engagement with communities of PWH and people vulnerable to HIV. Around half of the 57 priority jurisdictions for EHE are part of the Fast-Track Cities Initiative, which has been providing free technical assistance and training on best practices to cities and municipalities around the globe to end their local HIV epidemic since 2014. In a recent meeting with the OASH, Dr. Levine committed to a collaborative partnership with IAPAC to integrate EHE jurisdictions into the Fast-Track Cities Initiative networks. Mr. Vance was encouraged by comments at this meeting about using lessons learned from global HIV programs like PEPFAR to bolster the domestic HIV response. Given that many cities and municipalities in the Fast-Track Cities network are in PEPFAR-funded countries in sub-Saharan Africa, IAPAC and the Fast-Track Cities Institute are well positioned to provide collaborative education and share best practices.

IAPAC and the Fast-Track Cities Institute echo the concerns raised about how Gilead's decisions will interrupt HIV prevention care and treatment in the United States. PrEP is a vital component of ending the domestic HIV epidemic, and the USPSTF recommendation on PrEP will break down barriers to its use for a large swath of people. However, people in States that have not expanded their Medicaid programs—many of which are at the epicenter of the U.S. HIV epidemic—will not have equal access to the services recommended by USPSTF. Dedicated outreach in these States is necessary to ensure everyone for whom PrEP is appropriate has unfettered access to PrEP and its ancillary services. CDC allows EHE grant funding to pay for PrEP services. IAPAC and the Fast-Track Cities Institute asks that CDC reverse its current prohibition and allow recipients of HIV prevention funds to pay for PrEP regardless of whether the funds are deployed in an EHE priority jurisdiction. The administration also should work to secure commitments from manufacturers to donate generic PrEP medications to the Ready, Set, PrEP program and to incentivize States to broaden the types of providers who can prescribe PrEP.

Ernest Hopkins, senior strategist and advisor at the San Francisco AIDS Foundation, asked PACHA to consider in more depth how expanding harm-reduction services will help meet the goal of ending the HIV epidemic. The San Francisco AIDS Foundation is lobbying the State to legalize safe injection sites, as some communities across the country have already done. Such sites are an incredibly important tool not yet broadly available in the United States, but they could have a dramatic impact on the epidemic. Speaking as the **chair of the National Black Gay Men's Advocacy Coalition**, Mr. Hopkins supported the Biden administration's recent request that the NIH expand its comprehensive research plan on Black gay men. The current research portfolio and what is in the pipeline are woefully inadequate. For a community that has been so disproportionately affected by the epidemic, these gaps feel like an oversight. Mr. Hopkins commended NIH Director Francis Collins, M.D., for his recent efforts to review how systemic racism has impeded the research portfolio and the process at the NIH. He applauded the efforts to create this comprehensive research plan and supported creation of any special initiatives needed at the National Institute of Allergy and Infectious Diseases to further such research. Mr. Hopkins hoped that PACHA would educate and advocate on behalf of that important research.

Breanna Diaz, PWN policy director, said her organization calls for the creation and inclusion of a quality-of-life pillar in the EHE initiative and for a moratorium on molecular HIV surveillance until community concerns are met. The more than 1 million people living and aging with HIV in the United States are all affected by structural and social drivers of inequities, racial and gender disparities, lack of access to housing, and the lack of sexual and reproductive health care, yet EHE is completely missing analysis of and commitment to eliminating the social and structural drivers of inequity. Instead, EHE takes a strictly biomedical response that links ending the domestic HIV epidemic to viral load, viral suppression, and other individual health-related outcomes. Although these biomedical markers are components of the quality of life for PWH, they are not an acceptable proxy for a well-rounded understanding of well-being or quality of life. PWN firmly believes that quality of life for PWH deserves its own pillar within EHE, along with strategies, metrics, and indicators to measure success. For example, jurisdictions could be required to create sexual and reproductive health care guidance for providers to deliver to PWH, and that guidance could include information on how to access transition-related care, pregnancy care, breast- and chest-feeding care, and contraceptive care.

PWN and others have called for a moratorium on molecular HIV surveillance for years on the basis of concerns about informed consent, data privacy and confidentiality, and the risk of potential data misuse in civil, immigration, and criminal proceedings. PWN has provided many recommendations to PACHA and others that would address these concerns. PWN calls on EHE to, first, remove the requirement that EHE-funded jurisdictions conduct such surveillance until the concerns are addressed and, second, prohibit EHE-funded jurisdictions from conducting molecular HIV surveillance activities if they cannot meet the security storage and data sharing standards that PWN has outlined.

See Appendix A for all written public comments submitted.

PACHA Discussion

Dr. Wiesman explained that PACHA's subcommittees delve into topics in more detail and prepare resolutions for PACHA's consideration. He called for suggestions for topics for the PACHA subcommittees. He urged members to think in terms of advice to the HHS Secretary and the President that targets systemic changes that can remove structural barriers.

Mr. Phillips specifically asked that PACHA offer suggestions on the role that the private sector can play in the *HIV National Strategic Plan*. For example, some companies might have platforms that can be leveraged to reach more Hispanic or Latinx people. In 2022, ONAP will consider convening private-sector representatives to discuss PACHA's suggestions. Mr. Alton volunteered to assist in reaching out to the private sector, noting that companies not only have resources and platforms but also are large purchasers of care. As such, their negotiations with insurers have a major impact on health care coverage. Mr. Schmid hoped the discussion would include companies outside of the health care and medical fields, such as social media companies. Mr. Phillips added that combating HIV misinformation and mistrust requires engaging social media, technology, and other private-sector entities.

Mr. Phillips observed that he is interested in learning about existing data and indicators on SDH and quality of life to determine what could be implemented at the national level.

Participants briefly discussed terminology, with some expressing discomfort with the phrase "Black and Brown people." It was suggested that Hispanic/Latinx be used when applicable.

Through in-depth discussion, the following items were suggested as potential topics:

Immediate Federal Policy Issues

- PACHA input on updating the *HIV National Strategic Plan*, particularly emphasizing the importance of SDH, making services more accessible to everyone, and ensuring that the plan reflects a goal of ending the HIV epidemic for everyone at the same time. (This might be a topic for a joint meeting of the subcommittees on EHE and the Updated National HIV Strategy and Stigma and Disparities.)
- Impact of PrEP drug payment and prices on the 340B program and the resulting effects on small nonprofit organizations that depend on the 340B program to fund services, especially in communities of color. Data are needed on how many organizations are at highest risk. (From chat: see <https://www.nbcnews.com/nbc-out/out-health-and-wellness/-will-shut-us-hiv-prevention-clinics-brace-gilead-reimbursement-cuts-rcna1346>.)

Access and Accountability

- Addressing the challenges of access to PrEP and PEP and related services.
- Extending direct funding opportunities to small and minority-led organizations that are already serving priority populations.
- Accountability for Federally funded organizations; for example, hiring people from the priority population to be served (e.g., transgender, gay, BIPOC) in full-time positions with benefits.

- Cementing current access to telehealth and telemedicine services and addressing the need for broadband access.
- Amending the Ryan White CARE Act to cover PrEP and PEP for people at high risk for HIV.
- Improving equity and targeting SDH.
- Targeting programs to meet the needs of people at risk for HIV, as well as PWH.
- Conducting outreach to States and Territories.

Stigma and Disparities

- How to address homophobia, transphobia, and xenophobia; resources to fight stigma; defining intersectional stigma and exploring collaborative approaches to address it.
- Effect of Gilead's changes to paying for PrEP on undocumented people, many of whom live in the South.
- Geographic and international considerations that exacerbate stigma and discrimination.
- Stronger partnerships with cultural influencers in the entertainment industry and social media.

Data Collection and Use

- Inclusion of immigrant populations in research and programs.
- Input from PWN about quality-of-life indicators and the U.S. People Living with HIV Caucus agenda and recommendations.
- Working with IHS Tribal Epidemiology Centers and Tribal nations to eliminate the misclassification of American Indians and Alaska Natives in data.
- Improving data collection in general and about transgender and nonbinary people in particular.

Education and Training/Provider Issues

- Requirements or incentives for provider training about PrEP in areas with low PrEP uptake, such as rural areas and small cities. Working with professional medical organizations to encourage State medical licensing boards to require training.
- Leveraging the connections formed by ODP with pharmacists, pharmacies, and schools of pharmacy to increase their capacity to reach people in rural communities and those who lack access to health care providers.
- Expanding scopes of practice beyond the COVID emergency to allow more providers to offer care, such as pharmacists. (Look for data from California's experience.)
- Overcoming stigma and raising awareness among providers and ensuring that all providers have the education, training, tools, and willingness to provide care.

Other

- Economic empowerment and economic justice for PWH, including expanding the number of PWH in the workforce (e.g., by eliminating unnecessary educational degree requirements and recognizing the value of lived experience); HIV as a racial justice issue.
- All-hands-on-deck model for ending HIV with the same resources, intensity, urgency, and political will that were deployed for the COVID-19 pandemic.

Dr. Wiesman observed that PACHA's resolutions have touched on some of the issues raised, but it is a challenge to learn whether HHS or others acted on the proposals made, what is still needed, and how PACHA can help. It is important to keep pressing for accountability.

Next Steps and Closing Remarks from the PACHA Co-Chairs

Dr. Wiesman said PACHA remains committed to ensuring that members of the public have an opportunity to provide input into its deliberations. To this end, he looked forward to PACHA's restarting its practice of holding meetings around the country in the future.

Mr. Schmid outlined some of the achievements of PACHA during his term as Co-Chair and expressed his pride in all of those who made sure that the needs of the HIV community were met during the COVID pandemic. He thanked PACHA members and Ms. Hayes and Caroline Talev, M.P.A., for their outstanding support of PACHA. He also thanked the Federal partners for their tireless work toward a shared goal of ending HIV.

Ms. McNeese expressed her appreciation for being appointed to PACHA and hopes to make the most of the opportunity. She looks forward to a productive, dynamic future with PACHA. Dr. Wiesman noted that Dr. Schwartz will complete his term on PACHA in September, and he thanked Dr. Schwartz for his leadership, passion, and perspective. Ms. Hayes thanked her colleagues at OIDP (Ms. Talev and Emily Downes) for their contributions and also the consultants who support PACHA: audio engineer Ramon Reyes and meeting reporter Dana Trevas. She appreciated those members of the public who gave comments. The meeting adjourned at 4:48 p.m.

Appendix A: Written Public Comments

From: Joseph Varisco <joseph.varisco@gmail.com> [1] **Sent:** Wednesday, August 11, 2021 3:29 PM [1] **To:** Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov> [1] **Subject:** Fwd: Gilead funding opportunities: RFPs for HIV Age Positively and TRANScend initiatives

Dear PACHA,

I am writing to share the below information on Gilead's HIV Aging Positively initiative. One of the largest issues facing my HIV+ kin, and a community I will soon be part of in age, is the 50% of those living with HIV today are 50+ and within just two more years that will be closer to 75%. Healthcare systems, long term living centers, and other social and policy driven orgs focused on HIV have a major challenge ahead.

Fortunately, in my prior work via QIO: HIV Impact Education and as HIV & Aging Policy Action Coalition (HAPAC) Director (prior to COVID layoffs) I have had extensive experience in the both development of policy proposals, education/awareness campaigns, and the completion of a white paper study revealing the most up to date data on these demographics (see attached), which Aisha and Mike and speak further to supporting some of our efforts.

What I am proposing is to write the RFP myself or in conjunction with someone from your development team if available. I have successfully written, applied, and received over 1.5 million in grants and funding partnerships as well as all the additional responsibilities on reporting, collecting, materials, documentation, measuring goals, etc. Furthermore the variety of policy proposals that could become useful templates as maps for other states across the country and potentially nationally is primed, specifically when focusing on the Ryan White Planning Council membership and ensuring representation of key stake-holding populations are present and supported with advocacy toolkits.

Please feel free to reach out if you would like to discuss this further. My hope would be to fill out, apply, and work with a team on this initiative as opposed to QIO: HIV Impact Education doing so independently.

In Solidarity,

Joseph Varisco [1] Program Director

QIO: HIV Impact Education

T: 630.362.2893 [1] Pronouns: He/Him

----- Forwarded message -----^[1]From: **Gilead Corporate Grants**
<Grants@gilead.com>^[1]Date: Wed, Jul 28, 2021 at 4:05 PM^[1]Subject: Gilead funding
opportunities: RFPs for HIV Age Positively and TRANScend initiatives^[1]To:

July 28, 2021

Dear Community—

As part of Gilead’s commitment to ending the epidemic, we have invested in the development of two strategic initiatives to empower people living with and affected by HIV. Gilead HIV Age Positively® supports programs focused on improving the quality of life for those who are aging while living with or affected by HIV. Gilead TRANScend® provides direct grants and capacity-building assistance to trans and non-binary-led organizations. Informed by lessons learned from Phase 1 of each of these strategic initiatives, Gilead is delighted to announce two new funding opportunity announcements attached to this email.

HIV Age Positively Building on the successes from Gilead’s initial three-year investment at the intersection of HIV and aging through the HIV Age Positively initiative, we seek to support the continued development of supportive services and coordinated healthcare that meets the needs of aging people living with and affected by HIV. Older people living with HIV include long-term survivors, people who have lived with HIV for many years, some since the pre-HAART era, as well as newly diagnosed people aged 50 and older.

TRANScend A significant percentage of people living with and affected by HIV are people of trans and non-binary experience. As a company, Gilead is committed to working with the transgender and non-binary community in the fight against HIV/AIDS. We believe that all people should have access to quality healthcare, regardless of their gender identity, and seek to support communities that experience obstacles to care.

Key dates are listed in each request for proposals (RFP). We look forward to reviewing your proposals and announcing the next round of grantees later this year.

Please forward these RFPs and announcements to your networks.

Korab Zuka
Vice President, Public Affairs
Gilead Sciences

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Gilead HIV Age Positively[®] Organizing Center

Letter of Intent

Overview

Through the HIV Age Positively funding opportunity, Gilead seeks to establish the HIV Age Positively Collaborative (2022-2024) comprised of one Organizing Center and up to 24 Collaborative Member organizations. The Organizing Center will convene a Community Advisory Board (CAB). This collaborative will address the challenges and advance opportunities for aging people living with and affected by HIV through regular virtual meetings for shared learning opportunities, highlighting individual HIV and Aging program updates, providing feedback on members' program elements, discussing emerging issues, and sharing templates, resources, and best practices.

Eligibility Requirements

Organizations that meet the following requirements are eligible to apply for funding under this request for proposals:

1. Nonprofit status: IRS determination letter confirming current 501(c)3 tax status
2. Proven track record of sound financial stewardship and ability to deliver impactful programming
3. Institutional infrastructure, including administrative capacities
4. Core content expertise and a strong grounding in existing data and methodologies
5. Knowledge of social change approaches
6. Strong network and partnership capacity and ability to collaborate effectively
7. Ability to identify leverage points for action and broaden stakeholder base

In addition to the above, organizations applying for the Organizing Center role will have:

8. Demonstrated ability to engage a diverse membership and build community toward a common goal
9. Experience engaging and maintaining an active CAB that is inclusive and diverse
10. Experience in the field of HIV and social determinants of health
11. Management capacity and key staff credentials
12. Success in development, replication or expansion of successful approaches to convening a diverse, national collaborative
13. Strong communications and outreach strategies to reach the community as well as to educate decision makers at the state and federal level

Grant Award

14. The Organizing Center will be awarded up to \$1,500,000 with a grant period of three years and two months, November 1, 2021-December 31, 2024

How to Apply

- Please fill out the LOI by answering the 5 questions below. The fully completed LOI must be submitted to grants@gilead.com. If you have any questions about the process, please email grants@gilead.com. Kindly include "HIV Age Positively LOI" in the subject line of your email.

Key Dates and Deadlines

15. Deadline to submit LOI: August 6, 2021
16. Response from Gilead on LOI: August 12, 2021
17. Full Proposal for Qualifying Organizations due to Gilead: September 8, 2021
18. Response from Gilead on Full Proposals: October 31, 2021

Section A	Applying Organization Information
Organization Name	
Point of Contact Name and Title	
Tax ID Number	
Address	
Website	
Telephone	
Email	
Is your organization an existing grantee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your organization applied for or received funding from Gilead in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section B	Request
Program Title	
Amount Requested From Gilead	
Total Annual Organizational Budget	

Section C	Overview of Technical Assistance Plan
1. Provide a brief overview of your organization, including your mission and vision.	
2. Describe your capacity for engaging a diverse membership and building community toward a common goal.	

3. Share an assessment of your level of readiness to take on this effort, i.e. readiness of your leadership team, your staff and your board.

4. Outline your experience with and approaches to intersectional engagement.

5. Provide any other information you think will be helpful for us to know.

Acknowledgment of Terms

Please read each term below and check the corresponding box if you agree to the term.

- ☐ If grant-awarded by Gilead, we will ensure that all activity in connection with the project/funding is compliant with laws/regulations and any applicable Code of Practice.
- ☐ For the avoidance of doubt, we understand that the receipt of a grant shall impose no obligation upon the Grantee to promote or otherwise encourage the prescription, recommendation, purchase, supply, sale or administration of the products of Gilead or its affiliates.
- ☐ We understand that any provisional offer of grant funding by Gilead is subject to a contractual agreement setting out the terms of such funding; the contractual agreement must be signed and returned to Gilead before the commencement of any grant-funded activities; we must abide by the stipulations of the grant or donation outlined in the contractual agreement.
- ☐ If grant-awarded by Gilead, we agree to disclose the source of funding on all project-specific materials and, if applicable, the organization website.
- ☐ We understand that Gilead may disclose the provision of this grant or donation via its website and that the disclosure may include the following information: the name of the organization, a brief description of the activity and/or the amount of money provided.

By entering my name below, I hereby certify that the above statements are true and correct to the best of my knowledge.

Name & Title

Date

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HIV⁺AGE[®]
P O S I T I V E L Y

2021 United States Funding Opportunity Announcement by Gilead Sciences, Inc.

BACKGROUND

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer. Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California.

As part of our commitment to end the epidemic, Gilead supports community-led programs for people living with and affected by HIV to improve access to healthcare, reduce health barriers encountered by underserved populations, advance disease education, and support local communities. Importantly, addressing social determinants of health such as stigma, social factors and systemic barriers is vital to improving engagement in the care continuum.

Building on the successes from Gilead's initial three-year investment in HIV and aging through the Gilead HIV Age Positively[®] initiative, we seek to support the continued development of supportive services and coordinated healthcare that meets the needs of aging people living with and affected by HIV. Older people living with HIV include long term survivors, people who have lived with HIV for many years, some since the pre- HAART era, as well as newly diagnosed people aged 50 and older.

With numerous scientific advances and therapeutic options, those living with HIV who are on effective treatments can expect a median life expectancy of more than 70 years of age. In 2018, over 50% of people living with HIV in the United States were aged 50 and older, an increasing number living into their 70's and beyond. As people living with HIV live longer, they not only face the expected challenges associated with the natural aging process but may also experience significant challenges decades before their peers not living with HIV.

People aged 50 and older accounted for 17% of new HIV diagnosis in 2018. Being newly diagnosed with HIV after the age of 50 has complications unique to the aging population.

Just as the field of HIV has led the way in community-informed integrated and coordinated care models, there is an opportunity to apply these lessons learned to how people living with and affected by HIV want to grow old. With a focus on healthy aging, improving health outcomes and quality of life, Gilead aims to support creating the systems people living with HIV and affected by HIV want to age into. As the majority of people living with HIV are now aged 50 and older it is critical to address isolation, stigma and trauma as part of the coordinated care and policy agenda for aging older adults. Gilead believes a sustained focus on improving systems, informed by affected individuals and communities, will lead to supportive care for older people living with and affected by HIV.

PROGRAM AND PURPOSE

Gilead supports advocacy organizations, community organizations and healthcare entities around the world that work to empower people and improve lives. Through HIV Age Positively, Gilead will support organizations to participate in the HIV Age Positively Collaborative (2022-2024) to address the challenges and advance opportunities for aging people living with and affected by HIV through the development of social programs and policies that help aging people with HIV. Specifically, Gilead will support an Organizing Center and Collaborative Member organizations as part of the HIV Age Positively Collaborative.

19. Option A – Organizing Center: Selection of an Organizing Center to virtually convene a community advisory board (CAB) and collaborative-wide discussions on emerging issues, learning opportunities, processes for feedback on program elements, and dissemination of templates, resources and best practices created by collaborative members
20. Option B – Collaborative Member Grantee: Identify and support up to 24 diverse organizations with direct grants to participate in the HIV Age Positively Collaborative based on their programmatic work in two areas: Policy & Advocacy, Care & Wellbeing

The key goals of this current funding opportunity are to identify and evaluate potential programs and interventions in the following areas:

Policy & Advocacy

To realize accessible supportive services, coordinated systems of care, and a healthcare system that is meeting the needs of older people living with and affected by HIV, policy and advocacy are needed at the local, state, and national level. Potential projects may include a wide range of policy proposals and advocacy efforts to increase access and engagement for older people living with HIV ultimately increasing their overall health and well-being. Lessons learned from Phase 1 of HIV Age Positively included needs for programs and services to:

21. Create systems change within and without the HIV field toward a coordinated care model (policy work to ensure people living with HIV can access older-adults services at younger ages, coordination between HIV and aging programs at the local, state and federal level; supporting HIV and LGBTQ+ competency

- standards for aging services including nursing home and assisted living services)
22. Advocacy for the development and scaling of combinations of HIV-specific and older-adult (inclusive of people living with HIV) care
 23. Train and support a diverse community of policy advocates to take action to support aging people living with and affected by HIV
 24. Expand knowledge of and access to local, state and federal public aging programs
 25. Focus on expanding HIV-specific services for older adults and bridging with aging-specific services at the local, state, and national level
 26. Expand policy and funding to bolster financial security and access to public benefits including housing, mental health services, and substance use services
 27. Identify opportunities to develop strategic coalitions to implement an HIV and aging policy agenda at the local, state, and national level.
 28. Advocate for aging-specific services within HIV programming at the local, state and federal level including Ryan White and EHE
 29. Advocate for HIV-inclusive and aging-specific services at the federal level including maintaining Medicare Part D drug access protections across the Six Protected Classes and expand focus on high-quality care and quality of life

Care & Wellbeing

To realize social and health care services that meet the needs of older people living with and affected by HIV, potential projects may include: 1) person-centered training and tools to empower individuals to be their own advocates, 2) person-centered clinic and clinic- adjacent services, in person, online, and hybrid approaches to address difficulties older people may face with distributed healthcare and to help bridge the digital divide for older people 3) increase accessibility and effectively scale proven models of coordinated care and wellbeing services. Lessons learned from Phase 1 of HIV Age Positively included needs for programs and services to:

30. Scale proven models of coordinated personal health & health care, including managing complex conditions and co-morbidities
31. Train and equip the clinical and non-clinical workforce, including navigation services, to provide culturally competent and trauma-informed care for aging people living with and affected by HIV
32. Combinations of clinic-based and community based organization (CBO)-based, personal health and health care adjacent programs and services addressing isolation, stigma, and trauma
33. Scaling and replicating person-centered training and tools for self-management and those that advance access to supportive personal and health care services, including sexual and reproductive health
34. Develop in person, online and hybrid approaches, including leveraging technology, support and training for staff and participants, to overcome barriers to technology access
35. Vision beyond the HIV field with a systems approach making connection with adjacent services in aging, trauma-informed care, mental health, and wellbeing

The funding may not be used to build capacity to directly provide, facilitate, or expand, e.g. paying capital costs for treatment facilities, space refurbishment, medical equipment and supplies, medical expenses, medications, personnel, healthcare professional or allied healthcare professional compensation support, laboratory fees, or other costs of providing medical care.

Organizations interested in applying for funding under this initiative may only apply for funding under Option A or Option B, described above.

ROLES AND RESPONSIBILITIES

Organizing Center

The Organizing Center will be a direct grantee of Gilead and will be responsible for convening a CAB to support grantees' program development. The Organizing Center will be responsible for convening the Collaborative for regular virtual learning opportunities, processes for feedback on program elements, discussions on emerging issues, and disseminating templates, resources and best practices created by collaborative members.

Collaborative Member Grantee

Direct service grants will be awarded to a diverse cohort of organizations to actively participate in the HIV Age Positively Collaborative. Grantees will implement a wide range of programs to advance access to coordinated care and a robust policy agenda for aging and older adults affected by HIV. Collaborative Members will benefit together from the CAB and are expected to actively participate in virtual convenings through regular attendance and sharing learnings, resources, and best practices with the collaborative.

ELIGIBILITY CRITERIA

General qualifications for applicant organizations include:

- Nonprofit status: IRS determination letter confirming current 501(c)3 tax status
- Submission of previous two (2) fiscal years operating budget
- Submission of previous two (2) IRS 990 forms
- Letters of support from three (3) organizations or community members
- Proven track record of sound financial stewardship and ability to deliver impactful programming
- Institutional infrastructure, including administrative capacities
- Core content expertise and a strong grounding in existing data and methodologies
- Knowledge of social change approaches
- Strong network and partnership capacity and ability to collaborate effectively
- Ability to identify leverage points for action and broaden stakeholder base

Key capabilities required for organizations applying for the Organizing Center role:

- Demonstrated ability to engage a diverse membership and build community toward a common goal
- Experience engaging and maintaining an active CAB that is inclusive and diverse
- Experience in the field of HIV and social determinants of health
- Management capacity and key staff credentials
- Success in development, replication or expansion of successful approaches to convening a diverse, national collaborative
- Strong communications and outreach strategies to reach the community as well as to educate decision makers at the state and federal level

SELECTION CRITERIA

An organization may only apply to one of the options under this initiative. Successful proposals will clearly reflect:

- An investment in purposefully intersectional approaches to the work: racial justice, disability justice, elder justice, gender justice, economic justice, intergenerational work and other intersectional approaches to health equity work
- An emphasis on Black-led and non-Black people of color led organizations and programming
- A demonstrated commitment to organizational antiracism work with outcomes to advance and increase BIPOC leadership
- An understanding of the state of the field, and how the proposed approach can make a unique and important contribution to aging people living with and affected by HIV
- Clear program logic and a timely approach to address an identified unmet need
- Staff expertise and experience in line with project scope and the HIV Age Positively Collaborative goals
- Robust dissemination plan to share learning from grant-funded activities
- A demonstrated commitment to actively participate in the HIV Age Positively Collaborative
- Original, innovative ideas and proven excellence in program development and implementation

Key principles to guide the work of the HIV Age Positively Collaborative:

- **Racism is a public health crisis.** To achieve health equity we reckon with racism at the individual, organizational, and institutional level.
- **Meaningful involvement of community is essential.** Progress is made through hiring, promoting, involving impacted communities.
- **Leverage existing models of intervention and success.** Replicate and adapt existing models of intervention or best practices.
- **Innovation must lead to impact.** Innovation is most meaningful if it provides tangible, replicable solutions to real problems.
- **We are stronger together.** We convene to amplify each other and our collective work through increased engagement for shared learning, relationship building and collective storytelling.

EVALUATION AND REPORTING

Grantee organizations will be required to submit narrative and financial reports to Gilead for the purposes of monitoring progress toward project goals and ensuring budget adherence. Through both the reporting

process and related data collection, Gilead hopes to create opportunities to learn from both the successes and challenges faced by grantees and to assess ways to increase the impact of future programs.

Gilead may engage a third-party evaluation committee to provide formative evaluation elements to allow for course corrections as necessary with the goal of continuous improvement.

USE OF GRANT FUNDS

Gilead funding may be used for:

- Planning and demonstration projects
- Replication or expansion of successful interventions
- Policy and statistical analysis in line with programmatic goals
- Strategic communications, including education
- Community engagement and coalition-building
- Program research and evaluation

Gilead funding cannot support:

- Medications or purchasing of medications
- Direct medical expenses, including labs
- Existing deficits
- Basic biomedical research, Gilead-sponsored clinical research or clinical trials
- Projects that directly influence or advance Gilead's business, including purchase, utilization, prescribing, formulary position, pricing, reimbursement, referral, recommendation or payment for products
- Individuals, individual health care providers or physician group practices
- Events or programs that have already occurred
- Government lobbying activities
- Organizations that discriminate based on race, color, gender, religion, disability, sexual orientation, or gender identity or expression

HOW TO APPLY

Solicited grant proposals must be submitted online; the application can be found at <http://www.gilead.com/responsibility/corporate-contributions/north-america/how-to-apply>.

When submitting your application, please select community/patient as the grant type, include "HIV Age Positively" in your program title, and check the program tag "HIV Age Positively."

GRANT AWARDS

Organizing Center

The Organizing Center is eligible to apply for a maximum of \$1,500,000 for the period of three years and two months. Budget requests should be proportional to program scope and reflect reasonable, good faith estimates of the true operational costs related to the proposed project. Indirect costs of 10% may be requested on top of direct program costs (see appendix A to learn more about Gilead's indirect cost policy).

Collaborative Member Grantee

Collaborative Member awards to organizations will range between \$100,000 and \$700,000, with a grant period of 1-3 years. Budget should be based on actual program need and the reasonableness of proposed budgets relative to the program scope and impact will be a factor in final awards. Indirect costs of 10% may be requested on top of direct program costs (see appendix A to learn more about Gilead's indirect cost policy). Applicants may allocate up to 10% of the grant award outside of indirect cost to engage an independent program evaluator to conduct program evaluation.

KEY DATES & DEADLINES

Organizing Center

Letter of Intent due: August 6, 2021

Invitations for Organizing Center Applications sent: August 12, 2021
Deadline to submit grant proposals: September 8, 2021

Intent to fund announcement by: October 31, 2021
Organizing Center Grant period begins: November 1, 2021
Mid-year reports due: July 31, 2022

Grants end: December 31, 2024

Collaborative Member Grantee

Deadline to submit grant proposals: September 1, 2021
Intent to fund announcement by: October 31, 2021
Grant begins: January 1, 2022

Mid-year reports due: July 31, 2022

Grants end: December 31, 2024

INQUIRIES

Questions related to this Funding Opportunity Announcement should be directed to Shannon Weber at shannon.weber2@gilead.com. Please include "HIV Age Positively RFP" in the subject line.

DISCLAIMER STATEMENT

- Gilead reserves the right to approve or disapprove any application for any reason in its sole discretion.
- Award of a grant in any one cycle does not imply that a subsequent grant will be awarded without further application and approval.
- Application to the Corporate Grants program is not a promise of funding.

ABOUT GILEAD SCIENCES

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer.

For more than 30 years, Gilead has been a leading innovator in the field of HIV, driving advances in treatment, prevention and cure research. Gilead is committed to continued scientific innovation to provide solutions for the evolving needs of people affected by HIV around the world. The company also aims to improve education, expand access and address barriers to care, with the goal of ending the HIV epidemic for everyone, everywhere.

Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California.

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APPENDIX A - Indirect Cost Guidelines

Indirect costs are overhead expenses incurred by the applicant organization as a result of the project but that are not easily identified with the specific project. Generally, indirect costs are defined as administrative or other expenses that are not directly allocable to a particular activity or project; rather they are related to overall general infrastructure operations. Indirect costs are sometimes referred to as “overhead costs” and more recently by the government as “facilities and administrative costs.” Examples include executive oversight, accounting, grants management, legal expenses, utilities, technology support, and facility maintenance.

Gilead prefers, whenever possible, that specific allocable costs of an applicant organization's project should be requested and justified in the proposal as direct costs, including those for dedicated ongoing project management, facilities and support (further definitions are provided below).

As a company we seek to fund the actual cost of the proposed project, and to support the efficiency and effectiveness needed for improving the care of people living with life-threatening diseases around the world. Gilead will consider supporting a consolidated indirect cost fee on a case-by-case basis, provided that it constitutes 10% or less of the total proposed project cost.

For the purpose of funding the grants, Gilead has established basic definitions and guidance to be used by our applicants and prospective applicants (see below).

Through our philanthropy and grants programs, Gilead does not match the indirect-cost rates that the federal government may pay to its applicants and contractors. We recognize that this means that our applicants may need to engage in cost-sharing between projects, tap into unrestricted funds, or conduct other fundraising activities to cover unbudgeted operation costs.

Direct and Indirect Cost Definitions

Direct Costs	Indirect Costs
<p>⇒ Salaries of employees directly attributable to the execution of the project</p> <ul style="list-style-type: none"> <input type="checkbox"/> Includes project management <input type="checkbox"/> Includes administrative support solely dedicated to the project <p>⇒ Fringe benefits of employees directly attributable to the execution of the project</p> <ul style="list-style-type: none"> <input type="checkbox"/> Includes project management <input type="checkbox"/> Includes administrative support solely dedicated to the project <p>⇒ Travel for employees directly attributable to the execution of the project</p>	<p>⇒ Facilities not acquired specifically and exclusively for the project (e.g., Foundation, Institute, or University headquarters)</p> <p>⇒ Utilities for facilities not acquired for and not directly attributable to the project</p> <p>⇒ Information technology equipment and support not directly attributable to the project</p> <p>⇒ General administrative support not directly attributable to the project.</p> <p>Examples are as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Executive administrators <input type="checkbox"/> General ledger accounting <input type="checkbox"/> Grants accounting
<p>⇒ Consultants whose work is directly attributable to the execution of the project</p> <p>⇒ Supplies directly attributable to the execution of the project</p> <p>⇒ Sub-awards directly attributable to the execution of the project</p> <p>⇒ Sub-contracts directly attributable to the execution of the project</p> <p>⇒ Equipment acquired for and directly attributable to the execution of the project</p> <p>⇒ Facilities newly acquired and specifically used for the grant project (excludes existing facilities). Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A new field clinic <input type="checkbox"/> New testing laboratories <input type="checkbox"/> Project implementation unit office <p>⇒ Utilities for facilities acquired for and directly attributable to the execution of the project</p> <p>⇒ Information technology acquired for and directly attributable to the execution of the project</p> <p>⇒ Internal legal and or accounting staff and/or external legal counsel or accountants directly attributable to the project</p>	<ul style="list-style-type: none"> ○ General financial management ○ Internal audit function ○ IT support personnel ○ Facilities support personnel ○ Scientific support functions (not attributable to the project) ○ Environment health and safety personnel ○ Human resources ○ Library & information support ○ Shared procurement resources ○ General logistics support ○ Material management ○ Executive management ○ Other shared resources not directly attributable to the project ○ Institutional legal support ○ Research management costs <p>⇒ Depreciation on equipment</p> <p>⇒ Insurance not directly attributable to a given project</p>



2021 United States Funding Opportunity Announcement by Gilead Sciences, Inc.

BACKGROUND

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer. Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California.

As part of our commitment to end the epidemic, Gilead supports community-led programs for people living with and affected by HIV to improve access to healthcare, reduce health barriers encountered by underserved populations, advance disease education, and support local communities. Importantly, addressing social determinants of health such as stigma, social factors and systemic barriers is vital to improving engagement in the care continuum. As a company, Gilead is committed to working with the transgender and non-binary community in the fight against HIV/AIDS. We believe that all people should have access to quality healthcare, regardless of their gender identity, and seek to support communities that experience obstacles to care.

Despite the ongoing efforts of Gilead and many others in the HIV/AIDS field, it remains clear that HIV continues to disproportionately affect the non-binary and transgender community. The Centers for Disease Control and Prevention (CDC) estimates that 14% of all transgender women are living with HIV, with Black and Latina trans women disproportionately impacted. Social determinants of health increase non-binary and transgender people's vulnerability to HIV, including social rejection and stigma, inadequate access to competent care, high rates of intimate partner violence, and barriers to accessing employment, education and housing.

Gilead has been working closely with community leaders, advocates and healthcare providers across the United States for years to more fully address the most important needs among the non-binary and transgender community. Earlier this year, all fifteen Phase 1 TRANScend grantees convened to discuss Phase 1 successes and challenges.

Grantees focused on identifying strategies and providing recommendations to improve the health and wellness of transgender and non-binary communities for the planning of Phase 2.

The Phase 1 TRANScend grantee's recommendations were key to the development of this funding opportunity announcement. The grantees included Black, Indigenous, People of Color trans and non-binary-led organizations who provide direct services, advocacy and capacity building to transgender and non-binary organizations and communities. These grantees provided key recommendations on prioritizing funding for trans and non-binary-led organizations as well as the needs of these organizations to increase sustainability.

PROGRAM AND PURPOSE

Gilead supports advocacy organizations, community organizations and healthcare entities around the world that work to empower people and improve lives. Through TRANScend, Gilead will support trans and non-binary-led organizations that are working to improve the safety, health and wellness of the community.

Specifically, Gilead will support strategic program development, capacity building and implementation of direct service initiatives bolstered by strong community engagement efforts to build and sustain progress in reducing the impact of HIV within non-binary and transgender communities.

Funding will be provided through three distinct programmatic areas:

36. Option A – Grantmaking Organization: Selection of a lead philanthropic organization for regranting funds to a select number of grassroots organizations with total budgets of less than two hundred fifty thousand dollars (\$250,000) per year

37. Option B – Capacity Building Grantee: Selection of an intermediary organization to provide training and technical assistance services and capacity building support for trans and non-binary-led organizations

38. Option C – Direct Services Grantee: A limited number of direct grants to organizations with annual budgets that are two hundred fifty thousand dollars (\$250,000) or more

The funding may not be used to build capacity to directly provide, facilitate, or expand medical care, e.g. paying capital costs for treatment facilities, space refurbishment, medical equipment and supplies, medical expenses, medications, personnel, healthcare professional or allied healthcare professional compensation support, laboratory fees, or other costs of providing medical care.

Organizations interested in applying for funding under this initiative may only apply for funding under one of the above options.

ROLES AND RESPONSIBILITIES

Grantmaking Organization

The Grantmaking Organization will be a direct grantee of Gilead and will be responsible for developing a grants program that seeks to address the disproportionate impact of HIV within non-binary and transgender communities with a specific focus on supporting grassroots organizations with operating budgets that are less than two hundred fifty thousand dollars (\$250,000) per year.

Potential programs for funding include:

- Programs that address social determinants that have a direct impact on health outcomes
- Rapid response programs that address urgent or emergency needs
- Trauma-informed approaches that address substance use, mental health and wellness
- Community re-entry or navigation services that assist non-binary and trans-identified individuals post incarceration

- Professional development, education, and workforce training programs
- General operating grant support for grassroots trans and non-binary-led organizations that have the capacity or strong potential to implement successful programs
- Development of strategic coalitions with other trans and non-binary-led organizations to amplify advocacy and policy efforts

The Grantmaking Organization will be eligible to apply for a maximum of one million dollars (\$1,000,000) over the two-year grant period and is expected to make between 10 and 15 sub-grants to eligible organizations.

Grantmaking Organization's Roles and Responsibilities:

- ☐ Direct grantee of Gilead, provide routine reports on grant progress, impact and fiscal oversight of grant funding
- ☐ Develops governance structure to manage the grants application and selection process
- ☐ Develops operating plans and administrative procedures to efficiently and effectively manage the grant-making program
- ☐ Central grants management role in identifying strong grassroots non-binary and trans-led organizations to serve as sub-grantees, as well as administering and monitoring the grants to these organizations

Capacity Building Grantee

The Capacity Building Grantee will be a direct grantee of Gilead and will be responsible for providing capacity building to non-binary and trans-led organizations who request capacity building to increase their impact and sustainability via training and technical assistance, regardless of the organization's funding source. The Capacity Building Grantee is eligible to apply for a maximum of one million dollars (\$1,000,000) over the two-year grant period.

The Capacity Building Grantee will work with organizations to identify training needs that will increase impact and sustainability. In addition to training and technical assistance, the Capacity Building Grantee will identify opportunities to develop coalitions among non-binary and trans-led organizations as well as provide opportunities to share knowledge. The Capacity Building Grantee will develop a suite of trainings based on the needs of the organizations.

The Capacity Building Grantee will develop trainings in collaboration with the Grantmaking Organization and direct grantee organizations to ensure organizational sustainability.

Potential capacity building trainings include:

- ☐ Organizational Management & Sustainability Training
 - Leadership and staff development
 - Data management tracking and analysis
 - Human resources management
 - Fiscal management
 - Organizational and infrastructure development
- ☐ Program Management & Implementation Training
 - Program development and management
 - Trauma-informed approaches

- Program evaluation
- Knowledge sharing across trans and non-binary-led

organizationsCapacity Building Grantee's Roles and Responsibilities:

- ❑ Direct grantee of Gilead, reporting to Gilead on program progress, impact and fiscal oversight of grant funding
- ❑ Develops, in collaboration with the Grantmaking Organization and directly fundedgrantees described in the section below, training and technical assistance programs to ensure organizational sustainability
- ❑ Develops internal operating and administrative procedures to efficiently and effectively manage the work as the Capacity Building Grantee
- ❑ Critical training role assisting in the development of training plans for non-binary and trans-led organizations, featuring both leadership and program management training

Direct Service Grantees

Gilead will provide a limited number of direct grants to non-binary and trans-led organizations that have operating budgets greater than two hundred fifty thousand dollars(\$250,000) and have been providing services for at least three years. Direct Service Grantees will implement a wide range of programs to improve the health and well-being of transgender and non-binary communities. Priority will be given to non-binary and trans-led organizations that have a proven track record of providing services in the community.

Direct Service grants will be awarded to a cohort of organizations working to address theHIV burden among non-binary and transgender communities with a specific focus on non-binary and trans-led organizations with operating budgets of two hundred fifty thousand dollars (\$250,000) and above per year.

Potential Direct Service Grantee programs include:

- ❑ Programs that address social determinants that have a direct impact on healthoutcomes
 - Trauma-informed supportive services inclusive of mental health, anti-violence, substance abuse and sexual & reproductive health programs
 - Navigation or case management services that may assist across the carecontinuum with a specific focus on re-entry services
- ❑ Professional development and skills building programs for transgender and non-binary communities
 - Leadership development, workforce trainings, and empowerment programs for Transgender communities
- ❑ Emergency housing services for non-binary and trans-identified individuals
- ❑ Community mobilization programs for transgender and non-binary communities
- ❑ Policy and advocacy
 - Identify opportunities to develop strategic coalitions with other non-binary and trans-led organizations to develop a policy agenda for non-binary and transgender communities.

Direct Service Grantees Roles and Responsibilities:

- ☐ Direct grantees of Gilead via TRANScend
- ☐ Lead the development and implementation of strategic programs and services for Transgender communities
- ☐ Evaluate individual organizations program and services for effectiveness and submit findings to Gilead and other TRANScend grantees
- ☐ Attend meetings with capacity building grantee and grantmaking organization quarterly

PROGRAM MANAGEMENT MODEL

Grantee Type	Minimum Operating Budget	Grant Request Maximum	Key Responsibility
Grantmaking Organization	\$1,000,000	\$1,000,000	Re-granting to Trans Organizations
Capacity Building Grantee	\$500,000	\$1,000,000	Trainings & Technical Assistance
Direct Service Grantee	\$250,000	\$200,000	Direct Service Programs

ELIGIBILITY CRITERIA

General qualifications for applicant organizations include:

- ☐ Nonprofit status: IRS determination letter confirming current 501(c)3 tax status
- ☐ Submission of previous two (2) fiscal years operating budget
- ☐ Submission of previous two (2) IRS 990 forms
- ☐ Letters of support from three (3) trans-led organizations or community members
- ☐ Proven track record of sound financial stewardship and ability to deliver impactful programming
- ☐ Institutional infrastructure, including administrative capacities
- ☐ Core content expertise and a strong grounding in existing data and methodologies
- ☐ Knowledge of social change approaches
- ☐ Strong network and partnership capacity and ability to collaborate effectively
- ☐ Ability to identify leverage points for action and broaden stakeholder base

Key capabilities required to operate a complex multiyear program for Grantmaking Organization and Capacity Building Grantee:

- ☐ Experience in the field of HIV and social determinants of health
- ☐ Grantmaking or technical assistance experience with trans and non-binary-led organizations
- ☐ Ability to provide technical assistance to local grantees
- ☐ Track record of soliciting input and participation from local advocates

- ❑ Management capacity and key staff credentials
- ❑ Success in development, replication or expansion of successful approaches to HIVcare, prevention, policy and advocacy
- ❑ Strong communications and outreach strategies to reach the community as well as to educate decision makers at the state and federal level

SELECTION CRITERIA

An organization may only apply to one of the options under this initiative. Successful proposals will clearly reflect:

- ❑ An understanding of the state of the field and how the proposed approach can make a unique and important contribution to decreasing the incidence of HIV within the non-binary and transgender communities
- ❑ Original, innovative ideas and proven excellence in program development and implementation
- ❑ Clear logic to guide governance structure, operating and management plans
- ❑ Staff expertise and experience in line with proposed project scope
- ❑ Appropriate and practical resourcing and budgets with a clear articulation of Grantmaking Organization or Capacity Building Grantee operating budget over two-year grant period, including budgets to support sub-grantee organizations
- ❑ Robust dissemination plan to share learning from grant-funded activities

Key principles to guide the work of the three programmatic areas include:

- ❑ **Racism is a public health crisis**
 - To achieve health equity we reckon with racism at the individual, organizational, and institutional level.
- ❑ **Engage stakeholders and leverage local knowledge**
 - Work with local organizations within the transgender and non-binary community to sustain and increase the progress reducing HIV incidence.
 - Assess each organization to determine its level of sophistication, infrastructure, and talent within their organizations. This will inform a tailored set of capacity building needs, training and resources to support local organizations doing work on the ground in the non-binary and transgender communities.
- ❑ **Leverage existing models of intervention and success**
 - Often, what communities need most is replication or adaptation of existing models of intervention or best practices.
- ❑ **Evidence-based solutions**
 - Support evidence-based, practical strategies and ideas that have already demonstrated or have the potential to demonstrate real impact in the community.
- ❑ **Data collection, knowledge sharing and convening**
 - Opportunities to share information, best practices and other learnings will be offered to grantees through convening opportunities created by the

Capacity Building Grantee and Grantmaking Organization.

EVALUATION AND REPORTING

Grantee organizations will be required to submit narrative and financial reports to Gilead for the purposes of monitoring progress toward project goals and ensuring budget adherence. Through both the reporting process and related data collection, Gilead hopes to create opportunities to learn from both the successes and challenges faced by grantees and to assess ways to increase the impact of future programs.

Gilead may engage a third-party evaluation committee to include formative evaluation elements to allow for course corrections as necessary with the goal of continuous improvement.

USE OF GRANT FUNDS

Gilead funding may be used for:

- ☐ Replication or expansion of successful interventions
- ☐ Policy and statistical analysis in line with programmatic goals
- ☐ Strategic communications, including education
- ☐ Community engagement and coalition-building
- ☐ Program research and evaluation
- ☐ Re-granting funds to eligible organizations within the non-binary and transgender community

Gilead funding cannot support:

- ☐ Medications or purchasing of medications
- ☐ Direct medical treatment or expenses, including labs
- ☐ Existing deficits
- ☐ Basic biomedical research, Gilead-sponsored clinical research or clinical trials
- ☐ Projects that directly influence or advance Gilead's business, including purchase, utilization, prescribing, formulary position, pricing, reimbursement, referral, recommendation or payment for products
- ☐ Individuals, individual health care providers or physician group practices
- ☐ Events or programs that have already occurred
- ☐ Government lobbying activities
- ☐ Organizations that discriminate on the basis of race, color, gender, religion, disability, sexual orientation, or gender identity or expression

HOW TO APPLY

Grant proposals must be submitted online; the application can be found at <http://www.gilead.com/responsibility/corporate-contributions/north-america/how-to-apply>.

When submitting your application, please select community/patient as the grant type, include "TRANScend" in your program title, and check the program tag "TRANScend."

GRANT AWARDS

- ☐ The grant period for this award will be a two-year grant period.

- ❑ The Grantmaking Organization is eligible to apply for a maximum of one million dollars (\$1,000,000), inclusive of indirect costs at a maximum of 10% (see Appendix A for more information). An expected minimum of 80% will be regranted to grassroots organizations. Budgets should be based on actual program need and the reasonableness of proposed administrative budget relative to grantmaking budget.
- ❑ The Capacity Building Grantee will be eligible to apply for a maximum of one million dollars (\$1,000,000), inclusive of indirect costs at a maximum of 10% (see Appendix A for more information). An expected minimum of 80% will be direct program costs for trainings and convenings. Budgets should be based on actual program need and the reasonableness of proposed administrative budget.
- ❑ Direct Service grantees will be eligible to apply for a maximum of two hundred thousand dollars (\$200,000), inclusive of indirect costs at a maximum of 10% (see Appendix A for more information). Budgets should be based on actual program need and the reasonableness of proposed budgets relative to program scope and impact will be a factor in final awards.

KEY DATES & DEADLINES

- ❑ **Deadline to submit grant proposals: September 1, 2021**
 - ❑ Intent to fund announcement by: October 28, 2021
 - ❑ Grant period begins: January 1, 2022
 - ❑ Mid-year reports due: June 30, 2022

INQUIRIES

Questions related to this Funding Opportunity Announcement should be directed to Diana Oliva at Diana.Oliva@gilead.com. Please include "TRANScend RFP" in the subject line.

DISCLAIMER STATEMENT

- ❑ Gilead reserves the right to approve or disapprove any application for any reason in its sole discretion.
- ❑ Award of a previous Gilead grant does not imply that a subsequent grant will be awarded without further review and approval.
- ❑ Application to the Corporate Grants program is not a promise of funding.

ABOUT GILEAD SCIENCES

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer.

For more than 30 years, Gilead has been a leading innovator in the field of HIV, driving advances in treatment, prevention and cure research. Gilead is committed to continued scientific innovation to provide solutions for the evolving needs of people affected by HIV around the world. The company also aims to

improve education, expand access and address barriers to care, with the goal of ending the HIV epidemic for everyone, everywhere.

Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California.

TRANSCEND, the TRANSCEND Logo, GILEAD and the GILEAD Logo are trademarks of Gilead Sciences, Inc.

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APPENDIX A — Indirect Cost Guidelines

Indirect costs are overhead expenses incurred by the applicant organization as a result of the project but that are not easily identified with the specific project. Generally, indirect costs are defined as administrative or other expenses that are not directly allocable to a particular activity or project; rather, they are related to overall general infrastructure operations. Indirect costs are sometimes referred to as “overhead costs” and more recently by the government as “facilities and administrative costs.” Examples include executive oversight, accounting, grants management, legal expenses, utilities, technology support, and facility maintenance.

Gilead prefers, whenever possible, that specific allocable costs of an applicant organization’s project should be requested and justified in the proposal as direct costs, including those for dedicated ongoing project management, facilities and support (further definitions are provided below).

As a company, we seek to fund the actual cost of the proposed project, and to support the efficiency and effectiveness needed for improving the care of people living with life-threatening diseases around the world. Gilead will consider supporting a consolidated indirect cost fee on a case-by-case basis, provided that it constitutes 10% or less of the total proposed project cost. For the purpose of funding the grants, Gilead has established basic definitions and guidance to be used by our applicants and prospective applicants (see below).

Through our philanthropy and grants programs, Gilead does not match the indirect-cost rates that the federal government may pay to its applicants and contractors. We recognize that this means that our applicants may need to engage in cost-sharing between projects, tap into unrestricted funds, or conduct other fundraising activities to cover unbudgeted operation costs.

Direct & Indirect Cost Definitions

Direct Costs	Indirect Costs
<p>⇒ Salaries of employees directly attributable to the execution of the project</p> <ul style="list-style-type: none"> <input type="checkbox"/> Includes project management <input type="checkbox"/> Includes administrative support solely dedicated to the project <p>⇒ Fringe benefits of employees directly attributable to the execution of the project</p> <ul style="list-style-type: none"> <input type="checkbox"/> Includes project management <input type="checkbox"/> Includes administrative support solely dedicated to the project <p>⇒ Travel for employees directly attributable to the execution of the project</p>	<p>⇒ Facilities not acquired specifically and exclusively for the project (e.g., Foundation, Institute, or University headquarters)</p> <p>⇒ Utilities for facilities not acquired for and not directly attributable to the project</p> <p>⇒ Information technology equipment and support not directly attributable to the project</p> <p>⇒ General administrative support not directly attributable to the project. Examples are as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Executive administrators <input type="checkbox"/> General ledger accounting <input type="checkbox"/> Grants accounting <input type="checkbox"/> General financial management

<p>⇒ Consultants whose work is directly attributable to the execution of the project</p> <p>⇒ Supplies directly attributable to the execution of the project</p> <p>⇒ Sub-awards directly attributable to the execution of the project</p> <p>⇒ Sub-contracts directly attributable to the execution of the project</p> <p>⇒ Equipment acquired for and directly attributable to the execution of the project</p> <p>⇒ Facilities newly acquired and specifically used for the grant project (excludes existing facilities). Examples include:</p> <ul style="list-style-type: none"> ○ A new field clinic ○ New testing laboratories ○ Project implementation unit office <p>⇒ Utilities for facilities acquired for and directly attributable to the execution of the project</p> <p>⇒ Information technology acquired for and directly attributable to the execution of the project</p> <p>⇒ Internal legal and or accounting staff and/or external legal counsel or accountants directly attributable to the project</p>	<ul style="list-style-type: none"> ○ Internal audit function ○ IT support personnel ○ Facilities support personnel ○ Scientific support functions (not attributable to the project) ○ Environment health and safety personnel ○ Human resources ○ Library & information support ○ Shared procurement resources ○ General logistics support ○ Material management ○ Executive management ○ Other shared resources not directly attributable to the project ○ Institutional legal support ○ Research management costs <p>⇒ Depreciation on equipment</p> <p>⇒ Insurance not directly attributable to a given project</p>
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From: jean public <jeanpublic1@gmail.com>

Sent: Sunday, July 11, 2021 6:02 PM

To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>; INFO <INFO@taxpayer.net>; media <media@cagw.org>; INFO@njtaxes.org; info@afphq.org

Subject: Fwd: FIRE FAUCI

public comment on federal register

cut funding for this. the american public has spent far far too many trillions of dollars on this disease, which in fact has a method to get well from it. we do not need to be funding this agency at the very massively high level we have been funding it. i think fauci is misusing this money to get himself out of trouble that is showing up for him with his horrible misuse and mishandling of the covid pandemic that he caused. this comment is for the public record. i want fauci fired. i do not think he is working for the american people. i think he is working for himself. please receipt. jean public jean public1@gmail.com

[Federal Register Volume 86, Number 128 (Thursday, July 8, 2021)]
[Notices]
[Page 36144]
From the Federal Register Online via the Government Publishing Office
[\[www.gpo.gov\]](http://www.gpo.gov)
[FR Doc No: 2021-14496]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the Presidential Advisory Council on HIV/AIDS

AGENCY: Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice of a virtual meeting.

SUMMARY: As stipulated by the Federal Advisory Committee Act, the U.S. Department of Health and Human Service is hereby giving notice that the Presidential Advisory Council on HIV/AIDS (PACHA or the Council) will be holding the 71st full Council meeting utilizing virtual technology on Tuesday, August 3-Wednesday, August 4, 2021 from 1:00-5:00 p.m. (ET) on both days. The meeting will be open to the public; a public comment session will be held during the meeting. Pre-registration is required to provide public comment during the meeting. To pre-register to attend or to provide public comment, please send an email to PACHA@hhs.gov and include your name, organization, and title by close of business Monday, July 26, 2021. If you decide you would like to provide public comment but do not pre-register, you may submit your written statement by emailing PACHA@hhs.gov by close of business Wednesday, August 11, 2021. The meeting agenda will be posted on the PACHA page on HIV.gov at <https://www.hiv.gov/federal-response/pacha/about-pacha> prior to the meeting.

DATES: The meeting will be held on Tuesday, August 3-Wednesday, August 4, 2021 from 1:00-5:00 p.m. (ET) on both days. This meeting will be conducted utilizing virtual technology.

ADDRESSES: Instructions on attending this meeting virtually will be posted one week prior to the meeting at: <https://www.hiv.gov/federal-response/pacha/about-pacha>.

FOR FURTHER INFORMATION CONTACT: Ms. Caroline Talev, MPA, Public Health Analyst, Presidential Advisory Council on HIV/AIDS, 330 C Street SW, Room L609A, Washington, DC 20024; (202) 795-7622 or PACHA@hhs.gov. Additional information can be obtained by accessing the Council's page on the HIV.gov site at www.hiv.gov/pacha.

SUPPLEMENTARY INFORMATION: PACHA was established by Executive Order 12963, dated June 14, 1995, as amended by Executive Order 13009, dated June 14, 1996 and is currently operating under the authority given in Executive Order 13889, dated September 27, 2019. The Council was

established to provide advice, information, and recommendations to the Secretary regarding programs and policies intended to promote effective prevention and care of HIV infection and AIDS. The functions of the Council are solely advisory in nature.

The Council consists of not more than 25 members. Council members are selected from prominent community leaders with particular expertise in, or knowledge of, matters concerning HIV and AIDS, public health, global health, philanthropy, marketing or business, as well as other national leaders held in high esteem from other sectors of society. Council members are appointed by the Secretary or designee, in consultation with the White House.

Dated: June 9, 2021.

Caroline Talev,
Management Analyst, Office of Infectious Disease and HIV/AIDS Policy,
Alternate Designated Federal Officer, Presidential Advisory Council on
HIV/AIDS, Office of the Assistant Secretary for Health, Department of
Health and Human Services.

[FR Doc. 2021-14496 Filed 7-7-21; 8:45 am]

BILLING CODE 4150-43-P

From: Icerm Benefits <icermbenefits@gmail.com>

Date: August 3, 2021 at 8:23:47 AM EDT

To: "Presidential Advisory Council on HIV/AIDS (HHS/OASH)" <PACHA@hhs.gov>

Subject: Re: Signed Charge of Discrimination.pdf Radio Broadcasting (Asl and Vocal) of

This is

But the information that needed to be added

When I cameout transgender and Hiv positive

I was attacked by police and campus security guards , one held me hostage for a total of 29 days the other for about the 10 days, because I had raised questions against their ethics denying people with Hiv and aids from serving in the military which would have generated more then 100 Million dollars to treat emergency surgeries, independent housing, groceries and other personal remedies (excluding cosmetic surgeries such as Botox Or rhinoplasty)

The link to the lawsuit is here

“ Facts

Plaintiff sues Johnson & Wales University, the West Warwick Police Department, Attorney Matthew Parker and Johnson & Wales University Employee Stephanie Dixon. In his Complaint, Plaintiff alleges he was “expelled from College for Handling Narcan” and that he was held against his will in the office of Ms. Dixon, a counselor, who “made fun of [him] calling [him] Manic” and then had him transported to Rhode Island Hospital against his will. (ECF No. 1 at p. 4). He notes that he “Cameout [sic] Trans” and was subsequently “denied Access to the Computer Lab and Classes” and “sexually assaulted while an employee with the University.” Id. He claims that he has been sent “threatening” letters that state he will be “placed in Prison” if he “speaks up.” Id. He states that he is entitled to damages for “Bullying, Intimidation and Risk Factor” and that he was “permanently disabled after being beaten” by several West Warwick Police Officers on November 12, 2019. Id. at p. 6. He further offers that he was “shot at 7 times on Halloween Night.” Id. He seeks to hold Defendants liable. His Complaint contains a series of unrelated statements such as “Eugene is a former Boy Scout of North Kingstown and is considered to be the Only Known Person with an Actual Series of Communications Between Him and the Department of Homeland Security....” Id. at p. 7. He also states, “helpful Tips can be submitted to the FBI who is aware of this case using the name Jeanne Clery Act Violations at +1 401 272 8310.” Id. Attached to his Complaint and filed separately are several documents and emails Plaintiff purports to have filed with the United States Department of Education.”

We need Pacha to issue a charge of discrimination against Johnson and Wales University, Brown University, The Providence Fire Department and The East Providence Police Department as well as Dr.Solomon Carter Fuller Hospital and Framingham District Court since they broke OCR laws by prosecuting someone for filing a complaint (HHS) thus they interfered with the right to exercise Joy;;

https://ecf.rid.uscourts.gov/cgi-bin/show_public_doc?2020cv0335-12

Military Service Neglect *on Tue Oct 13 2020 commented:*

(5)the term “bodily injury” means— (A)a cut, abrasion, bruise, burn, or disfigurement; (B)physical pain; (C)illness; (D)impairment of the function of a bodily member, organ, or mental faculty; or (E)any other injury to the body, no matter how temporary; and (6)the term “corruptly persuades” does not include conduct which would be misleading conduct but for a lack of a state of mind. (b)As used in section 1505, the term “corruptly” means acting with an improper purpose, personally or by influencing another, including making a false or misleading statement, or withholding, concealing, altering, or destroying a document or other information. (c)This chapter does not prohibit or punish the providing of lawful, bona fide, legal representation services in connection with or anticipation of an official proceeding. Complaint as true and has drawn all reasonable inferences in his favor. *Estelle v. Gamble*, 429 U.S. 97 (1976). In addition, this Court has liberally reviewed Plaintiff's allegation

[Reply](#) | [Flag as Offensive](#)

[Clery@Ed.Gov](#) Tips on Tue Oct 13 2020 commented:

[Clery@Ed.Gov](#) / Clery Group Your Specific Concerns Coercing, Approaching the Victim using words such as Defendant or other defamatory comments constitutes as cruel and unusual punishment

Sent from my iPhone

On Aug 2, 2021, at 7:45 PM, Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov> wrote:

For clarification, is the email and attachment your submission for public comment? Thank you.

From: Icerm Benefits <icermbenefits@gmail.com>
Sent: Monday, August 2, 2021 11:23 AM
To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>
Cc: ReportIt@wpri.com; reportfraud@websterbank.com
Subject: Signed Charge of Discrimination.pdf Radio Broadcasting (Asl and Vocal) of

Hello

This information is a signed charge of Discrimination relating to the United States Army and United States Air Force Reserve denying people with Hiv and aids from receiving emergency fema funding, clothes, gift cards and management of a life savings after they stole more then 60,000-120,000 thousand dollars of students loans

Please print this copy for your notes which clearly describes the accounts of what happened accurately, be warned Joe Biden is threatening to Have police, Fire and military use force against protestors by suing them for 50,000 which violates article 10

Article 10 protects **your right to hold your own opinions and to express them freely without government interference**. This includes the right to express your views aloud (for example through public protest and demonstrations) or through: published articles, books or leaflets. television or radio broadcasting.

Www.Patriot1Tech.Com will secure your office

Sent from my iPhone

From: Noah Raper <noahshivstory@gmail.com>
Sent: Tuesday, August 3, 2021 12:33 PM
To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>
Subject: HIV education

Hi,

My name is Noah Raper. I'm 50 years old, have been HIV+ since the age of 21, practically my entire adult life. I am undetectable, have tcells above 1000 and have never had an opportunistic infection. I owe much of my stats to my Dr. Dr Raffanti was my first Dr at age 21 and I feel extremely blessed to have him oversee and advise me on his thoughts on my options to maintain a undetectable viral load.

Education has always been the guiding factor in decision making. My comment/ question is why isn't anyone focusing on the basics of HIV education? Many states have discriminatory HIV laws, many law makers are living with 1980's knowledge of HIV. So many states still label saliva of an HIV+ person to be a deadly pathogen despite saliva not being a mode of transmission. The U=U campaign is an amazing tool and a life changer for someone living with HIV. How can i get a law maker to understand u=u when they believe saliva is a mode of transmission. Many still believe it's a gay disease. The level of ignorance that I've encountered has often left me feeling frustrated and at times down right angry.

August 2014 I was arrested after being assaulted by a family member. When the cops arrived the family member made up a lie and said I spit on them trying to give them AIDS. It was a complete lie but when the cop asked if i had AIDS I began to explain the I'm HIV+ and have never had an aids diagnosis. When i admitted being HIV+ the handcuffs went on and i found myself facing 15 years in prison and required to register as a sex offender.

I was blessed. After posting \$28,500 bail I was connected to an attorney the obtained security video from the mass merchandise store where the assault took place. She was able to prove I never spit on anyone and 7 months later the charges were dismissed and expunged.

If HIV education were common place many of these antiquated laws would have a higher chance of being updated or removed. I know there are many areas of research and new discoveries happening frequently. Commercials on tv advertising HIV meds and briefly mentioning u=u but no one is starting with the basics, how HIV is transmitted.

If y'all opportunities to encourage teaching the basics of HIV it might help make a difference in the overwhelming amount of ignorance surrounding HIV. Who knows, a group of distinguished experts might be the source of information that helps law makers see how many of the HIV laws discourage testing and treatment. It's my understanding a person can't be charged if they don't know their status.

Thank you for your tireless efforts in hopes of seeing a day when HIV is a thing of the past.

Sincerely,

Hi everyone, my name is Eiman Elmileik and I am in my last year of medical school at Michigan State University. I am also currently the HIV Policy Advocate Intern at the AIDS Institute. During my time at the AIDS Institute, I researched the impact of HIV/AIDS on African-born people living in the United States. Through my research I learned that this population may be disproportionately affected by HIV/AIDS.

Issue:

HIV/AIDS surveillance data about African-born people living in the United States.

Background:

The HIV/AIDS data on African-born people living in the US is limited. Many states do not report statistics regarding the prevalence of HIV/AIDS among African born people living in the US. Most states only report data on Black people and do not make the distinction between US-born Black people and African-born Black people. According to data from US Census Bureau, New York, New Jersey, Washington DC, Virginia, Maryland, Minnesota, Texas, Georgia, Massachusetts, Pennsylvania, California, and Washington have the top concentration of African immigrants in the US however, only Washington state and Minnesota report HIV surveillance data about African-born people. Out of all 50 states, Minnesota and Washington state are the only states that report this data.

The Minnesota Department of Health reports that African-born women have the largest prevalence rate of HIV/AIDS in Minnesota. In Washington state, based on 2019 HIV surveillance data, African-born people had the highest incidence of HIV behind, white people and foreign-born Hispanic people. So, in the two states where this data is reported, African-born people are disproportionately affected. There may be other states where African born people are disproportionally impacted but there is not enough data to make this determination.

Recommendation:

Data about African-born people with HIV/AIDS should be included in the HIV/AIDS annual surveillance report by every state who has an African-born population greater than 40,000.

Benefits:

Including African-born people in a state's annual HIV/AIDS surveillance report will:

- Allow for a greater understanding of how this population is impacted by HIV/AIDS and allow us to learn about the disparities that affect them.
- It will also ensure that this population is not neglected
- Allow for the implementation of targeted and culturally sensitive interventions to reduce the incidence of HIV/AIDS among this population

August 11, 2021

Re: Networks of People Living with HIV Public Comment to the Presidential Advisory Council on HIV/AIDS

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

These comments are offered on behalf of the US People Living with HIV Caucus and the undersigned networks of people living with HIV collectively representing tens of thousands of people living with HIV in the United States.¹ As the federal government prepares to release an updated National HIV/AIDS Strategy (NHAS) and considers augmenting the Ending the HIV Epidemic Plan (EHE), we have engaged in an extensive analysis of federal policies and the impact that these policies, and their limitations, have had on people living with HIV in the United States.

Forty years into the HIV epidemic, important advances have been made, but many of the underlying inequities contributing to the ever-increasing social, economic, and political vulnerability of people living with HIV have been inadequately and inconsistently addressed in the national response. People living with HIV still confront deliberate and unwarranted stigma and violence, suffer from social isolation and mental health challenges, face outright criminalization on the basis of our health condition, and cannot access affordable, quality medical care, or life-sustaining essentials such as housing, education, and employment. Importantly and tragically, despite the availability of HIV treatment, far too many people living with HIV are still suffering and dying from preventable causes – whether virally suppressed or not.

As declared during the July 2021 opening panel of the *O'Neill Institute at Georgetown Law's HIV Policy Project Convening on Quality of Care and Quality of Life for People Living with HIV Beyond Viral Suppression*, the national HIV response must include a clear focus on improving and enhancing quality of life for people living with HIV. We assert that the most immediate way to achieve this is by adding a Quality of Life pillar, with commensurate indicators and commitments, to the National HIV/AIDS Strategy and the Ending the HIV Epidemic plan.

As one panelist noted, "We have already lost ground on Quality of Life with the focus on bio-medical benchmarks." This comment supports the people living with HIV community's analysis that there are critical areas, beyond viral suppression, that the federal government must address and act where progress has stalled. We as a nation cannot continue to lose ground.

¹ We are the U.S. People Living with HIV Caucus, Positive Women's Network-USA, SERO Project, National Working Positive Coalition, International Community of Women Living with HIV- North America, Thrive SS, Positively Trans, Reunion Project, and Global Network of People Living with HIV.

While we applaud the federal government's efforts that recognize much more work still needs to be done to end the HIV epidemic in the United States, this work will not be complete without realizing how vital Quality of Life is to the people living with the HIV community. The addition of a fifth pillar to the Ending the Epidemics initiative and fifth goal to the NHAS that addresses the social determinants of health is progress and a step forward to a quality of life desired by all people, including people living with HIV. But we must go one step further and realize that the ultimate recognition of the humanity of people living with HIV is to add a fifth pillar and goal which, once and for

all, states and acknowledges that Quality of Life for people living with HIV in and of its own right is a worthy goal. We deserve explicit support, beyond our viral loads, for the whole health, human rights, dignity and wellbeing of people living with HIV across our life span.

Why is the addition of this fifth pillar and goal important? Many people living with HIV have had to contend not just with HIV but with the ongoing indignities and disrespect of a society that continues to use their fear of HIV and our intersecting identities and circumstances as a battering ram that leaves people living with HIV as a class of societal outcasts. Quality of Life means freedom from intersectional and institutionalized stigma and the attending trauma resulting from this stigma that continues to traumatize and retraumatize us throughout our lives. Quality of life means having the options that support our freedom to exercise agency to choices that support retention in care and viral suppression. Quality of Life is the cart that must come before the medical indicators. Relying solely on biomedical indicators makes it easy to categorize people living with HIV as “patients” or “consumers” rather than first and foremost as people.

Quality of Life happens during and after the social determinants of health have been addressed, enabling us to fully participate as the lead directors of our physical and mental health. How do we get there? The U.S. People Living with HIV Caucus wrote a policy agenda that serves as a road map on addressing the critical issues impeding our Quality of Life. *Demanding Better: An HIV Federal Policy Agenda by People Living with HIV*² makes plain the need for the federal government to commit to improving Quality of Life for people living with HIV by:

1. Creating a minimum standard of care and Quality of Life for people living with HIV and promulgating regulations requiring those providing healthcare to people living with HIV to conform to those standards and monitor and report how these standards are being upheld. Such standards should include mental health and social support indicators in addition to indicators on preventable diseases.
2. Establishing access to online and in-person benefits counseling/advisement for people living with HIV; designing systems to improve the portability of benefits between jurisdictions; and creating programs to train, recruit, and hire people living with HIV into the HIV workforce and other employment opportunities.
3. Fully funding Housing Opportunities for People with AIDS and other federal housing programs; enforcing the Fair Housing Act to address housing discrimination on the basis of HIV status.
4. Requiring federally funded HIV programs to track and address housing for people living with HIV.
5. Improving the Supplemental Nutrition Assistance Program (SNAP) to account for regional differences, increasing overall benefits, continue extensions of work requirements, and reducing administrative burdens for people living with HIV.

² *Demanding Better An HIV Federal Policy Agenda by People Living with HIV*, (June 2021), available at <https://www.pwn-usa.org/wp-content/uploads/2021/07/Networks-Policy-Agenda-FINAL.pdf>.

6. Improving, expanding, and funding access to sexual and reproductive healthcare for people living with HIV, including transition-related care, and monitoring this progress with metrics in the federal HIV response.
7. Funding research and creating accessible guidelines for birthing people living with HIV to breast/chest-feed their children that do not include criminalization.
8. Declaring an immediate moratorium on invasive, nonconsensual HIV surveillance practices such as molecular HIV surveillance until there are consistent, strong, safeguards for such data.

This body of work should be developed in meaningful consultation with networks of people living with HIV. There is much we need to achieve. However, through robust partnership between organized formations of those who are most directly impacted by HIV and policymakers, including the federal government, we can ensure the vision of the NHAS is made real: “The United States will be a place where... every person with HIV has high-quality care and treatment and lives free from stigma and discrimination. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.”

Respectfully submitted,
 US People Living with HIV
 Caucus Positive Women's
 Network-USA Sero Project
 Thrive SS
 National Working Positive
 Coalition MPact
 The Reunion
 Project Ribbon
 NYTAG
 Positively Trans
 HIV Racial Justice Now
 International Community of Women Living with HIV - North America